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TECHNICAL REPORT

Programs Addressing Psychological Health and Traumatic Brain Injury Among U.S. Military Servicemembers and Their Families

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Prepared for the Office of the Secretary of Defense

Center for Military Health Policy Research

A JOINT ENDEAVOR OF RAND HEALTH AND THE RAND NATIONAL DEFENSE RESEARCH INSTITUTE

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Preface

Over the last decade, U.S. military forces have been engaged in extended conflicts that are characterized by increased operational tempo, most notably in Iraq and Afghanistan. While most military personnel cope well across the deployment cycle, many will experience difficulties handling stress at some point, will face psychological health challenges, or will be affected by a traumatic brain injury (TBI). Over the past several years, the Department of Defense (DoD) has implemented numerous programs to support servicemembers and their families in these areas. These programs address various components of biological, psychological, social, spiritual, and holistic influences on psychological health along the resilience, prevention, and treatment continuum and focus on a variety of clinical and nonclinical concerns. In response to this proliferation of programs, the Assistant Secretary of Defense for Health Affairs asked the RAND National Defense Research Institute to develop a comprehensive catalog of existing programs currently sponsored or funded by DoD to address psychological health and TBI.

This report addresses this objective, providing a definition of what constitutes a program, an overview of these programs, and a description of how programs relate to other available resources and care settings. The contents of this report will be of particular interest to national policymakers within DoD and should also be helpful for health policy officials within the U.S. Department of Veterans Affairs (VA). The remaining activities will be documented in reports to be released at later dates.

This research was sponsored by the Assistant Secretary of Defense for Health Affairs and the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) and conducted jointly by RAND Health's Center for Military Health Policy Research and the Forces and Resources Policy Center of the RAND National Defense Research Institute (NDRI). The Center for Military Health Policy Research taps RAND expertise in both defense and health policy to conduct research for the Department of Defense, the Department of Veterans Affairs, and nonprofit organizations. NDRI is a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint Staff, the Unified Combatant Commands, the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community.

For more information on the Center for Military Health Policy Research, see http://www.rand.org/multi/military.html or contact the co-directors (contact information is provided on the web page). For more information on the Forces and Resources Policy Center, see http://www.rand.org/nsrd/ndri/centers/frp.html or contact the director (contact information is provided on the web page).

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Summary

Between 2001 and late 2010, over 2.2 million servicemembers were deployed in support of military operations in Iraq and Afghanistan. Despite the recent drawdown of troops in Iraq, the high operational tempo of the past decade, longer deployments, and frequent redeployments have resulted in significant mental health problems among servicemembers. While most military personnel cope well under these difficult circumstances, many have experienced and will continue to experience difficulties related to post-traumatic stress disorder (PTSD, an anxiety disorder that can develop after direct or indirect exposure to an event or ordeal in which grave physical harm occurred or was threatened) or major depression. Others live with the short- and long-term psychological and cognitive consequences of TBI, an injury that has become increasingly common with the growing use of improvised explosive devices on the battlefield. These issues may also have consequences for military families, as struggles related to PTSD, depression, or TBI may affect marriage and intimate relationships, the well-being of spouses and partners, parenting practices, and children's well-being.

A variety of factors—including increased news coverage regarding the psychological and cognitive consequences of deployment, recommendations resulting from the work of highly visible advisory committees, the expansion of numbers of mental health providers available in military clinical care settings, and the establishment of DCoE—have created significant motivation and momentum for developing programs to support servicemembers and their families. Despite the proliferation of programs and related efforts, an ongoing challenge for DoD is to identify and characterize the scope, nature, and effectiveness of these various and ever-evolving activities. Prior to this report, there has been no full accounting of what programs exist and how these programs complement "traditional" service provision and routine care.

Focus of This Study

The goal of this study is to provide a "snapshot" of all programs currently sponsored or funded by DoD that address psychological health and TBI. In this report, we characterize these programs; identify barriers to implementing them fully and maximizing their effectiveness; and provide recommendations for clarifying the role of programs, examining gaps in routine service delivery that could be filled by programs, and reducing barriers that programs face.

We used a multifaceted approach to identify programs for inclusion in this study. Initially, we sought to identify as many potential programs as possible (e.g., through web and media searches; review of program materials and public domain documents; and consultations with military personnel, nonprofit organizations, and subject matter experts). Then we obtained

information about the potential programs through interviews with program representatives or, when program representatives were not available, through publicly available documentation. We then applied a set of inclusion and exclusion criteria to determine which entities were programs. Our efforts focus on programs that were active during our field period, which began in December 2009 and ended in August 2010. Programs identified after this report was written will be added to the Innovative Practices for Psychological Health and Traumatic Brain Injury online database on the RAND website, located at http://www.rand.org/multi/military/innovative-practices.html, that houses information about each program.

What Is a Program?

In this study, the term *program* is used to describe entities that provide active services, interventions, or other interactive efforts to support psychological health, as well as care for servicemembers (and their families) who are experiencing such problems as PTSD, anxiety, depression, and TBI. Programs are distinct from clinical care services (e.g., mental health services, clinical services for physical health problems) and non–clinical care services (e.g., services provided in chaplaincy or community and family support departments, including other services unrelated to psychological health and/or TBI). The programs that are discussed in this study may be provided within the same facility or organizational structure that provides these other types of services. Programs are also distinct from *resources*, a term that here refers to one-way, passive transmission of information (e.g., a directory that lists services available at an installation).[1] Programs to address psychological health and TBI rely on a strong and growing research base to identify new treatments and best practices. While research projects are explicitly beyond the scope of this study, some research projects include an intervention component that could be classified as a type of program.

In the study, we identified a total of 211 programs. Identifying these programs was a complex task, and one key finding from our work is that no single source within DoD or any of the branches of service maintains a complete listing of programs, tracks the development of new programs, or has appropriate resources in place to direct servicemembers and their families to the full array of programs that best meet their needs. Programs may be initiated in a number of different ways, including centrally by the Office of the Secretary of Defense (OSD), by a branch of service, or based on the interests of a small number of individuals at a single installation, further complicating efforts to identify and track programs over time.

A Typology of Program Activities

To better understand the types of services provided by the programs, we grouped programs based on their mission, goals, and activities to develop a typology that can be used to describe *what programs do*. As a result of these efforts, we identified three broad areas along the prevention, identification, and treatment continuum (Table S.1), each of which is further categorized by two or more specific themes. Together, these encompass 23 key activities in which programs engage. In addition, we describe three more specific areas of focus (Table S.2) that are common

[1] In some cases, it was difficult to identify whether an entity was best classified as a program or a resource.

Table S.1
Typology of Program Activities: Prevention, Identification, and Care for Psychological Health Problems and Traumatic Brain Injury

Area	Theme	Activities
Preventing problems	Reducing the incidence of psychological health problems and TBI	• Improving resilience and the ability to handle stress among members of the military community • Promoting readiness, increasing combat and operational stress control, and preparing for the psychological health consequences of combat
	Employing public health approaches	• Preventing incidents of domestic violence • Preventing incidents of sexual assault • Reducing the risk of substance abuse • Preventing suicide
Identifying individuals in need and connecting them to care	Providing information, connecting individuals to care, and encouraging help-seeking	• Operating a telephone hotline that provides immediate access to counselors and other resources • Serving as an information hub that provides referrals to care • Reducing barriers associated with seeking help for mental health conditions or TBI and/or providing education regarding specific conditions
	Identifying individuals with mental health concerns or TBI	• Conducting routine screening for mental health problems or TBI in the absence of reported symptoms • Increasing the capacity for early identification of mental health problems outside the health care system, with the goal of referring individuals to care when needed
Caring for servicemembers and families in need	Providing or improving clinical services	• Providing comprehensive care for severe or persistent problems among wounded, ill, and injured servicemembers • Improving transitions between care settings and providers, improving coordination and continuity of care, or providing case management • Providing clinical services for mental health concerns, TBI, or other clinical concerns
	Offering mental health services in nontraditional locations to expand access to care	• Embedding mental health providers in primary care or other non–behavioral health clinical settings or other initiatives to improve treatment for mental health conditions in primary care settings • Embedding mental health providers within military units
	Nonclinical activities that provide support	• Training servicemembers to provide peer-to-peer support for improving psychological health • Offering complementary and alternative treatment services to help address the consequences of mental health concerns and TBI • Providing spiritual support
	Responding to incidents of concern	• Responding to incidents of domestic violence • Responding to incidents of sexual assault • Responding to substance abuse problems • Engaging in post-suicide response

to some of the programs included in this report, with eight common key activities.[2] The categories in this typology are not mutually exclusive, and many programs are described by more than one category.

[2] Providing training, education, or support to servicemembers is not included here because it is the default activity for nearly all programs in this report, except those offering similar services to care providers.

Table S.2
Typology of Program Activities: Specific Areas of Program Focus

Theme	Activities
Providing training, education, or support for specific populations	• Providing training, education, or support for health care providers, chaplains, or educators • Providing training, education, or support for military leaders, including officers and noncommissioned officers • Providing training, education, or support for servicemembers' families • Programs that promote psychological health for National Guard, Reserve, or Coast Guard servicemembers
Providing support during times of military transition	• Providing support for servicemembers and their families during transitions between deployment phases • Providing support for servicemembers as they transition to civilian life
Internet-based interventions and the use of new technologies	• Internet-based education or delivery of interventions • Application of new technologies

Program Characteristics

We also characterized the programs according to a variety of topics, including branch of service, targeted participants, approach, scale, and clinical and nonclinical issues addressed, among others.

Branch of Service and Deployment Phase. Each branch of service has a unique set of needs for addressing psychological health services and TBI among its servicemembers. Variation in need is related to the relative size of each service, its operational tempo, the types of activities in which its servicemembers engage, and other services that may be available to support servicemembers and their families. Most programs, regardless of branch of service, focus their efforts on uniformed servicemembers, with some programs offering services to family members and civilian employees. Within each branch of service, more programs are typically offered for active-duty servicemembers than for those in the National Guard or Reserve components. Although some programs focus on a single deployment phase, the large majority of programs address multiple deployment phases or are not related to a deployment phase.

Clinical and Nonclinical Issues Addressed by the Programs. Because multiple mental health issues may occur simultaneously and because TBI is frequently associated with accompanying mental health issues, programs typically address more than one clinical issue. In general, though, fewer programs focus on TBI than on issues associated with psychological health—including depression, PTSD, substance use, suicide prevention, and general psychological health. In terms of nonclinical issues addressed, many programs focus on issues related to families and/or children, resilience, stress reduction, deployment, or postdeployment and reintegration.

Evidence Base. Based on the information reported to us during our interviews, DoD-wide and Army programs are more likely to report that their interventions are evidence based than programs serving the Air Force, Navy, and Marine Corps. We did not assess the strength of the evidence base employed, so it remains possible that these differences reflect varying perceptions of the individuals interviewed. It is also possible that there is differential availability of an adequate evidence base for the particular programs of interest to each of the services. Comparatively few programs—between one-tenth and one-third of programs targeting any branch of service—have had an outcome evaluation in the past 12 months. While more than

three-quarters of all programs that we include in this report collect some process data (such as numbers of program participants or their satisfaction with the program), many fewer collect data on the outcomes of the services they provide.

Barriers to Maximizing the Effectiveness of Programs

Our analysis identified a number of potential barriers that must be addressed in order to maximize program effectiveness.

Information Is Highly Decentralized

During our interviews, a number of program representatives noted that they did not know whether others in the DoD community had similar programs or materials they could borrow or learn from, what approaches other programs had used, and whether other programs had been successful in the past. In part as a result of this lack of sharing of knowledge, programs proliferate without utilizing a centralized evidence base or source for materials. This can lead to significant inefficiencies, such as multiple programs developing teaching points and training materials on the same topic.

Programs Are Developed in Isolation from the Existing Care System

Some programs are designed to encourage the early identification of mental health concerns and to provide appropriate referrals to clinical care where needed. However, relatively few programs are established in partnership with or sustain formal relationships with existing clinical or supportive counseling services, except where such programs are embedded as an inherent part of the existing care system. This lack of linkage and partnership can leave programs without a consistent course of action when follow-up care is needed.

Programs Face Common Barriers

Programs also face many barriers in providing services. The most common barriers mentioned by our interviewees included inadequate funding, resources, or staff capacity; potential concerns about the stigma associated with receiving mental health services, including fear of career repercussions; and inability to have servicemembers spend adequate amounts of time with the program staff and/or materials because of other obligations on the part of participants or providers. Other barriers were mentioned less frequently, including program logistics (such as hours of operation, transportation, and administrative barriers to participation); a lack of awareness among potential participants about the program and/or its services; and the lack of full support from military leadership. Several programs also reported concerns regarding a lack of continuity of care when servicemembers are deployed or undergo a permanent change of station.

Evaluation Is a Challenge

Programs are evaluated infrequently—fewer than one-third of programs in any branch of service reported having had an outcome evaluation in the past 12 months. At the same time, for those programs conducting an evaluation, the rigor of the evaluation may vary in terms of whether it was conducted by an independent party or by program staff, whether it had a con-

trol group, whether it examined both processes (implementation efforts) and outcomes, and the appropriateness of the metrics used.

Recommendations

Based on our interviews with program representatives and the process of identifying these programs, we identified several high-level priorities for DoD:

- Take advantage of programs' unique capacity for supporting prevention, resilience, early identification of symptoms, and help-seeking to meet the psychological health and TBI needs of servicemembers and their families.
- Establish clear and strategic relationships between programs and existing mental health and TBI care delivery systems.
- Examine existing gaps in routine service delivery that could be filled by programs.
- Reduce barriers faced by programs.
- Evaluate and track new and existing programs, and use evidence-based interventions to support program efforts.

Take Advantage of Programs' Unique Capacity for Supporting Prevention, Resilience, Early Identification of Symptoms, and Help-Seeking to Meet the Psychological Health and Traumatic Brain Injury Needs of Servicemembers and Their Families

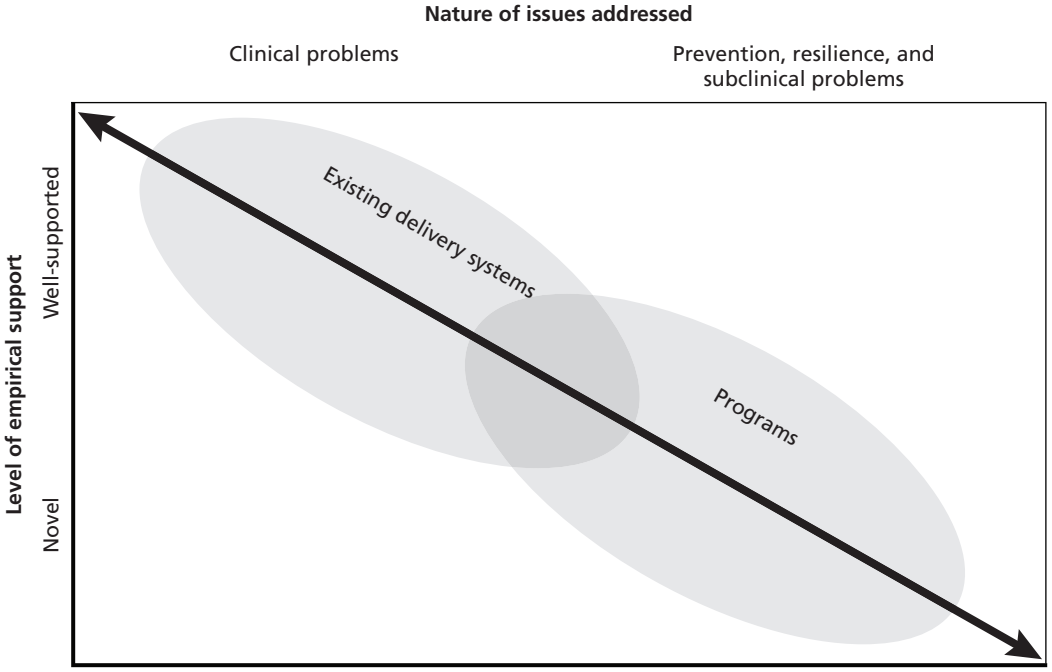
Our work finds a lack of clarity regarding the role of programs and the unique contribution that they can make to addressing psychological health and TBI among members of the military community. This section offers recommendations regarding how to capitalize on the strengths that programs often possess in order to address these issues.

Recommendation 1.1: Develop programs' capacity for early identification, promotion of help-seeking, and referrals to appropriate resources for members of the military community with mental health concerns. Programs can potentially play a unique role in training and education to support early identification of concerns and symptoms, encouraging individuals to seek help, and identifying resources to provide such assistance.

Recommendation 1.2: Programs bring particular strength in focusing on prevention and resilience; this capacity should be further developed. Programs offer opportunities to build skills in these areas among servicemembers and their families. The growth of such programs should emphasize the adoption of evidence-based approaches. At the same time, careful attention should be paid to the messages developed as part of these programs. Overemphasis on resilience may have the unintended consequence of increasing stigma, since individuals with symptoms of psychological health problems may feel that help-seeking is a sign that they are not resilient.

Recommendation 1.3: Programs should serve as testbeds for piloting new and innovative approaches to psychological health and TBI care. Figure S.1 presents an overview of the ideal characteristics of services provided by programs and by the existing delivery system, including clinical care and supportive counseling services. It illustrates where the existing delivery system and programs would each ideally place their primary emphasis. Under this framework, the majority of care provided in existing delivery systems should consist of treatment approaches that are supported by an empirical evidence base, although care in these set-

Figure S.1
Ideal Characteristics of Services Provided by Programs and the Existing Delivery System



tings may also rely in part on treatment approaches that have mixed or less empirical support. Ideally, novel or unproven treatment approaches would be avoided in this setting, except when explicitly part of a clinical trial or other research project with appropriate protections in place for servicemembers and their families who receive such treatment. Programs offer opportunities to test new and innovative approaches for addressing psychological health and TBI and can provide a mechanism for building the evidence base for both clinical care and for nonclinical approaches. With appropriate research and evaluation to demonstrate program effectiveness, a subset of programs may be scaled up for widespread implementation, or program approaches might become part of routine care, when appropriate.

Establish Clear and Strategic Relationships Between Programs and Existing Mental Health and Traumatic Brain Injury Care Delivery Systems

Reliable and accessible lines of communication and established referral processes between programs and existing clinical care systems are essential to ensure that programs can meet their potential to serve as a means of early identification of clinical and subclinical symptoms, to function as testbeds for new and innovative approaches to care, and to address subclinical cases and enable the health care system to focus on those servicemembers with more-severe concerns.

Recommendation 2.1: Programs should complement or supplement existing services. Programs may do so by focusing on subclinical psychological needs, which can divert some of the burden on the clinical care system and supportive counseling services; by focusing on prevention, resilience, and early identification of problems; by embedding mental health providers in nontraditional locations, such as within military units or in primary care settings; or by providing services in coordination with the clinical care system. While there are existing

programs that address subclinical psychological needs and those that embed mental health providers in nontraditional settings, this recommendation is intended to suggest the need for increasing and/or expanding those types of programs.

Recommendation 2.2: Ensure that systems exist to support appropriate handoffs between programs and other settings and that transitions in care are appropriately coordinated. Ensuring appropriate referrals and transitions between providers and care settings is essential for ensuring that servicemembers' and family members' needs for care are met, that their care is continuous and coordinated, and that they transition safely between care providers. This focus on continuity of care is particularly important for programs that are focused on early identification of problems and those that provide limited treatment.

Recommendation 2.3: Track referrals from programs to existing clinical care systems on a continual basis, including the volume of referrals and rates of follow-up on referrals received. Since many programs are designed to help servicemembers and their families identify potential mental health problems in their early phases, it is important to ensure that appropriate resources and follow-up services are available when needed and to understand the extent to which individuals follow through on referrals that are made. For individuals to successfully access follow-up care when referred from programs, there needs to be adequate capacity to provide services in clinical and supportive counseling settings.

Examine Existing Gaps in Routine Service Delivery That Could Be Filled by Programs

Ideally, a report such as this would describe specific gaps in services provided by programs, highlighting content areas, specific populations, and geographic regions where new program development would offer significant benefit. In order to do so, however, we would need information that is not currently available, since few programs begin with a formal needs assessment or an estimation of the numbers of servicemembers and family members in need of assistance. Our recommendations therefore highlight the prerequisite for conducting such a gap analysis: a comprehensive needs assessment.

Recommendation 3.1: Conduct a comprehensive needs assessment designed to identify how many servicemembers and family members are in need of services, what their characteristics are, what types of assistance they need, and where they are located. A formal, comprehensive needs assessment conducted throughout DoD is a fundamental prerequisite for understanding what services are necessary for addressing psychological health and TBI. This needs assessment should establish the magnitude of demand for different types of services, the characteristics of individuals in need, and their geographic locations. This analysis should identify the full range of services needed, including need for clinical services, prevention and resilience training, and nonclinical support services, as well as the magnitude of the existing need. It should also describe the extent to which the routine care system—including clinical services and support services—currently meets those needs.

Recommendation 3.2: Conduct a formal gap analysis to identify how well programs are meeting the identified needs, opportunities that exist to improve current programs, and where need exists to develop new programs. A formal gap analysis would build on the information described in this report to provide an in-depth understanding of the extent to which existing programs meet the needs identified in the needs assessment and where gaps exist that warrant the development of new programs. When appropriate information is available and a gap analysis is feasible, it will be important to integrate the results of individual program evaluations to provide details on what types of programs and approaches work best and have the

greatest likelihood of being expandable, replicable, or appropriately adapted for use in other settings.

Recommendation 3.3: Adopt a single, integrated conceptual framework for psychological health across DoD. Adoption of a single departmentwide conceptual framework would provide significant benefits, reducing the current confusion and ambiguity when attempting to examine psychological health services and programs across the branches of service and allowing programs to be categorized and evaluated consistently.

Reduce Barriers Faced by Programs

We found that programs encountered a number of barriers in the course of their efforts and focused our recommendations on some particularly notable barriers.

Recommendation 4.1: Continue widespread efforts to reduce stigma and institutional barriers associated with seeking treatment for mental health problems and traumatic brain injury. Efforts to reduce the stigma associated with receiving such care among servicemembers must continue. To effectively do so, it may be helpful for training messages within DoD to focus on mental health problems as part of a range of reactions to combat and operational stress, to emphasize help-seeking as an appropriate response, and to avoid setting unrealistically high expectations for resilience. To encourage servicemembers to seek care when needed, it must be evident to them that the career repercussions associated with seeking treatment are limited. There may also be opportunities to modify policy to reduce concerns in this area.

Recommendation 4.2: Improve continuity of services over the course of the deployment cycle and during transitions associated with permanent change of station. For servicemembers or family members participating in a program, continuity of care is important throughout the deployment cycle and across permanent change of station, and programs need a method to ensure such continuity. One model may be transitional coordination and coaching for servicemembers who are participating in programs or receiving clinical or supportive counseling services.

Recommendation 4.3: Improve the sharing of information across programs. One common issue that was raised by program representatives was the lack of information they had about other programs that were attempting to accomplish goals similar to theirs. Recommendations 5.1, 5.2, 5.4, and 5.5 include methods that may help to alleviate this concern.

Evaluate and Track New and Existing Programs, and Use Evidence-Based Interventions to Support Program Efforts

The lack of a process to systematically develop, track, and evaluate programs is likely to result in the proliferation of untested programs that are developed without an evidence base, an inefficient use of resources, and added cost and administrative inefficiencies. Further, it raises the potential that some programs—despite the best intentions of their originators—may cause harm or delay entry into the system of care, and that such harm would not be identified in a systematic or timely fashion.

Recommendation 5.1: The evidence base regarding program effectiveness needs to be developed. Existing programs and those under consideration for future development should be required to embed an ongoing evaluation in their efforts that addresses at least four key questions: (1) What works well? (2) What are the unanticipated consequences of the program? (3) What are the opportunities for improvement? (4) What lessons were learned during program implementation that can affect the successful transferability of the program to new organiza-

tions or locations? Where possible and appropriate, evaluations that contribute to this evidence base should draw from a common set of measures to allow for comparability across programs.

Recommendation 5.2: The evidence base regarding program effectiveness needs to be centralized and made accessible across DoD. New programs should be built on the existing evidence base wherever possible and should focus on one of three approaches: (1) replicating programs that have been evaluated and shown to be effective while employing available evidence regarding lessons learned and transferability; (2) utilizing evidence-based components of existing programs or other evidence-based approaches to care provision in order to develop new programs, with an evaluation designed as an inherent part of the program before it begins operation; or (3) using new treatments, techniques, or materials that are developed explicitly as pilot programs, incorporating a rigorous, detailed research study as an inherent part of the program before it begins operation, and not replicating or expanding the utilization of these new approaches until research and evaluation have shown them to be effective. The evidence base needs to be accessible across DoD to ensure that organizations that are considering the development of new programs or implementation of existing programs can utilize this information.

Recommendation 5.3: Programs that are shown to be ineffective should be discontinued and should not be replicated. If an evaluation is sufficiently rigorous and provides adequate evidence that a program is ineffective or is harmful, the program should be discontinued and should not be replicated elsewhere. Without such a policy and its uniform enforcement, DoD runs the continual risk of a poor investment of tax dollars in programs that have been demonstrated to be ineffective, are likely to have unintended consequences, and may harm servicemembers.

Recommendation 5.4: A central authority should set overall policies and establish guidelines regarding programs, including guidelines governing the proliferation of new programs. In order to avoid the proliferation of programs without adequate evidence and the duplication of effort across services to identify best practices, DoD should identify a central authority charged with the coordination of programs between branches of service and within OSD, centralization of the evidence base regarding program effectiveness (Recommendation 5.2), and ongoing tracking of programs (Recommendation 5.5).

Recommendation 5.5: Both new and existing programs should be tracked on an ongoing basis by a single entity, preferably the same organization that is charged with developing guidance regarding program proliferation. Over the long run, DoD needs to develop an infrastructure to build on this compendium and to ensure that its contents are kept current. One way to accomplish this is to require all ongoing and new programs to register with a centralized database and to provide key pieces of program information for inclusion in the database, such as program name, target population, point of contact, and key activities. In order to ensure that the compendium is complete, DoD should adopt a single definition of what constitutes a program.

Conclusions

A variety of factors—including increased news coverage regarding the psychological and cognitive consequences of deployment, the recommendations resulting from the work of highly visible advisory committees, the expanded numbers of mental health providers available in

military clinical care settings, and the establishment of DCoE—have created significant motivation and momentum for developing programs to support servicemembers and their families.

While this attention is both necessary and laudable, the proliferation of programs creates a high risk of a poor investment of DoD resources. Our report suggests that there is significant duplication of effort, both within and across branches of service. Without a centralized evidence base, we remain uncertain as a nation about which approaches work, which are ineffective, and which are—despite the best intent of their originators—potentially harmful to servicemembers and their families. Given the financial investment that the nation is making in caring for servicemembers with mental health problems and TBI, servicemembers and their families deserve to know what these investments are buying. Strategic planning, centralized coordination, and the sharing of information across branches of service, combined with rigorous evaluation, are imperative for ensuring that these investments will result in better outcomes and will reduce the burden that servicemembers and their families face.

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The first five listed authors formed the core analysis and writing team; all remaining team members are listed alphabetically.

Abbreviations

5FMQ	Five Facets of Mindfulness Questionnaire
A&FRC	Airman and Family Readiness Center
AAR	after action report
AAS	American Association of Suicidology
ABHC	Automated Behavioral Health Clinic
ACE	Ask, Care, Escort
ACEP	Army Center for Enhanced Performance
ACPE	Association for Clinical Pastoral Education
ACS	Army Community Service
ACSAP	Army Center for Substance Abuse Programs
ACS-LES	Assessment for Signal Clients—Life Events Scale
ACT	Acknowledge, Care, and Tell
ADAMS	Alcohol and Drug Abuse Managers/Supervisors
ADAPT	Alcohol and Drug Abuse Prevention and Treatment
ADHD	attention deficit hyperactivity disorder
AFB	Air Force Base
AFI	Air Force Instruction
AFPD	Air Force Policy Directive
AFSOC	Air Force Special Operations Command
AFSPP	Air Force Suicide Prevention Program
AFW2	Air Force Wounded Warrior program
AHAW	America's Heroes at Work
AHLTA	Armed Forces Health Longitudinal Technology Application

AMC	Army Medical Center
AMEDD	Army Medical Department
AMSR	Assessing and Managing Suicide Risk
ANAM	Automated Neuropsychological Assessment Metrics
AR	Army Regulation
ART	Airman Resilience Training
ASAM	American Society of Addiction Medicine
ASAP	Army Substance Abuse Programs
ASIST	Applied Suicide Intervention Skills Training
ASSP	Army Suicide Prevention Program
ATOM	Automated Tools and Outcome Measures
AUDIT	Alcohol Use Disorders Identification Test
AW2	Army Wounded Warrior program
B-CBT	brief cognitive behavioral therapy
BCT	basic combat training
BHC	behavioral health consultant
BHIN	Behavioral Health Information Network
BHIP	Behavioral Health Integration Program
BHOP	Behavioral Health Optimization Program
BMEDDAC	Bavaria Medical Department Activity
BRAVE	Building Resilience and Valuing Empowered
BSAD	Brief Screen for Adolescent Depression
BUMED	Navy Bureau of Medicine and Surgery
C5	Comprehensive Combat and Complex Casualty Care
CAIB	Community Action Information Board
CAM	complementary and alternative medicine
CAMS	Collaborative Assessment and Management of Suicidology
CAPS	Child Adjustment to Parental Supervision
CAPT	Captain
CAREOPS	Caregiver Optimization Systems

CATEP	Confidential Alcohol Treatment and Education Pilot
CBCT	Cognitive-Behavioral Couples Therapy
CBT	cognitive behavioral therapy
CCH	Chief of Chaplains
CCRP	Care Coalition Recovery Program
CDMRP	Congressionally Directed Medical Research Programs
CDP	Center for Deployment Psychology
CEMM	Air Force Center of Excellence for Medical Multimedia
CGFAP	Coast Guard Family Advocacy Program
CISM	Critical Incident Stress Management
CNIC	Commander Navy Installations Command
CONEX	Container Express
COSC	Combat and Operational Stress Control
COSFA	Combat and Operational Stress First Aid
COSR	Combat and Operational Stress Reaction
COSR/SR	Combat and Operational Stress Reaction/ Staff Resiliency
CPE	Clinical Pastoral Education
CPSP	Care Provider Support Program
CPT	Cognitive Processing Therapy
CRI	Community Resiliency Initiative
CSC	Combat Stress Control
CSF	Comprehensive Soldier Fitness
CSL	Center for Spiritual Leadership
CSSP	Citizen Soldier Support Program
D-RAT	Down-Range Assessment Tool
DA	Department of the Army
DAMIS	Drug and Alcohol Management information System
DAPA	Drug and Alcohol Program Advisor
DCO	Defense Connect Online
DCoE	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

DDRP	Drug Demand Reduction Program
DESTRESS-PC	Delivery of Self Training and Education for Stressful Situations—Primary Care
DHCC	Deployment Health Clinical Center
DoD	Department of Defense
DoDEA	Department of Defense Education Activity
DoDI	Department of Defense Instruction
DoL	Department of Labor
DPH	Directors of Psychological Health
DPMT	Department of Pastoral Ministry Training
DRRI	Deployment Risk and Resilience Inventory
DSM	Defense Stress Management
DTC	Deployment Transition Center
DVBIC	Defense and Veterans Brain Injury Center
EAP	Employee Assistance Program
EFT	emotional freedom technique
EMM	Emergency Medical Ministry
FAMOPS	Family Optimization Systems
FAP	Family Advocacy Program
FIRP	Federal Individual Recovery Plan
FLO	Family Liaison Officer
FMWRC	Family and Morale, Welfare and Recreation Command
FOCUS	Families OverComing Under Stress
FOCUS-C	FOCUS for Couples
FRC	Federal Recovery Coordinators
FRCP	Federal Recovery Coordination Program
FRG	Family Readiness Groups
FRO	Family Readiness Officer
FY	fiscal year
GAO	Government Accountability Office
HART	Air Force Palace Helping Airmen Recover Together

HIV	human immunodeficiency virus
HPO	human health and performance optimization
HQMC	Headquarters Marine Corps
IAVA	Iraq and Afghanistan Veterans of America
ICF	International Classification of Functioning, Disability, and Health
IDS	Integrated Delivery System
IED	improvised explosive device
IG	Inspectors General
iRest	Integrative Restoration
ISRT	Installation Suicide Response Team
ITA	Innovative Technology Applications
JAN	Job Accommodations Network
JIF	Joint Incentive Funds
JS2S	Junior Student 2 Student
L-LAAD	leader-led after-action debrief
LINKS	Lasting Intimacy, Nurturing, Knowledge, and Skills
LINN	Living in the New Normal
LOA	line of action
LOA-2	Line of Action–2
MACE	Martial Arts Center of Excellence
MAJCOM	major command
MAMC	Madigan Army Medical Center
MCA CoE	Military Child and Adolescent Center of Excellence
MCCS	Marine Corps Community Services
MCEC	Military Child Education Coalition
MCMAP	Marine Corps Martial Arts Program
MCTFS	Marine Corps Total Force System
MCWIITS	Marine Corps Wounded, Ill, and Injured Tracking System
MDNG	Maryland National Guard
MEDCOM	Army Medical Command

METC	Medical Education and Training Campus
MFLC	Military and Family Life Consultants
MFRI	Military Family Research Institute
MHAT	Military Health Advisory Team
MINI	Mini-International Neuropsychiatric Interview
MMFT	Mindfulness-Based Mind Fitness Training
MOA	memorandum of agreement
MORE	My Ongoing Recovery Experience
MOS	Military OneSource
MOST	Marine Operational Stress Training program
MOU	memorandum of understanding
MPA14	Mayo-Portland Adaptability Inventory
MRP2	Medical Retention Processing 2
MRT	Master Resiliency Training
MSRP	Medical Soldier Readiness Processing
mTBI	mild traumatic brain injury
MTF	military treatment facility
MTU	Mobile Telehealth Unit
MUPS	Medically Unexplained Physical Symptoms
MWR	morale, welfare, and recreation
NADAP	Navy Alcohol and Drug Abuse Prevention Program
NASD	National Alcohol Screening Day
NCCOSC	Navy Center for Combat and Operational Stress Control
NCIS	Naval Criminal Investigative Service
NCO	noncommissioned officer
NDSD	National Depression Screening Day
NGB	National Guard Bureau
NGPHP	Air National Guard Psychological Health Program
NICoE	National Intrepid Center of Excellence
NIH	National Institutes of Health

NOSC	Navy Operational Support Center
NSPS	National Security Personnel System
ODEP	Office of Disability Employment Policy
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OMK	Operation: Military Kids
OPNAVINST	Office of the Chief of Naval Operations Instruction
OPORD	Operations Orders
OPTEMPO	operational tempo
OQ	Outcome Questionnaire
OSC	Operational Stress Control
OSCAR	Operational Stress Control and Readiness
OSD	Office of the Secretary of Defense
PA	physician assistant
PCCWW	President's Commission on Care for America's Returning Wounded Warriors
PCL	PTSD Check List
PCL-M	PTSD Checklist–Military Version
PCL-R	PTSD Checklist–Revised
PCM	primary care manager
PDFRC	Pre-Deployment Family Readiness Conference
PDHA	Post-Deployment Health Assessment
PDHAT	Post-Deployment Health Assessment Tool
PDHRA	Post-Deployment Health ReAssessment
PHA	Periodic Health Assessment
PHAP	Psychological Health Advocacy Program
PHP	Psychological Health Program
PHQ	Patient Health Questionnaire
PI	primary investigator
PICK	Premarital Interpersonal Skills, Choices, and Knowledge
PME	professional military education

POM	program objective memorandum
PPSCP	Professional Postgraduate Short Course Programs
PREP	Prevention Relationship Enhancement Program
PRMC	Pacific Regional Medical Command
PROQOL	Professional Quality of Life Scale
PRP	Penn Resiliency Project
PRRP	Post-Traumatic Stress Residential Rehabilitation Program
PSQI	Pittsburgh Sleep Quality Index
PTO	Prevention, Treatment and Outreach
PTSD	post-traumatic stress disorder
QUEST	Question, Understand, Expedite, Stay, Take
RA	research assistant
RC	Reserve component
RCC	Regional Care Coordination
RCP	Recovery Coordination Program
RCT	randomized controlled trial
RE-HIP	Re-Engineering Healthcare Integration Programs
REBT	rational emotive behavior therapy
RESPECT-Mil	Re-Engineering Systems of Primary Care Treatment in the Military
ROTC	Reserve Officer Training Corps
RSES	Response to Stressful Experiences Scale
RTD	Return to Duty
RWW	Returning Warrior Workshops
S2S	Student 2 Student
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPR	Sexual Assault Prevention and Response
SAPRO	Sexual Assault Prevention and Response Office
SARC	sexual assault response coordinator
SARP	Substance Abuse and Rehabilitation Program
SAVE	Suicide Awareness Voices of Education

SAVI	Sexual Assault Victim Intervention
SCP	Specialized Care Program
SDQ	Strengths and Difficulties Questionnaire
SDS	Sheehan Disability Scale
SELF	Soldier Evaluation for Life Fitness
SHARP	Sexual Harassment/Assault Response and Prevention
SMH	Screening for Mental Health
SOC	Senior Oversight Committee
SOF	Special Operations Force
SOS	Signs of Suicide
SPC	suicide prevention coordinator
SPRINT	Special Psychiatric Rapid Intervention Team
SRP	soldier readiness processing
STAI-T	State-Trait Anxiety Inventory, Trait version
STD	sexually transmitted disease
STEPS UP	Stepped Enhancement of PTSD Services Using Primary Care
STRONG STAR	South Texas Research Organizational Network Guiding Studies on Trauma and Resilience
SWAPP	Soldier Wellness Assessment Pilot Program
T2	National Center for Telehealth and Technology
T2WRL	Telehealth and Technology Web Resource Locator
TAA	Transition Assistance Advisor
TAMC	Tripler Army Medical Center
TAPS	Tragedy Assistance Program for Survivors
TAU	treatment as usual
TBI	traumatic brain injury
Tele-TBI	telehealth–traumatic brain injury
TFA	Trauma First Aide
TLD	Third Location Decompression
TRIAP	TRICARE Assistance Program
TSR	Trauma Stress Response

TTU	transportable telehealth units
UMT	Unit Ministry Team
UNH	University of New Hampshire
USAISR	U.S. Army Institute of Surgical Research
USCENTCOM	U.S. Central Command
USCG	U.S. Coast Guard
USMC	U.S. Marine Corps
USSOCOM	U.S. Special Operations Command
USUHS	Uniformed Services University of the Health Sciences
VA	U.S. Department of Veterans Affairs
VAS	Visual Analog Scale
VBH	Virtual Behavioral Health
VD	Video Doctor
VR	virtual reality
VR-GET	Virtual Reality Graded Exposure Therapy
vTBI	Virtual Traumatic Brain Injury
VTC	video teleconferencing
WAQ	Warrior Adventure Quest
WAROPS	Warrior Optimization Systems
WCSRP	Warrior Combat Stress Reset Program
WMT	Warrior Mind Training
WRAP	Warrior Resilience Assessment—Post-Deployment
WRMAC	Walter Reed Army Medical Center
WRP	Warrior Resiliency Program
WRT	Warrior Resilience & Thriving
WSP	Warrior Strengthening Program
WTU	Warrior Transition Unit
WWA	Wounded Warrior Act
WWR	Wounded Warrior Regiment

CHAPTER ONE

Introduction

Between 2001 and late 2010, over 2.2 million servicemembers were deployed in support of military operations in Iraq and Afghanistan, including Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and the newest phase of operations in Iraq, Operation New Dawn (U.S. Department of Veterans Affairs Office of Public Health and Environmental Hazards, 2010). Despite the recent drawdown of troops in Iraq, members of the military community have been confronted by the high operational tempo of the past decade, longer deployments, and frequent redeployments. While most military personnel cope well under these difficult circumstances, many have experienced and will continue to experience difficulties related to post-traumatic stress disorder (PTSD, an anxiety disorder that can develop after direct or indirect exposure to an event or ordeal in which grave physical harm occurred or was threatened) or major depression. Others live with the short- and long-term psychological and cognitive consequences of traumatic brain injury (TBI), an injury that has become increasingly common with the growing use of improvised explosive devices (IEDs) on the battlefield (Tanielian and Jaycox, 2008).

These issues have resulted in negative publicity in the lay press about the conditions under which servicemembers are treated and a multitude of high-level reports regarding care for our wounded warriors. In turn, this attention has prompted a proliferation of programs in recent years to support individuals dealing with mental health issues, including major depression, risk of suicide, and PTSD, as well as programs that address TBI (which also includes mild traumatic brain injury [mTBI] or concussion). In fact, of the programs that will be described later in this report, 55 percent were initiated in 2007 or later in response to identified gaps or needs.

This chapter provides a high-level summary of the recent policy context and of several reports that have served as the impetus or motivation for many of these programs. This description is not intended to be comprehensive but rather is meant to highlight the depth and breadth of attention around these issues. This chapter also summarizes several key steps taken by the Department of Defense (DoD) to respond to these identified gaps. These steps have also paved the way for the creation of programs through increased leadership, funding, or infrastructure.

Psychological Health in the Military

Estimates in 2004 suggested that over one-quarter of returning troops had mental health conditions (Hoge et al., 2004), while a later report found that among servicemembers who had been deployed for OEF/OIF as of October 2007, approximately one-fifth reported symptoms consistent with current PTSD and major depression, and about the same number reported

having experienced a probable TBI while deployed (Schell and Marshall, 2008). In 2009, mental disorders accounted for more hospitalizations of U.S. servicemembers than any other category of diagnoses (Armed Forces Health Surveillance Center, 2010b). Similarly, conditions accounting for the largest proportion of outpatient medical encounters in 2009 included substance abuse disorders, mood disorders, anxiety disorders, and adjustment disorders (Armed Forces Health Surveillance Center, 2010a).

While the psychological health of servicemembers has taken center stage, issues of depression and anxiety among servicemembers' families and children are equally important to the military and can result from a family member's deployment. In 2009, approximately 1.98 million children had one or both parents in the military, 1.25 million of whom had parents on active duty and 728,000 of whom had parents in the Reserve components (Department of Defense, 2009a). Since 2001, over 800,000 parents have deployed to Iraq or Afghanistan (Glod, 2008). In addition to worrying about the safety of their loved ones, many families undergo periods of emotional destabilization and disorganization immediately following deployment and redeployment, as family roles and responsibilities are shifted (American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members, 2007). The mental health of returning servicemembers may also have consequences for their families, as struggles related to PTSD, depression, or TBI may affect marriage and intimate relationships, the well-being of spouses and partners, parenting practices, and children's outcomes (Karney et al., 2008; Chandra et al., 2010). Evidence suggests, for example, that parental deployment may have negative relationships with a range of social and emotional outcomes for children, including anxiety symptoms and emotional or behavioral problems (Chandra et al., 2010; Chandra et al., 2011).

The Recent Policy Context

While there has been a heightened awareness of the psychological health issues facing servicemembers and their families in recent years, issues related to PTSD and suicide were highlighted as an everyday issue in top media outlets as early as 2005. In 2006, the Department of Defense Task Force on Mental Health was authorized to provide an assessment of and recommendations for improving the efficacy of mental health services. Public attention around the care of wounded, ill, or injured servicemembers grew in 2007 when *The Washington Post* published an in-depth news feature critical of the leadership, supervision of staff, and housing conditions at the Walter Reed Army Medical Center (Priest and Hull, 2007). In response to this increased public attention and criticism, DoD leaders commissioned multiple task forces and reports to examine the needs of returning servicemembers and to make recommendations for how to improve support for those who returned from combat wounded, ill, or injured. Such groups included the Department of Defense Independent Review Group and two independent but complementary groups commissioned by President George W. Bush: the President's Task Force on Returning Global War on Terror Heroes, which focused on the U.S. Department of Veterans Affairs (VA), and the President's Commission on Care for America's Returning Wounded. In 2009, the most recent report from the Mental Health Advisory Team (MHAT) was released, and in 2010, the final report of the Department of Defense Task Force on the Prevention of Suicide was released, providing additional insight and recommendations around mental health and health care.

Department of Defense Task Force on Mental Health

The Task Force on Mental Health was authorized by Section 723 of the National Defense Authorization Act for Fiscal Year 2006 (Public Law 109-163, 2006) to "examine matters relating to mental health and the Armed Forces." Composed of seven military and seven civilian professionals with mental health expertise, the task force was charged with producing a report assessing the efficacy of mental health services and providing recommendations for improvement (Department of Defense Task Force on Mental Health, 2007). The task force's findings and recommendations were organized around four goals. These included (1) building a culture of support for psychological health (e.g., dispel stigma, improve access to mental health professionals, embed psychological health training throughout military life); (2) ensuring a full continuum of excellent care for servicemembers and their families (e.g., make prevention, early intervention, and treatment universally available; maintain continuity of care across transitions; ensure high-quality care for servicemembers and their families); (3) providing sufficient resources and allocating them according to requirements (e.g., provide adequate resources for mental health services, allocate staff according to need, ensure an adequate supply of military providers); and (4) empowering leadership (e.g., formalize collaboration to coordinate care, establish visible leadership and advocacy for mental health).

Department of Defense Independent Review Group

The coverage of conditions at Walter Reed Army Medical Center prompted Defense Secretary Robert Gates to form an independent review group (known as the Marsh-West Group) to assess outpatient treatment at Walter Reed and at the National Naval Medical Center, the two primary U.S.-based military treatment facilities receiving wounded servicemembers from OIF and OEF. Their findings suggested that while high-quality inpatient care was being provided, care quality declined once servicemembers transitioned to outpatient status. Of particular concern were deficits in care coordination, case management, and medical expertise with respect to mental health, PTSD, and TBI. The recommendations of the review group were released in April 2007 and included strategies to improve case management services, the establishment of a center of excellence focused on the treatment of PTSD and TBI, increasing efforts focused on Reserve component servicemembers, and clearer lines of communication with families with respect to benefits and entitlements (Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center, 2007).

The President's Task Force on Returning Global War on Terror Heroes

In March 2007, President George W. Bush established the Task Force on Returning Global War on Terror Heroes, chaired by Department of Veterans Affairs Secretary Jim Nicholson. Broadly, the intent of this task force was to provide a comprehensive review of care for wounded veterans of OIF and OEF, identify gaps in those services and benefits, solicit recommendations from federal agencies on strategies to address identified gaps, and ensure that relevant federal agencies were communicating and cooperating effectively. This task force's governmentwide action plan, also released in April 2007, included 25 recommendations focused on four areas of need: health care; disability benefits; employment, education, and housing; and outreach (Task Force on Returning Global War on Terror Heroes, 2007).

The President's Commission on Care for America's Returning Wounded Warriors

President Bush subsequently established the President's Commission on Care for America's Returning Wounded Warriors (known as the Dole-Shalala Commission) in July 2007. Complementing and somewhat overlapping the objectives of the Task Force on Returning Global War on Terror Heroes, the commission focused primarily on issues facing the "seriously injured," such as those who receive payments under the Traumatic Injury Protection of Servicemembers' Group Life Insurance. The commission was tasked with examining the transition of OIF/OEF returning wounded servicemembers to military or civilian life; evaluating the coordination and delivery of key health, employment, and other benefits services; and determining servicemembers' awareness of and access to benefits and services. The commission was also charged with consulting with advocacy groups and service providers in the pursuit of the above objectives while developing necessary recommendations to address identified gaps. The commission developed six recommendations, all of which required major transformation to the care and management of the seriously injured (President's Commission on Care for America's Wounded Warriors, 2007). These recommendations were

- creating a corps of well-trained recovery coordinators to serve as a single point of contact for servicemembers
- completely overhauling the disability evaluation and compensation system
- improving the prevention, diagnosis, and treatment of TBI and PTSD and taking aggressive action to reduce the stigma surrounding PTSD
- strengthening support to families of the seriously injured
- developing an information technology system to assist with coordination of data
- fully funding and supporting Walter Reed Army Medical Center until its scheduled closure.

Congress Passes the Wounded Warrior Act

In light of public scrutiny, Congress passed the Wounded Warrior Act (WWA) as part of the National Defense Authorization Act for Fiscal Year 2008 (Public Law 110-181, 2008). The WWA provided additional funds and authorization to address identified gaps and called for improved collaboration across DoD and the VA to address problems with care coordination, improve the disability evaluation system, and better support family members of the wounded. The WWA also called for the creation of a Wounded Warrior Resource Center and the development of centers of excellence related to psychological health, PTSD, and TBI and included provisions for additional compensation and benefits for injured servicemembers and their families.

Mental Health Advisory Teams

The U.S. Army Surgeon General chartered the OIF Mental Health Advisory Team (MHAT) in July 2003. Its mission was to assess OIF-related mental health issues and to provide recommendations to the OIF medical and line commands. Since then, several MHAT teams have been sent to conduct assessments in theater, and reports have been issued regularly:

- MHAT-II, published in January 2005, examined the behavioral health needs, delivery systems, and training requirements of the OIF area of operations and assessed the imple-

mentation of the OIF area of operation suicide prevention program recommendations made by MHAT-I (MHAT-II, 2005).
- MHAT-III, published in May 2006, examined the behavioral health of soldiers and the behavioral health care system and provided recommendations regarding care for soldiers engaged in future deployments to Iraq (MHAT-III, 2006).
- MHAT-IV, published in November 2006, expanded previous MHAT efforts to include marines and focused on assessing soldier and marine mental health and well-being, examining the delivery of behavioral health care in OIF, and providing recommendations for sustainment and improvement to command (MHAT-IV, 2006).
- MHAT-V, published in February 2008, was the first MHAT to examine the mental health of soldiers in OEF as well as OIF, although the analyses, reports, and recommendations for OIF and OEF are independent from one other and designed to be stand-alone documents (MHAT-V, 2008).
- MHAT-VI, published in May and November 2009, assessed soldier behavioral health, examined the delivery of behavioral health care in OIF, and provided recommendations for sustainment and improvement to command. MHAT-VI differed from previous MHATs in that it collected data from two samples: a Maneuver Unit sample and a Support and Sustainment sample (MHAT-VI, 2009a; MHAT-VI, 2009b).
- At the time of this writing (May 2011), MHAT-VII is currently in progress.

MHAT data collection varied somewhat for each team but involved a range of efforts, including anonymous surveys and focus groups of soldiers and marines, as well as surveys and focus groups of behavioral health, primary care, and unit ministry providers.

Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces

Section 733 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110-417, 2008) directed the Secretary of Defense to establish a task force on suicide prevention charged with developing recommendations for a "comprehensive policy designed to prevent suicide by members of the Armed Forces." The report, released in August 2010, provided 49 findings and 76 targeted recommendations falling into four primary focus areas (Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, 2010):

- Focus Area 1, Organization and Leadership, highlighted the need for an effective organizational structure with engaged and informed leadership that will result in a coherent policy, as well as procedural standardization and oversight.
- Focus Area 2, Wellness and Enhancement Training, addressed the need to improve overall well-being and resiliency, not only by reducing stress but also by providing programs and training to maintain and enhance both the mental and physical health of servicemembers and their families.
- Focus Area 3, Access to, and Delivery of, Quality Care, addressed the need to provide care that is both accessible and of high quality.
- Focus Area 4, Surveillance, Investigations, and Research, focused on the need for standardized, timely, consistent, and centrally driven surveillance data; evaluation of suicide prevention programs; and basic research around suicide prevention.

Department of Defense Response to Prior Recommendations

The reports described above identified a number of gaps in the treatment and rehabilitation of returning wounded, ill, and injured servicemembers and their families. Collectively, the gaps and recommendations provided by the numerous high-level reports offered a roadmap for improving the treatment and support of servicemembers and their families facing issues related to psychological health and TBI. Several major initiatives are highlighted in this section.

Directors of Psychological Health

Recommendation 5.4.1 of the Department of Defense Task Force on Mental Health was to establish visible leadership and advocacy for psychological health (Department of Defense Task Force on Mental Health, 2007). In response, each branch of service established the position of director of psychological health. Most recently, the Air National Guard added its own wing-level director of psychological health positions (Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, 2010). The director's role for each branch of service includes strategic planning around issues related to psychological health and TBI; monitoring and reporting on the availability, accessibility, and quality of mental health services; monitoring the psychological health of servicemembers and their families; and ensuring communication with the departments responsible for the provision of mental health care at relevant installations and military treatment facilities.

Wounded Warrior Programs

A common theme of several of the high-level reports described above was that wounded servicemembers and their families need a single case manager and a single point of contact for information about the services available to them as they transition from combat settings to military life in garrison and to civilian life. Each service created a Wounded Warrior program to meet the unique needs of its own wounded, ill, or injured servicemembers. Wounded Warrior programs provide a number of nonmedical services, including assistance with pay and benefits, education and job assistance, coordination with medical case managers and providers (including mental health support), and call centers. These programs have distinct oversight by their respective branches of service and vary in the content of the services provided: the Wounded Warrior Regiment (Marine Corps), the Army Wounded Warrior program (AW2) and Warrior Transition Units (WTUs), the Navy Safe Harbor program, and the Air Force Wounded Warrior program (AFW2).

Wounded, Ill, and Injured Senior Oversight Committee

In 2007, the Secretary of Defense and the Secretary of Veterans Affairs chartered and cochaired a Senior Oversight Committee (SOC) to streamline, de-conflict, and expedite the efforts of DoD and the VA to address concerns about the processes for treatment, evaluation, and transition of wounded servicemembers. The SOC created and was organized around eight workgroups, known as lines of action (LOAs). These eight LOAs were focused on (1) the disability evaluation system; (2) prevention, identification, treatment, recovery, rehabilitation, and research on TBI and PTSD; (3) case and care management; (4) the sharing of data between the two departments; (5) medical facilities; (6) designing a continuous care plan; (7) reviewing and coordinating the latest legislation related to wounded warriors and their families; and (8) personnel, pay, and financial support (McGinn, 2009).

Line of Action–2

As described above in the section on the Wounded, Ill, and Injured Senior Oversight Committee, the focus of Line of Action–2 (LOA-2) was on developing, coordinating, and implementing DoD policies, programs, and oversight in the areas of TBI and psychological health. The LOA-2 Red Cell (consisting of two subject matter experts [SMEs] from each branch of service plus two representatives from the VA) was tasked with addressing more than 300 recommendations from the multiple high-level reports discussed above. Its goals were identifying strategies to improve access to care for TBI and psychological health, enhancing care quality, increasing psychological resilience, decreasing stigma, improving screening and surveillance of psychological health and TBI, enhancing transition care and support, and enhancing collaboration in research. One major outcome of the LOA-2 Red Cell efforts was the creation of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE).

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

Established in November 2007, DCoE aims "to assess, validate, oversee and facilitate prevention, resilience, identification, treatment, outreach, rehabilitation, and reintegration programs for psychological health and traumatic brain injury to ensure the Department of Defense meets the needs of the nation's military communities, warriors and families" (Department of Defense, 2010b). DCoE accomplishes this mission by partnering with DoD, the VA, and a national network of military and civilian agencies, clinical experts, advocacy groups, and academic institutions to establish best practices and quality standards for addressing psychological health and TBI. DCoE brings together eight directorates and six component centers, each described briefly below.

The eight directorates are

- Clearinghouse, Outreach and Advocacy: provides information, tools, and resources to warriors, families, leaders, clinicians, and the community
- Communications: informs external audiences about the work of DCoE and about issues related to psychological health and TBI
- Psychological Health Clinical Standards of Care: promotes optimal clinical practice standards to maximize the psychological health of warriors and their families
- Research: addresses psychological health and TBI through research, evaluation, and surveillance
- Resilience and Prevention: assists the services and DoD in optimizing resilience, psychological health, and readiness for servicemembers and their families
- Strategy, Plans and Programs: fosters and promotes strategic management efforts that help prevent and treat TBI and promote psychological health
- Training and Education: assesses training and education needs and identifies, integrates, develops, and disseminates effective training and educational programs
- Traumatic Brain Injury Standards of Care: works to develop state-of-the-science clinical standards to maximize recovery and functioning and provides guidance and support in the implementation of clinical tools (DCoE, undated[c]).

The six component centers of DCoE are

- Defense and Veterans Brain Injury Center (DVBIC): a collaboration between DoD, the VA, and civilian partners that serves active-duty military, their dependents, and veterans having TBI through medical care, clinical research initiatives, and educational programs
- Center for Deployment Psychology: a DoD training consortium, developed to promote the education of psychologists and other behavioral health specialists about issues pertaining to the deployment of military personnel
- Deployment Health Clinical Center: assists clinicians in the delivery of postdeployment health care by providing assistance and medical advocacy for military personnel and families with deployment-related health concerns
- Center for Traumatic Stress: conducts research, education, consultation, and training on preparing for and responding to psychological effects and health consequences of traumatic events
- National Center for Telehealth and Technology (T2): leverages a variety of technologies to help servicemembers with psychological health and TBI challenges and manages DCoE's telehealth and technology programs
- The National Intrepid Center of Excellence (NICoE): provides advanced services for the assessment, diagnosis, treatment planning, and long-term follow-up for psychological health and TBI; conducts research, tests protocols, and provides training and education to patients, providers, and families (DCoE, undated[b]).

Study Rationale and Objectives

We have summarized above some of the major efforts and improvements implemented to better support servicemembers and their families when facing issues related to psychological health, PTSD, and TBI, yet they represent only a fraction of newer work in this area. In recent years, there has been significant growth in programs across the resilience, prevention, and treatment continuum (described in Chapter Two), spanning a wide range of domains, including biological, psychological, social, spiritual, and holistic.

One ongoing challenge for DoD is to identify and characterize the scope, nature, and effectiveness of these various and ever-evolving activities. While some attempts to generate lists and inventories of programs have been initiated, none have been intended to be comprehensive in the areas of psychological health and TBI. The National Resource Directory, for example, provides access to services and resources at the national, state, and local levels that support recovery, rehabilitation, and community reintegration, but it addresses a wide variety of topics, including employment, benefits, housing, and health. DCoE's T2 Web Resource Locator (T2WRL) is an online directory of resources related to psychological health and TBI. However, its primary focus is on provider locations, websites, hotlines, virtual reality clinics, support groups, and online resources rather than on programs (see Chapter Three for clarification of the distinction between resources and programs). DCoE's Clearinghouse serves as a central source where individuals may obtain current information regarding psychological health and TBI. The primary focus of the Clearinghouse is on education and connecting individuals in need to clinical services, rather than maintaining a catalog of existing programs as they are defined in this report.

There have also been several relevant independent reviews that have been deliberately narrower in scope. Booz Allen Hamilton has conducted an environmental scan on behalf of

DCoE to identify clinical support tools, education programs, and research in the areas of psychological health and TBI (Booz Allen Hamilton, 2009). Work by the RAND Corporation provides detailed overviews of programs related to resilience (Meredith et al., 2011) and suicide prevention (Ramchand et al., 2011).

To date, no one has systematically identified all DoD-funded programs designed to address issues related to psychological health, PTSD, or TBI among servicemembers and their families. Prior to this report, there had been no full accounting of what programs exist and how these programs complement "traditional" service provision and routine care.

In this report, we present a "snapshot" of all programs currently sponsored or funded by DoD that address psychological health and TBI. Our efforts focus on programs that were active during our field period, which began in December 2009 and ended in August 2010.

Chapter Two summarizes several of the major military models for thinking about psychological health and TBI. Chapter Three summarizes our inclusion criteria, clarifies our working definition of the term *program*, and takes a closer look at other activities that provide services for psychological health and TBI, including clinical care, supportive services, a variety of resources, and research initiatives. Chapter Four presents the methods that we used to identify programs for inclusion, and Chapter Five describes the study results. Chapter Six provides recommendations and conclusions based on our findings. Appendix A includes several tables that jointly provide a directory of programs by their characteristics, with detailed program descriptions contained in Appendix B. Appendix C describes the entities that are excluded from this report. Appendix D includes detailed lists that describe how programs fit into the typology of program activities that we present in Chapter Five, and Appendix E includes definitions of the terms we use to describe the programs in this report.

CHAPTER TWO

Conceptualizing Psychological Health and Traumatic Brain Injury

Conceptual models of psychological health are useful for thinking about the design of effective programs. The design of a program's activities, approach, target population, and timing within the deployment cycle, for example, will vary depending on how psychological health is conceptualized and where within that conceptual model the program is targeting its efforts. There is currently no integrated framework for psychological health within DoD, though some of the branches of service have adopted their own, described later in this chapter. This lack of a uniform and unified model has the potential to create inefficiencies, contradictory information, and duplicative efforts, particularly if programs with similar objectives are being developed from conflicting models. This chapter summarizes some of the more common military models for conceptualizing psychological health and prevention that have served as the basis for many programs included in this report. These frameworks may also be useful for understanding where potentially untapped opportunities for prevention and intervention lie.

Defining Readiness: The Historical Perspective

Historically, the military had viewed psychological health as a dichotomy: A servicemember was either (a) ready (fit for full duty, mission focused, and fully productive) and under the responsibility of unit leaders or (b) ill and under the responsibility of caregivers (Koffman, 2008). Those who were ill included those with mental health issues, such as depression, anxiety, or PTSD, and were not considered fit for duty. A limited number of servicemembers fell in between these two extremes and were considered temporarily non–mission ready (Koffman, 2008). This model represents an oversimplification of the complex risk and recovery processes related to mental health. There would be little utility in providing programs to support the psychological health of servicemembers and their families under this conceptualization of readiness, because servicemembers who are under the responsibility of unit leaders would be viewed as not needing support to improve or maintain psychological health.

Rethinking Readiness: Operational Stress and Resilience Continuums

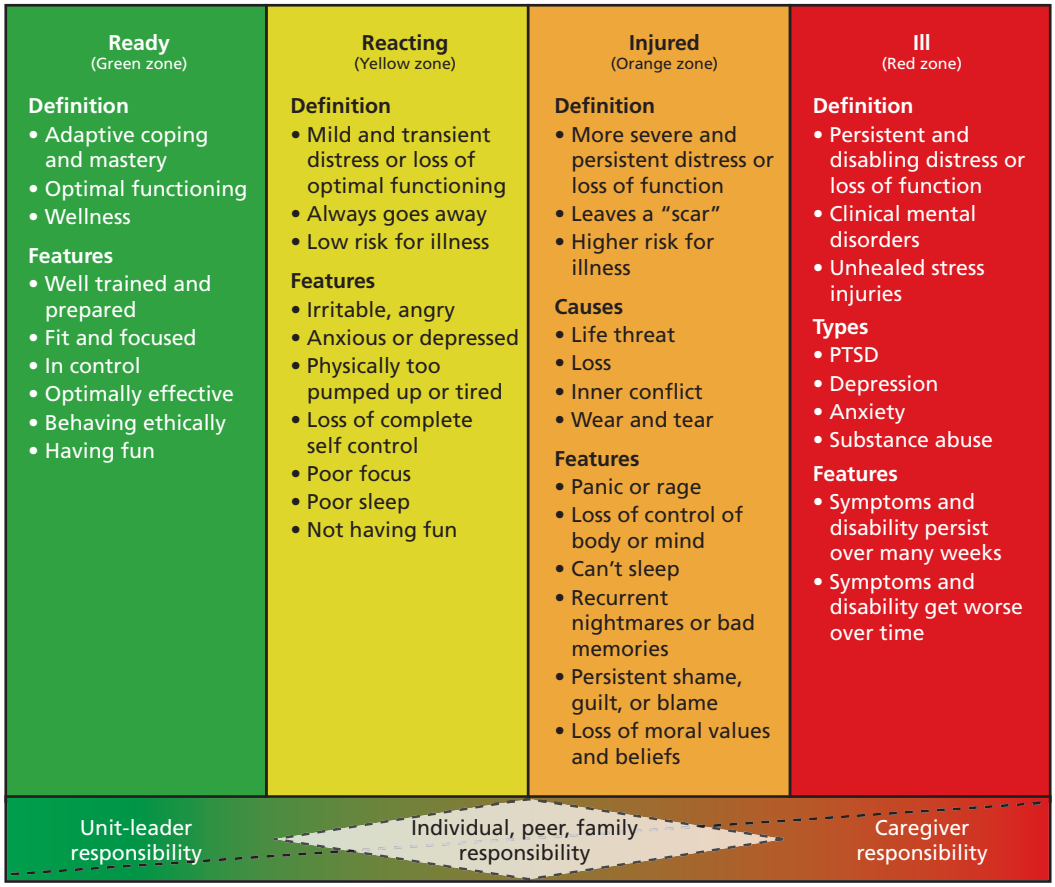
In recent years, there has been a growing recognition that psychological health comprises a continuum of states and that responsibility for psychological health jointly rests with the servicemember, unit leadership, chaplains, and/or medical staff. In this conceptualization, the level of responsibility of each type of individual is dependent on where the servicemember is

along the continuum—for example, medical staff have a larger responsibility for injured or ill individuals (U.S. Navy Chief of Naval Operations, undated). Two models exist for this paradigm: the Combat and Operational Stress Continuum shared by the Navy and Marine Corps (U.S. Marine Corps and U.S. Navy, 2010) and DCoE's Resiliency Continuum (DCoE, undated[a]). Further, the military community has added a focus on Total Force Fitness that complements these conceptualizations of readiness.

Navy and Marine Corps Combat and Operational Stress Continuum

The Navy and Marine Corps conceptualize combat and operational stress along a continuum of colors ranging from green (ready) to yellow (reacting) to orange (injured) and red (ill), as shown in Figure 2.1 (U.S. Marine Corps and U.S. Navy, 2010). Individuals in the green zone are functioning well, prepared, and fit. Individuals in the yellow zone may have mild, transient stress reactions, which are common, and may be anxious or irritable. Individuals in the orange zone have more-severe, persistent symptoms that are considered significant departures from their usual behavior. Such symptoms may be the result of trauma, fatigue, grief, or moral injury (defined as involvement in events that transgress deeply held moral beliefs and therefore cause psychological harm; Litz et al., 2009). Individuals in the red zone have a severe disor-

Figure 2.1
Navy and Marine Corps Combat and Operational Stress Continuum



SOURCE: U.S. Marine Corps and U.S. Navy, 2010.
RAND *TR950-2.1*

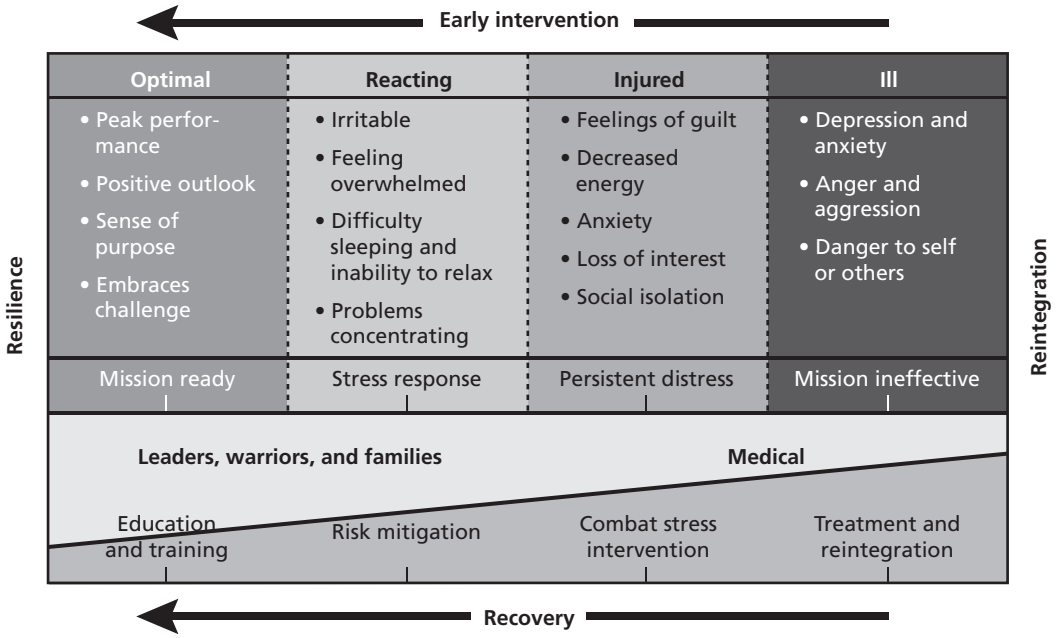
der in need of significant clinical care, such as major depression, anxiety, substance abuse, or PTSD.

DCoE's Resilience Continuum

Similar to the Navy and Marine Corps Combat and Operational Stress Control (COSC) model, this model moves away from the medical/illness–based model to a leader-driven psychological health, resilience, and performance philosophy. The resilience continuum includes the following states: optimal (mission ready), reacting (stress response), injured (persistent distress), and ill (mission ineffective). This model also provides insight into programming that may be appropriate for each stage, ranging from education and training to risk mitigation, combat stress intervention, and treatment and reintegration. Figure 2.2 displays DCoE's Resilience Continuum (DCoE, undated[a]).

Although the resilience continuum has a focus on psychological health, it is applicable for conceptualizing resilience to TBI as well. Education and training around mitigating risk for combat and noncombat TBI (e.g., helmet safety, fall prevention, seat belt use) may come from military and nonmilitary sources, including public health campaigns. Research has also demonstrated that individuals with mild TBI often make full recoveries (Deb et al., 1999; White, Driver, and Warren, 2008), and even those with moderate and severe brain injuries show evidence of positive psychological growth and change over time (Powell, Ekin-Wood, and Collin, 2007; Hawley and Joseph, 2008).

Figure 2.2
DCoE Resilience Continuum



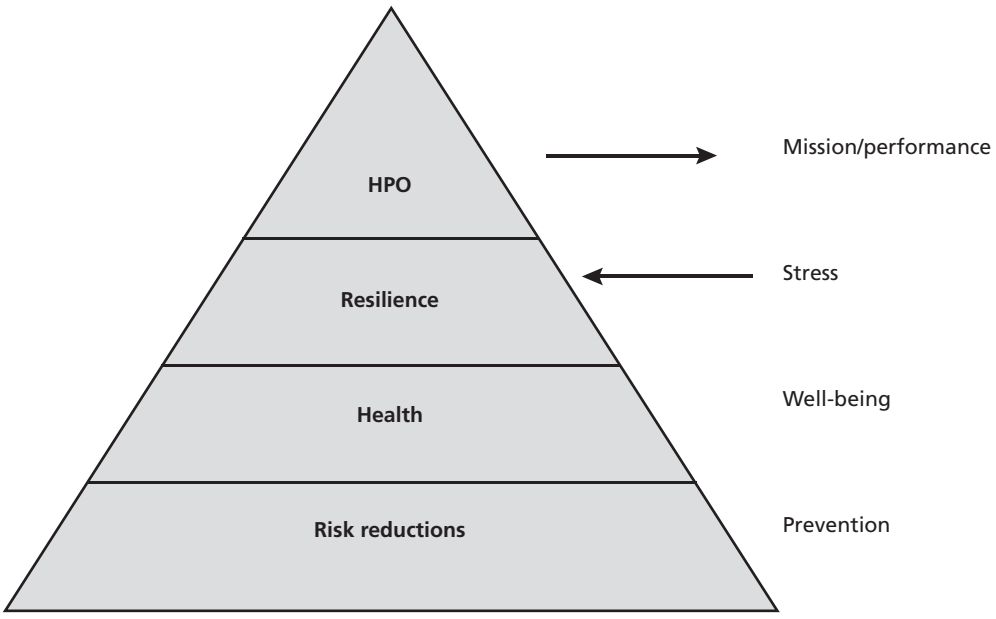
SOURCE: DCoE, undated[a].
RAND *TR950-2.2*

Total Force Fitness

Total Force Fitness is a newer paradigm regarding mission readiness that includes the integration of four fitness domains of the mind (spiritual, psychological, behavioral, and social) and four fitness domains of the body (physical, nutritional, medical, and environmental) (Jonas et al., 2010b). The foundation of Total Force Fitness is conceptualized as a pyramid, shown in Figure 2.3, with risk reductions at the foundation. The focus of the risk reduction layer is on the prevention of breakdowns that may mitigate readiness to respond to challenges at the physical, psychological, family, and social levels. The next layer includes health and wellness practices "that allow a person to sustain balance and be symptom free" (Jonas et al., 2010b). Sitting on top of health is stress resistance and resilience to changing environments, and the top layer is human health and performance optimization. Although the Total Force Fitness model is not specific to psychological health, psychological resilience is considered one of four major pillars required for optimal functioning.

The Chairman of the Joint Chiefs of Staff, Admiral Mike Mullen, has provided leadership in helping DoD adopt the Total Force Fitness paradigm. In his 2009–2010 Guidance to the Joint Force, ADM Mullen established three priorities, one of which is to look holistically at the health of the force to "better prepare our force and care for our people" (Mullen, 2009, p. 1). At ADM Mullen's request, the concept of Total Force Fitness was developed by the Consortium for Human and Military Performance at the Uniformed Services University of the Health Sciences in conjunction with the Samueli Institute.

Figure 2.3
Total Force Fitness



NOTE: HPO = human health and performance optimization.
SOURCE: Jonas et al., 2010b. Used with permission.
RAND *TR950-2.3*

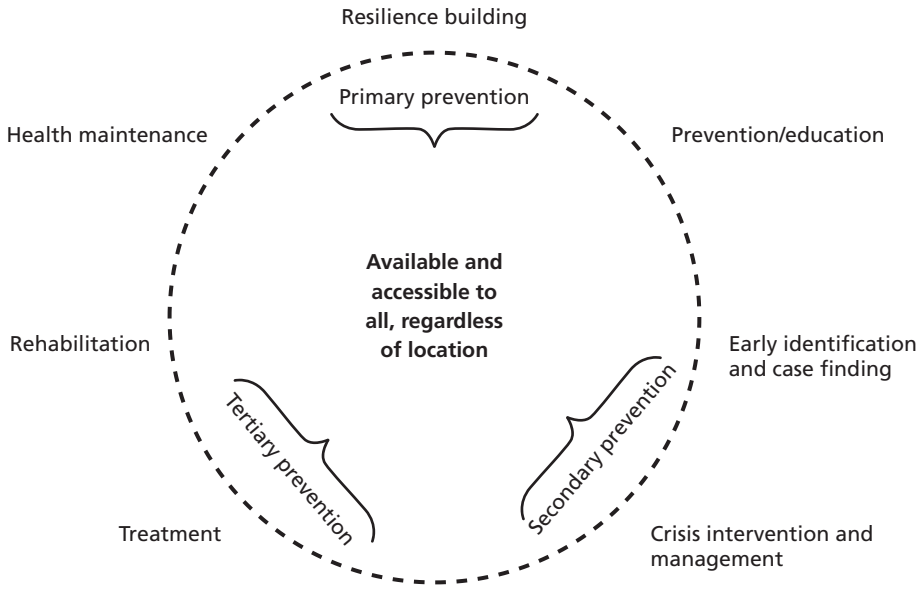
Conceptualizing Prevention

Although the above models conceptualize psychological health within the context of mission readiness and force fitness, they are closely related to broader conceptualizations of prevention that have been in use in the public health arena for many years. These models focus on three types of prevention: primary, which aims to reduce the incidence of new cases; secondary, the goal of which is to reduce existing cases; and tertiary, which aims to reduce complications (Commission on Chronic Illness, 1957). Applying these prevention models to the conceptualizations of psychological health and readiness discussed above provides insight into ways in which programs may be aligned with the needs of an individual at a given point on the operational stress or resilience continuum. DCoE's Resilience Continuum, described in Figure 2.2, provides one example of how conceptualizations of prevention may be incorporated into psychological health and readiness frameworks. This model describes education and training (primary prevention) as occurring under states of optimal psychological health, with risk mitigation (secondary prevention) under the reacting state, combat stress intervention (secondary or tertiary prevention) under injured, and treatment and integration (tertiary prevention) shown under ill.

Model from the Department of Defense 2007 Mental Health Task Force Report

The 2007 Department of Defense Mental Health Task Force report included a conceptual model for thinking about psychological health (Defense Health Board Task Force on Mental Health, 2007), shown in Figure 2.4. In this model, primary prevention focuses on prevention and education, health maintenance, and resilience-building and is intended for all segments of the population, regardless of whether mental health symptoms are present. Secondary prevention includes more-targeted activities toward individuals who are at elevated risk for dif-

Figure 2.4
Department of Defense Mental Health Task Force Model of Psychological Health



SOURCE: Defense Health Board Task Force on Mental Health, 2007.
RAND *TR950-2.4*

ficulties. Such activities may include early identification of cases, as well as crisis intervention and management. Tertiary prevention activities include clinical treatment and rehabilitation to prevent recurrences and to facilitate the management of chronic illness. This model is based on an Institute of Medicine model in long-standing use that characterizes the mental health intervention spectrum as including phases related to prevention, treatment, and maintenance (Mrazek and Haggerty, 1994), as well as other prior work (Defense Health Board Task Force on Mental Health, 2007).

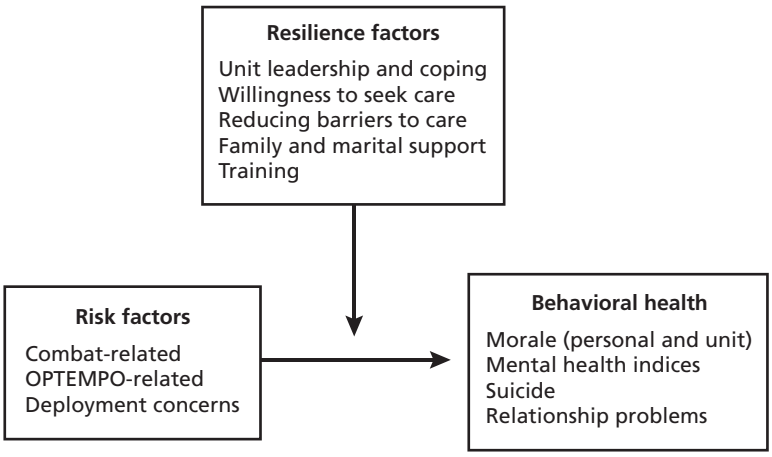
Combat and Well-Being Model

The MHAT-VI based its work on a model adapted from Bliese and Castro (2003), which argued that behavioral health outcomes are driven by three major classes of risk factors: combat-related events, the current operational tempo, and other deployment-related concerns (MHAT-VI, 2009a). As a result, the model suggests that outcomes can be improved either by reducing or eliminating these three categories of risk factors or by strengthening protective factors so that servicemembers are better able to cope when exposed to factors that put them at risk. The model (shown in Figure 2.5) emphasizes that risk factors are largely immutable or beyond an individual's control, highlighting the importance of fostering resilience and protective factors among servicemembers.

Conceptualizing Functioning and Reintegration

TBI varies widely in terms of injury, recovery, and reintegration, posing a challenge to developing a conceptual model or a single standard of care. TBI varies in severity and symptomatology and often co-occurs with PTSD, chronic pain, or other mental or physical health problems (Lew et al., 2009). Given the heterogeneity of TBI severity, symptomatology, and prognosis for full recovery, greater emphasis is generally placed on functioning and reintegration into society.

Figure 2.5
Mental Health Advisory Team VI Combat and Well-Being Model



SOURCE: MHAT-VI, 2009a.
NOTE: OPTEMPO = operational tempo.
RAND *TR950-2.5*

International Classification of Functioning, Disability, and Health

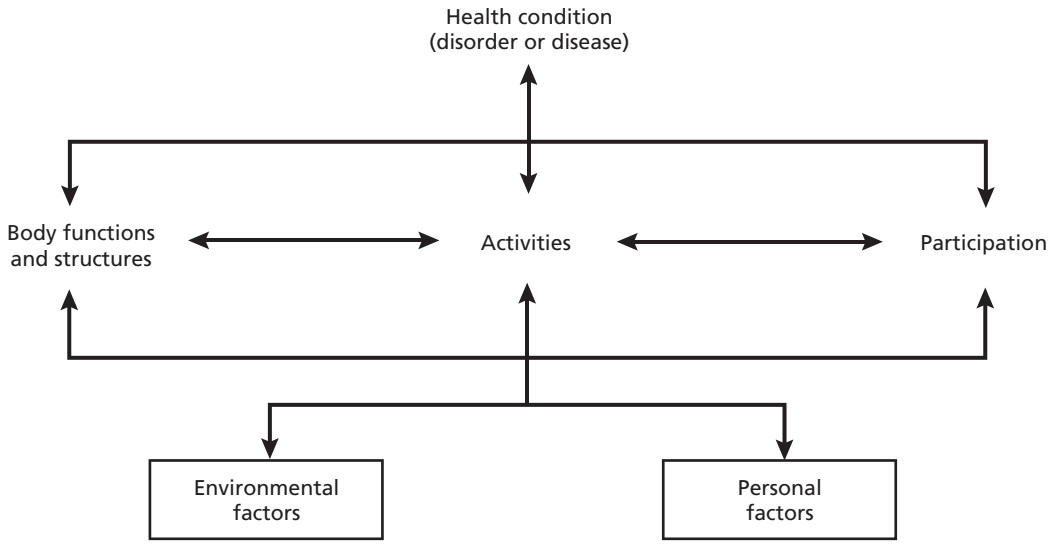
The International Classification of Functioning, Disability, and Health (ICF) was developed by the World Health Organization to "provide a unified and standard language and framework for the description of health and health-related states" (WHO, 2001, p. 3). While not developed directly to refer to TBI, this framework can support conceptualizing functioning and reintegration for servicemembers with TBI.

This classification system was developed to help providers conceptualize health and recovery planning by looking at the interactions between physiological functions and body structures, actions, and activities occurring within a particular context (Sandberg, Bush, and Martin, 2009). The ICF consists of two parts: (1) Functioning and Disability (how the body is structured and how it functions; and participation in or execution of tasks such as activities of daily living) and (2) Contextual Factors (environmental factors, including the physical and social environment; and persona factors such as lifestyle and education). (See Figure 2.6.) This framework has been used successfully to understand the challenges OEF and OIF veterans face as they reintegrate into the community and may allow for more individually relevant treatment planning (Resnik and Allen, 2007; Sandberg, Bush, and Martin, 2009; WHO, 2001).

Summary

These conceptual models highlight a range of potential approaches that programs might employ to improve psychological health among servicemembers and their families. Our definition of what constitutes a program, provided in the next chapter, includes services and activities provided across the spectrum of approaches described in each of these conceptual models.

Figure 2.6
Interactions Between the Components of the ICF



SOURCE: World Health Organization, 2001. Used with permission.
RAND *TR950-2.6*

CHAPTER THREE

What Is a Program?

One of the most significant challenges in identifying and assessing programs designed to address psychological health and TBI is defining what constitutes a program. In the military, the term is used to describe a wide variety of services, such as the Marine Corps Suicide Prevention Program or the Army's Master Resiliency Training Program. It is also used, either informally or formally (i.e., as part of an official name), to describe organizational efforts to distribute educational materials (such as the Deployment Health and Family Readiness Library); to gather information (such as the Post-Deployment Health Assessment program); or to sponsor task forces, committees, or events (such as the Army's Health Promotion, Risk Reduction, and Suicide Prevention program). Individual research studies may be part of larger programs of research. Toolkits, guidelines, and checklists are also sometimes characterized as programs, as are media campaigns.

To help define what constitutes a program and illustrate how programs to address psychological health and TBI are related to other types of services, we developed a conceptual framework that guided this study, which is discussed in this chapter. We provide an overview of the framework, explain the criteria used to identify programs in this study, and describe other "non-program" types of services available to members of the military community.

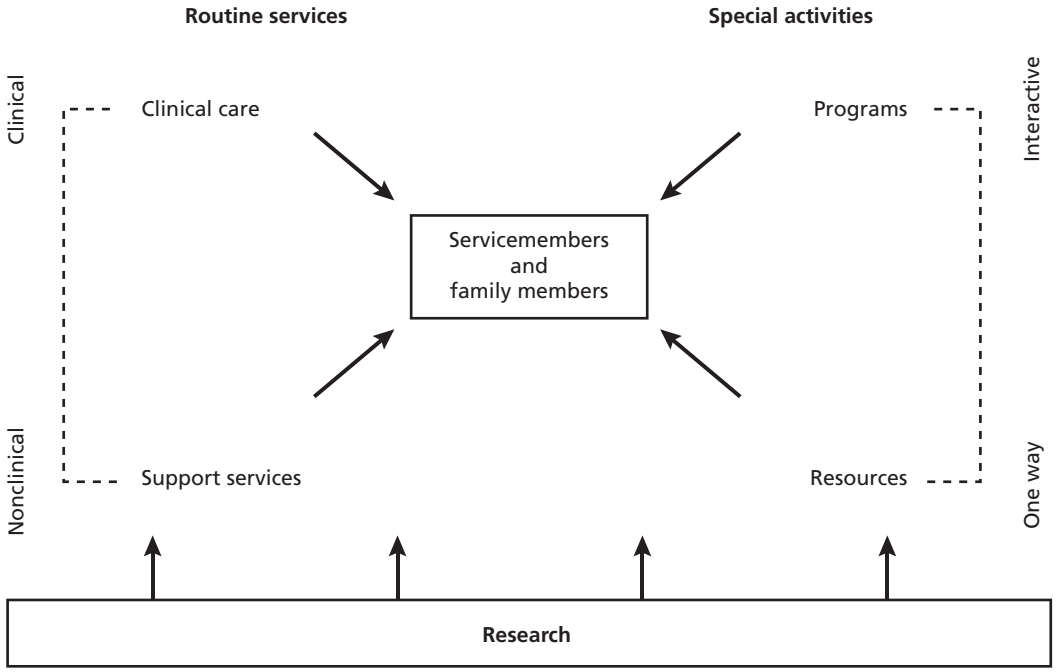
Conceptual Framework

The conceptual framework that guided this study is shown in Figure 3.1. The framework is intended to illustrate the types—not the physical or organizational locations—of services and activities that are designated as programs designed to address psychological health and TBI.

Taken as a whole, the figure illustrates the context in which programs and other types of health and support services occur. The left side of the figure focuses on existing clinical and nonclinical services provided to members of the military community, while the right side focuses on "special activities," our term for the array of activities focusing specifically on psychological health and TBI that are in addition to standard care. Given that clinical and nonclinical services are not mutually exclusive, the dashed line in Figure 3.1 represents the range of services and care available. A similar dashed line suggests a parallel relationship between programs and resources. We provide an overview of these categories here and then discuss each type of service or activity in more detail later in this chapter.

The routine services shown on the left provide the context within which many programs operate:

Figure 3.1
Conceptual Framework



RAND *TR950-3.1*

- **Clinical care services** (shown in the upper left corner) include both mental health services and clinical services for physical health problems—which are provided at military treatment facilities (MTFs) and via TRICARE (the health plan of the Military Health System).
- **Nonclinical support services** (shown in the lower left corner) include services provided in chaplaincy or in community and family support departments, which may offer a variety of supportive counseling services, as well as other services unrelated to psychological health and/or TBI (e.g., financial counseling).

The right side of Figure 3.1 shows special activities—activities designed specifically to address psychological health or TBI that are in addition to standard care. We group these special activities into two categories:

- **Programs** (shown in the upper right corner), which are the focus of this study, provide services, interventions, or other efforts that address psychological health or TBI that entail a component of interaction with members of the military community. The programs discussed in this report may be offered within the same facilities or under the auspices of clinical care or nonclinical support services, or they may be housed elsewhere within DoD in offices specifically designated to support them or as part of other organizational efforts. While some program efforts may overlap with services provided in routine clinical care and nonclinical settings, many programs are likely to be unique efforts that are not directly related to the services provided in these environments.
- **Resources** (shown in the lower right corner) offer a one-way, passive transmission of information, such as a brochure or directory that lists services available on an installa-

tion. Programs may incorporate the use of resources into their activities but by definition must include more than just the dissemination or transmission of information contained in these resources.

Finally, many of the efforts to address psychological health and TBI rely on a strong and growing research base to identify new treatments and best practices. This **research base** is shown at the bottom of Figure 3.1. While research projects are explicitly beyond the scope of this review, some research projects—particularly pilot projects with an evaluation arm—include an intervention component that could be classified as a type of program. In the study, we designated as programs those research projects that have relevant, explicitly defined interventions but excluded those conducting clinical trials of drugs or devices and those without interventions (e.g., projects designed to assess the prevalence of a condition or utilization of services). We did not, however, conduct an exhaustive search for all research projects being conducted in the area of psychological health and TBI.

Inclusion and Exclusion Criteria

The conceptual framework shown in Figure 3.1 provides a broad view of the role of programs in relation to other types of services that may be accessed by servicemembers and their families. We used the categories shown in the figure as the basis for developing a set of criteria to distinguish programs that address psychological health and TBI from other types of services and care and used these inclusion and exclusion criteria to determine what types of services and activities would be designated as programs for this study.

Table 3.1 shows the inclusion and exclusion criteria. Those services and activities meeting all of the inclusion criteria and none of the exclusion criteria are designated as programs, are the primary focus of this report, and will be discussed at length in Chapter Five.

Excluded Services and Activities

In this section, we provide additional information about the types of services other than programs that are shown in Figure 3.1: clinical delivery systems, family and community support services, and resources. These services are not designated as programs, according to our definition. However, these services can support or facilitate programs in their efforts to address psychological health and TBI and may be housed within the same physical or organizational location.

Existing Clinical Delivery Systems

We define routine clinical care (the upper left quadrant of Figure 3.1) as the environments, providers, and services that are typically available to servicemembers and their families seeking health care across installations and branches of the armed forces. Routine clinical care services provide a context within which the programs that are the broader focus of this report operate, since many of the programs rely on the routine care system to provide day-to-day clinical services that complement those provided by the programs.

Table 3.1
Inclusion and Exclusion Criteria

Criteria Type	Description
Inclusion criteria	The activity focuses on improving psychological health and/or services related to TBI. This includes a wide array of activities focusing on prevention or resilience; education and training; stigma reduction, improving access to care, or otherwise reducing barriers to obtaining care; and treatment. It includes all relevant clinical issues, such as depression, PTSD, substance use, suicide prevention, general psychological health, and TBI, as well as nonclinical issues that are often addressed by mental health professionals, such as deployment-related issues, domestic violence, families and children, legal concerns, postdeployment and community or family reintegration, relationships, resilience, spiritual concerns, and stress reduction. The activity is sponsored or funded by DoD, including through • any DoD office, activity, agency, service, or command • the VA/DoD Joint Incentive Funds (JIF) • any DoD memorandum of understanding (MOU) or memorandum of agreement (MOA) • funding by one of the branches of service. The activity involves an intervention, efforts designed to affect a specific outcome, or the direct provision of services. The activity has a target audience including active-duty, National Guard, or Reserve component servicemembers; their family members; or providers serving these individuals. The activity conducts its efforts either in theater or out of theater and was in operation at some point between December 2009 and August 2010.
Exclusion criteria	The activity includes an intervention that is not focused on psychological health and/or TBI. This includes efforts such day care, housing, family survivor programs not focused on psychological health (e.g., financial benefits programs), job training, entertainment, and construction projects. The activity involves standard or routine care, such as clinical care at a military treatment facility, or focuses on standard clinical education, such as continuing medical education or internships. The activity consists of screening tools that are not directly associated with an intervention, such as checklists and resources designed to help leaders recognize signs of mental health problems. The activity uses only one-way passive transmission of information without an intervention designed to affect a particular outcome. This may include, for example, websites that contain phone numbers for suicide prevention hotlines, efforts to distribute brochures, or task forces and committees. The activity is a research project that does not involve an intervention (such as research designed to assess the prevalence of clinical conditions or utilization of services) or where the intervention is a clinical trial of a drug, treatment, or device. The activity consists solely of laws, policies, DoD instructions, memoranda, or reports. The activity is an advisory team, working group, advocacy group, task force, committee, or conference. The activity is an administrative department, office, or center. If one of these organizations runs a program that itself meets the inclusion criteria, the program is included in this report, but the administrative department, office, or center is not. For example, some central DoD offices set policies that are independently implemented by each branch of service. Since only the service-specific programs directly interact with servicemembers and their families and meet our inclusion criteria, the central DoD office would not be included.

Treatment Providers and Environments of Care. [1] Active-duty military personnel have several options when seeking help for mental health problems, including services provided by DoD and services purchased through TRICARE. Members of the military community may access clinical mental health services through specialty mental health settings in MTFs, primary care, and civilian network providers. In addition, there are a number of programs, described in Appendix B, that support the delivery or expansion of routine clinical care services to increase access to mental health and TBI care.

Specialty Mental Health Care Within Military Treatment Facilities. MTFs are the primary source of specialty mental health care for military personnel. Within MTFs, services are traditionally provided by mental health clinics, which may be either stand-alone or located in base hospitals. MTFs are staffed by an array of providers, including uniformed service and civilian psychiatrists, psychiatric nurse practitioners, primary care physicians, psychologists, social workers, and enlisted mental health technicians. Services available typically include diagnostic evaluations, medication management, prevention activities, outreach, personnel-related functions, and psychotherapeutic treatments for mental health conditions, such as PTSD and major depression.

Mental Health Services in Primary Care. Despite the fact that specialty mental health care is widely available, many servicemembers choose to receive mental health treatment at their primary care clinic because it may be perceived as a less stigmatizing portal of care, given that primary care clinics provide a range of services beyond mental health care (Koffman, 2007). While such care is offered directly by primary care providers, increasingly, mental health professionals are also being integrated into primary care medical practices as part of the programs described in Chapter Five.

Civilian Network Providers. Servicemembers may also seek mental health services from civilian TRICARE network providers. Civilian network providers offer a wide array of treatment options, from empirically based therapies to general supportive psychotherapy and less conventional techniques. Active-duty servicemembers must receive behavioral health care services at an MTF when such services are available. All other individuals (e.g., family members) typically require a referral from their primary care manager and prior authorization from the insurance provider. Out-of-system care in the civilian sector is also available on an out-of-pocket basis.

Routine Screening. All servicemembers must complete a Post-Deployment Health Assessment (PDHA) within 30 days after returning home from deployment. In addition, all branches of DoD are mandated to screen returning servicemembers for PTSD through the Post-Deployment Health ReAssessment (PDHRA) process between 90 and 180 days after deployment (Deployment Health Clinical Center, 2011), which includes completing an online health screening and having an interview with a medical provider to discuss any positive symptoms endorsed by the servicemember (Deployment Health Clinical Center, 2011). The PDHA and PDHRA include specific screening items related to PTSD, depression, and TBI, and positive responses to this self-report screening instrument are followed up with supple-

[1] This section draws heavily from a chapter in a recent RAND report (Burnam et al., 2008) and is supplemented with information from the peer-reviewed literature and interviews we conducted with mental health service administrators in the Air Force, Navy, and Army. Specifically, we asked administrators to note recent changes in the structure of care services beyond the expanded availability of behavioral health care that were related to the Psychological Health and Traumatic Brain Injury program, which added hundreds of behavioral health providers across all DoD branches of service (Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, 2010).

mental assessments and/or referrals for medical or mental health consultation. In addition to screening postdeployment, a 2008 memorandum from the Assistant Secretary of Defense for Health Affairs directed all services to implement mandatory baseline predeployment neurocognitive assessments within 12 months prior to deployment (U.S. Navy, 2010). In-theater and in-garrison screening and assessment for concussion and TBI are administered broadly to all servicemembers who may be at risk for having a mild TBI.

Treatment. How a servicemember is treated for PTSD and other postdeployment adjustment or mental health disorders depends on when and where the servicemember first makes contact with the health system. Treatment providers working in combat environments, in primary care settings, and in specialty mental health facilities have different priorities and access to different resources; thus, treatment itself takes on different forms. Core components of PTSD and depression treatment, however, include pharmacotherapy and psychotherapy. Core components of treatment for TBI include early intervention to lessen current symptoms and prevent further injury and management of persistent TBI symptoms. DoD and the VA share clinical practice guidelines for the treatment of PTSD and TBI (Veterans Health Administration, 2004). Although clinicians are not mandated to use the guidelines, the guidelines are meant to "inform and support clinicians" by providing decision trees for prevention, assessment, and treatment (Veterans Health Administration, 2004, p. i).[2]

Family and Community Services

Family and community services play a critical role in supporting the psychological health of servicemembers and their families. While each branch of the military offers a slightly different mix of programs and services, they generally fall under four broad areas: (1) family support, (2) child and youth services, (3) counseling and advocacy support, and (4) morale, welfare, and recreation. These programs are typically housed and implemented outside of the medical command or health care system and are aimed more broadly at improving quality of life for servicemembers and their families.

Family Support. Family support services are designed to help families address and cope with a range of challenges, including those that may arise because of military life or deployment. Although the structure of family support services varies by branch of service, they address similar issues, including responsible living, good citizenship, and personal readiness (such as financial management, employment skills, career counseling, and job search assistance). Also included is transition assistance, including relocation counseling and reentry workshops, with specific support for families and family members with special medical and/or educational needs. Family readiness support helps families prepare for, adjust to, and cope with deployments and redeployments, and it provides crisis and disaster support for man-made and natural disasters.

Child and Youth Services. Child and youth services are designed to alleviate some of the additional pressure of parental deployment and military life by providing free and accessible child care or structured activities for children. Child development and school-age programs are designed to "protect the health and safety of children; to promote their physical, social, emotional, and cognitive development; and to enhance their readiness for later school experiences" (Department of Defense, 2009b, p. 25). Youth programming involves a series of planned activ-

[2] Foa et al. (2008) provide clinical practice guidelines for the treatment of PTSD; clinical practice guidelines for the treatment of depression are available from the American Psychiatric Association (2010).

ities appropriate to the recreational, developmental, social, physiological, psychological, cultural, and educational needs of children up to 18 years old. Child and youth services also offer short-term nonmedical counseling and support for children and youth, as well as support for teachers and schools serving military children.

Counseling and Advocacy Support. All branches of service offer a range of general psychological and behavioral health counseling and referral services that complement clinical care and treatment and are typically provided outside of MTFs.

Counseling and Referral. A complete spectrum of support services is offered to active-duty servicemembers and their families to assist with personal and family concerns. These include individual, marital, parent-child, family, and group counseling services, focusing primarily on issues that are not related to clinical diagnoses. In addition, screenings and referrals are provided for mental health problems, along with the provision of consultation and educational services. DoD has implemented counseling options that are free and confidential, including Military OneSource and the Military and Family Life Consultants program[3] (The White House, 2011), which are described in more detail later in this report.

Family Advocacy. The Family Advocacy Program (FAP) is a component of counseling and referral services, but it primarily focuses on child and domestic abuse (Department of Defense, 2004). FAP focuses on the prevention of child and domestic abuse through public outreach and education programs and through standardized programs targeted at individuals who are identified as being at-risk of committing child abuse or domestic abuse. FAP facilitates early identification, intervention, support, and referral for victims of abuse and focuses on the assessment, rehabilitation, and treatment for alleged perpetrators of child or domestic abuse. More details about Family Advocacy Programs specific to each branch of service are included later in this report.

Sexual Assault Prevention and Response. The Sexual Assault Prevention and Response (SAPR) Program, specified in DoD Instruction 6495.02, is intended to "prevent and eliminate sexual assault" through programs that establish a culture of response and accountability and to provide care and services to victims of sexual assault (Department of Defense, 2008). The Sexual Assault Prevention and Response Office (SAPRO) is designed to be "the single point of accountability and oversight for sexual assault policy in the Military, providing guidance to DoD components and facilitating the resolution of issues common to all Military Services and joint commands."[4] The objectives of SAPRO are to create training and education programming to prevent sexual assault, to improve support for victims when it does occur, and to enhance system accountability. In accordance with SAPRO policies, each service runs its own SAPR program, known in the Army as the Sexual Harassment/Assault Response and Prevention (SHARP) program. More details about the SAPR program specific to each branch of service are included later in this report.

Substance Abuse. Military substance abuse programs are considered necessary for mission readiness and include prevention, testing, treatment, and response components for both alcohol and drug abuse (Department of Defense, 1999). The programs are implemented at the installation level; as a result, there is some local and regional variability. Each branch of service also offers a range of resources and guides for leaders that provide an overview of alcohol

[3] Since this interview was conducted, this program has been renamed Military and Family Life Counselors.

[4] Suzanne Holroyd, personal communication, May 21, 2010.

abuse detection, intervention, response, treatment, and prevention, with specific information on intervention and treatment referral. More details about substance abuse programs specific to each branch of service are included later in this report.

Chaplains. Every military unit is served by at least one chaplain. He or she counsels servicemembers of any (or no) faith and often serves as a point of entry into mental health care. Chaplains train and deploy with units and, as a result, have close familiarity with unit needs. Chaplains provide spiritual guidance, advise on spiritual issues, officiate at ceremonies, and provide religious education and workshops to servicemembers. In addition, military chaplains offer nonclinical counseling, which means that they do not rely on formal psychotherapeutic approaches. Chaplains routinely refer servicemembers to other sources of care and assistance, including formal mental health resources. Discussions with chaplains are confidential, making chaplains a trusted source for counseling services for members of the military community.

Morale, Welfare, and Recreation. There are three types of morale, welfare, and recreation (MWR) programs. Mission-sustaining programs are services that promote the physical and psychological well-being of military personnel (Department of Defense, 2009c) and include armed forces entertainment, physical fitness and athletic programs, on-installation parks, basic social recreation programs, and others. Basic community support programs support the physiological and psychological needs of servicemembers and their families (Department of Defense, 2009c) and include community support services, activities, and infrastructure that are intended to turn a DoD installation into a temporary hometown. Services may include child care and youth programs, recreation and community centers, and outdoor recreation programs. Revenue-generating programs include recreational activities that enhance a sense of community while generating income to cover most of their operating expenses (Department of Defense, 2009c), such as hospitality and lodging programs or special-interest recreational programs (e.g., scuba diving, horseback riding, bowling, and golf).

Resources

Beyond existing systems providing psychological health, medical, and support services, programs operate in an environment characterized by offices, policies, messaging campaigns, and other resources. In our conceptual framework, programs in some way directly and actively provide services or interventions that address psychological health and/or TBI, while resources (shown in the lower right quadrant of Figure 3.1) provide a passive, one-way transmission of information. In some cases, it was difficult to identify whether an entity was best classified as a program or a resource; where doubt existed, we included these entities as programs, and they are described in Chapter Five and Appendix B. Resources include informational websites; routine reporting, databases, and registries; CDs, videos, books, and other media; guides and checklists; messaging themes; policies; task forces and committees; and conferences.

Websites. Website resources include those designed to provide one-way transmission of information, such as disseminating crisis hotline phone numbers or information about the existence of programs. Other resources include social networking sites that serve as a means of connection and support for members of the military community; these are not designated as programs because most of these sites are not monitored by mental health professionals and do not provide services that directly affect psychological health. In contrast, those websites that are designed to provide an intervention or to affect a specific outcome, such as the Real Warriors Campaign website (designed to reduce barriers associated with seeking care) and

Military OneSource (which includes a website as well as counseling services), were included as programs.

Routine Reporting, Databases, and Registries. Databases and registries may be used in research with military populations or as an impetus for a program. While the collection of data on TBI, mental health service utilization, or the psychological health of servicemembers can provide an important resource, it does not constitute a program, according to our definition.

CDs, Videos, Books, and Other Media. CDs, videos, books, and other media, such as informational brochures, generally provide one-way transmission of information regarding psychological health and TBI.

Guides and Checklists. Psychological health and TBI guides and checklists are designed to help identify servicemembers who may be at risk for problems or steps to be taken in case of concern. They do not provide services but may indicate where to obtain additional help.

Messaging Themes. Resources also include messaging themes that are sometimes part of a media campaign or the core theme of a program but do not have an interactive component. This may include, for example, TBI prevention and safety campaigns about the use of helmets and seat belts.

Policies. Policies may mandate the provision of services and can serve as the impetus for programs. Policies on their own are not included in this report but are noted in the program descriptions when they spurred a specific program that addresses psychological health or TBI.

Task Forces and Committees. Task forces and committees are generally categorized as resources, since they do not directly provide services or interventions. These entities are typically established to help military leadership understand the nature of a problem or to work collectively to develop and implement recommendations for addressing specific issues.

Conferences. A wide variety of events and conferences are held each year that focus on improving psychological health and reducing or treating TBI. In general, such events do not provide services or interventions directly targeting servicemembers but instead provide a forum for dissemination of information, including research and best practices, and to engage various segments of the DoD community around issues of concern.

CHAPTER FOUR

Methods

This chapter describes the methodology used for identifying programs and conducting data collection and analysis.

Identifying Programs

Identifying programs funded by DoD that focus on psychological health and TBI was not a straightforward task. As a result, we used a multifaceted approach to identify programs for inclusion in this report. Our general approach was to identify as many potential programs as possible in order to ensure that none were omitted and to apply the inclusion and exclusion criteria shown in Chapter Three only after we had adequate information about each potential program, generally obtained through an interview with a program representative. The methods we used to identify programs, described below, were web and other media searching, scanning conference agendas and program materials, reviewing relevant documents that were in the public domain, consulting with military personnel, obtaining DoD lists of programs, consulting with staff at nonprofit organizations, consulting with topic-area experts within RAND, and snowball sampling. We continued searching for new potential programs until we reached saturation—that is, until our efforts consistently identified only potential programs of which we were already aware. After this was achieved, we continued to scan for potential programs as we analyzed our data and wrote this report. Programs identified after this report was written will be added to the Innovative Practices for Psychological Health and Traumatic Brain Injury online database on the RAND website, located at http://www.rand.org/multi/military/innovative-practices.html, that houses information about each program. RAND will maintain this compendium in online format and strive to keep it current through 2012, adding programs that are identified through passive means, such as newsletters and media coverage.

Over the course of our efforts, we contacted 593 individuals to help identify or provide detailed information on potential programs. We identified a total of 652 potential programs, 211 of which met our inclusion and exclusion criteria and are included in this report. Alphabetical lists of programs in tables that display their characteristics are shown in Appendix A, with detailed descriptions of each program included in Appendix B.

Web and Other Media Searching

All team members performed extensive Internet searches to identify potential psychological health and TBI programs, using search terms such as "'military, Department of Defense, Army, Navy, Air Force, OR Marine Corps' AND 'psychological health, mental health, depression, PTSD, OR traumatic brain injury.'" In addition, team members regularly scanned news media, subscribed to daily or weekly email distribution lists from organizations likely to report on new programs (such as DCoE), and used social media (such as Facebook) to search for information on potential programs.

Scanning Conference Agendas and Program Materials

Team members attended conferences related to military health to learn about programs and initiatives via presentations, posters, and networking and also reviewed conference agendas and program materials. Conferences include the Warrior Resilience Conference (November 2009), the Military Health System Conference (January 2010), the Departments of Defense and Veterans Affairs Suicide Prevention Conference (January 2010), the Air Force Community Action Information Board Meeting (April 2010), and the Navy/Marine Combat and Operational Stress Conference (May 2010).

Reviewing Public Domain Documents

We reviewed the following documents to identify potential programs:

- Quadrennial Defense Review Report (Department of Defense, 2010a)
- Statement of Brigadier General Loree K. Sutton, M.D., Director, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury to the Committee on Veterans' Affairs, United States House of Representatives on Department of Defense and Suicide Prevention (Sutton, 2010)
- Army Health Promotion, Risk Reduction, and Suicide Prevention Report (Department of the Army, 2010).

Consultation with Military Personnel

We consulted broadly with personnel in DoD, including individuals in each branch of service, and various military installations. This included individuals who at the time were serving as the directors of psychological health for each branch of service and the National Guard, as well as any individuals they recommended we contact. Many of these individuals supplied lists of potential programs for our use. We also consulted with the Army Suicide Prevention Task Force. Finally, we made calls to 241 medical treatment facilities and to offices related to counseling, family services, personnel, and chaplaincy at 32 additional military installations to identify programs. This is in addition to the 593 individuals with whom we spoke who are described above.

Obtaining Department of Defense Lists of Programs

We identified and reviewed the following lists of programs available within DoD:

- entities funded under the LOA-2 mandate from the DoD and VA Senior Oversight Committee

- entities listed in DCoE's T2WRL and those maintained by DCoE's Clearinghouse
- entities listed in the National Resource Directory (National Resource Directory website, undated).

Consultation with Staff at Nonprofit Organizations

We interviewed staff at the Iraq and Afghanistan Veterans of America (IAVA) and the Wounded Warrior Project to identify potential programs of which they were aware.

Consulting Topic-Area Experts Within RAND

Given RAND's long history of research and analysis in the areas of psychological health and TBI, we consulted colleagues within RAND regarding potential programs of which they were aware. This includes staff members who at the time were working on projects across DoD related to resilience, suicide prevention, mind-body interventions, and military family life, as well as those working on Army deployment cycle and service delivery optimization efforts. We also drew from two reports that contained considerable information on suicide prevention and resilience programs (Ramchand et al., 2011; Meredith et al., 2011), as well as from RAND's 2008 report *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Tanielian and Jaycox, 2008).

Snowball Sampling

Finally, we used snowball sampling techniques to identify potential programs. As we completed each interview with a program representative (see below), we asked about additional programs related to psychological health and/or TBI. We sought to interview any potential programs of which we were previously unaware.

How We Counted Programs

Some programs share a common name and originate from a common policy or instruction but are independently implemented by each branch of service and therefore may have varying features. In these cases, such as the Yellow Ribbon Reintegration Program or substance abuse programs, we include and count each branch of service's program separately. In contrast, there are a number of programs, such as the Semper Fit Health Promotion Program, that are essentially the same program with some minor installation-specific variations. In these cases, we count such programs only once. Where possible, we identified programs that have organizational ties to one another and indicate this information in our description of each program.

Data Collection

RAND staff made at least six attempts via phone and/or email to contact staff responsible for each potential program. For a small number of programs that did not respond (n=24), we were able to develop descriptions of the programs from publicly available documentation (primarily via the Internet), and, thus, we include them in this report. The remaining programs were excluded because they did not meet the inclusion criteria shown in Chapter Three or because of a lack of adequate information. A subset of these excluded programs is described in Appendix

C, including those that were identified as ineligible after an interview was conducted (n=80) and those entities that were identified as research or a resource without an interview (n=94). Table 4.1 shows the dispositions of all of the potential programs that we identified.

Response Rate

We calculated our response rate following the American Association for Public Opinion Research's *Standard Definitions,* Response Rate 3 (American Association for Public Opinion Research, 2008). To do so, we applied an eligibility rate to those potential programs that we were unable to reach and for which we could not establish eligibility (n=27). This eligibility rate represents the estimated proportion of these 27 cases that would have been eligible for the survey, assuming that the eligibility rate for programs that we did reach applied to those that we did not reach. It is defined as

$$\frac{\text{total number of completed interviews}}{(\text{total number of completed interviews} + \text{total number of ineligibles})}$$

Applying this eligibility rate (0.3106) to our data resulted in a response rate of 85.2 percent. This calculation assumes that programs that are included in this report, but whose descriptions were developed from publicly available data, are counted as nonrespondents. Our final completion rate, which includes entries developed from publicly available data as well as those we interviewed, is 96.2 percent.

Table 4.1
Dispositions of Potential Programs Identified

Disposition	Number of Potential Programs
Total number of unique entities identified	653
Ineligible, excluded	415
No interview: identified as research or a resource	94
No interview: identified as ineligible based on other criteria	241
Interview conducted: identified as ineligible	80
Eligible, included, interview completed	187
No response to request for interview	51
No response, excluded, inadequate publicly available information	27
No response, included, description prepared from publicly available information	24

NOTE: The total number of programs included in this report is 211 and comprises the 187 programs for which an interview was completed and the program was deemed eligible for inclusion and the 24 programs for which there was no response to a request for an interview but a description could be prepared from publicly available information.

Table 4.1 also reveals a very high rate of entities that were identified as potential programs but were deemed ineligible for inclusion after further investigation. Nearly 70 percent of the entities identified through the processes described earlier in this chapter were determined to be ineligible based on the inclusion and exclusion criteria shown in Chapter Three. Additional information is available in Appendix C.

Program Interviews

We conducted 30- to 60-minute interviews with each potential program that appeared to meet our inclusion criteria; some were subsequently excluded as a result of the information obtained during the interview. Interviews were conducted between December 2009 and August 2010, and the information included in the program descriptions in Appendix B was correct as of the date of the interview. As an extra assurance, a report including the program description prepared by RAND staff was sent to each interviewee, who was asked to review the report and ensure its accuracy. These reports were sent to 183 programs that were interviewed and were returned by 153 programs (83.6-percent return rate). RAND staff have not independently verified information reported to us by the program representatives.

The topics addressed during the interviews are as follows:

- branch of service and installations served
- organization responsible for administering the program
- start and end date of the program in its current form
- mission, goal, or objectives of the program
- activities and/or services provided by the program
- impetus or motivation for the development of the program
- mode of service delivery (e.g., face-to-face, online)
- evidence base for the content of the program
- domain addressed: biological, psychological, social, spiritual, holistic
- clinical and nonclinical issues addressed (e.g., PTSD, TBI, stress reduction)
- deployment phase to which the program is related (e.g., predeployment, redeployment)
- targeted participants and numbers served
- potential barriers to participation
- cost to participants
- outreach and activities to increase participation
- program funding and staffing
- efforts to evaluate the program and/or maintain documentation on participants served.

Analysis

We reviewed the activities and mission or goal of each program to identify the breadth of program activities across DoD and used this information to categorize these programs into a typology of their activities. Detailed lists that describe to which typology categories each program belongs are shown in Appendix D.

We further describe programs in a variety of ways, presenting information on

- branch of service (DoD-wide, Army, Army Reserve, Army National Guard, Air Force, Air Force Reserve, Air National Guard, Navy, Navy Reserve, Marine Corps, Marine Corps Reserve)
- targeted participants (servicemembers, veterans, family members, civilians)
- deployment phase (predeployment, deployment, redeployment, postdeployment, not related to deployment phase)
- domain (based on an expanded biopsychosocial model, which includes programs that focus on biological, psychological, social, spiritual, and/or holistic aspects of the experiences of servicemembers and their families)
- approach (provision of clinical care; education or training regarding psychological health and/or TBI, including the provision of information regarding these conditions; activities to prevent psychological health problems or TBI or increase resilience in the face of potential psychological health challenges; outreach to connect members of the military community to needed services)
- scale (implemented primarily at one installation, implemented at more than one installation but not across an entire service, implemented across an entire service, implemented across multiple services or the entire DoD, not implemented at time of interview)
- clinical issues addressed (depression, PTSD, substance use, suicide prevention, TBI, general psychological health)
- nonclinical issues addressed (deployment-related, domestic violence, family and/or children, legal, postdeployment and reintegration, relationships, resilience, spiritual, stress reduction, other)
- whether they include evidence-based interventions (Programs with evidence-based interventions have activities and/or interventions that have been evaluated and shown to be effective in one or more research studies or evaluations. This information was supplied by the interviewees; RAND did not independently assess the strength of the evidence base for the programs.)
- whether outcome evaluations have been conducted in the past 12 months
- data that the program currently collects (process data, outcome data).

Additional detail regarding the definition of these characteristics is included in Appendix E. These categories are rarely mutually exclusive. For example, many programs provide services to multiple types of targeted participants, using multiple approaches, or addressing several clinical and nonclinical issues. As a result, there is no single denominator against which to compare numbers of programs. With rare exception, therefore, we do not present statistics, but only counts of programs in various categories. Our discussion of the results draws on these counts but is not based on formal statistical tests of differences between the categories being discussed.

For each program that was interviewed and included in this report, we display several items composing an independent analysis made by RAND staff based on the information obtained from the program during interviews and from publicly available documentation. The "RAND Analysis" section of each program description addresses the questions shown in Table 4.2, which also indicates the range of possible answers. These questions and categories represent a subset of a larger analytic tool, which is the focus of a separate RAND research project.

Table 4.2
Questions Addressed in RAND Analysis Section of Program Descriptions

Question	Responses
Does the goal address what the program is trying to accomplish (i.e., objectives), the target population, and the desired outcomes (i.e., if those objectives are accomplished the changes that occur in the target population)? (Only one may be selected.)	a. The goal does not exist or does not state any of the following: what the program is trying to accomplish, the target population, and the desired outcomes. b. The goal states at least one of the following: what the program is trying to accomplish, the target population, and the desired outcomes. c. The goal states two of the following: what the program is trying to accomplish, the target population, and the desired outcomes. d. The goal states what the program is trying to accomplish, the target population, and the desired outcomes.
Does the program face any of the following barriers to implementation? (More than one may be selected.)	a. Not enough funding or resources b. Not enough qualified staff c. Targeted participants not aware of program d. Perception of stigma associated with services e. Program staff or service providers not on board or fully bought into the program model f. Program is not large enough to handle the number of interested participants g. Leadership not on board h. Referral sources not providing enough referrals i. Program logistics are prohibitive to participants (e.g., hours of operation, location) j. Cost of program prohibitive to participants k. Difficult to get the time with participants to implement the program l. No barriers reported by interviewee m. Other barriers
Has this program conducted an outcome evaluation (that assessed whether the program had the intended impact) in the past 12 months? (Only one may be selected.)	a. Yes b. No c. Don't know
At the time of the interview, what type of data collection was currently under way?	Process data (focuses on program implementation and operation): a. Yes b. No Outcome data (used to identify the results of a program's efforts): a. Yes b. No
Scale of program implementation (Only one may be selected.)	a. Small scale program, being implemented primarily at one installation b. Moderate scale program, being implemented at more than one installation but not across the entire service c. Large scale program, being implemented across an entire service d. Very large scale, being implemented across multiple services or the entire Department of Defense e. Not being implemented at time of interview

Beyond these tabulations of information regarding program characteristics and the RAND analysis of each program, we include brief qualitative case studies that highlight the implementation processes experienced by a small number of programs. These case studies are based on our interviews with program representatives and serve to highlight the diversity of the full breadth of programs in this report. We also provide an assessment of how the programs included in this report help to address the recommendations highlighted in earlier reports, including those of some of the task forces discussed in Chapter One. This information is drawn from our interviews and the content of these reports. Finally, we describe the barriers and challenges that programs reported, presenting general themes that emerged during our interviews.

CHAPTER FIVE

Results

Our findings are divided into multiple sections. The first describes the programs we identified and what we learned as we found them. Next, we provide a typology of program activities, followed by a description the characteristics of the programs included in this report. This information is supplemented by additional detail included in Appendixes A and B. Next, to elucidate some of these findings, we also present case studies that describe the process by which programs are developed and operated in greater detail. We also include a discussion of how the programs we describe in this report address recommendations from the reports of earlier task forces. The chapter closes with a section that highlights some of the challenges and barriers that we identified during the course of our interviews with program representatives. Resolving these challenges will be necessary if DoD is to fully and efficiently implement programmatic solutions to address the recommendations from earlier task force reports.

Identifying Programs

We identified a total of 211 programs meeting the inclusion criteria shown in Chapter Three. Identifying these programs was a complex task, described in detail in Chapter Four. As noted earlier, existing DoD-wide lists and inventories are not comprehensive in this topic area. Further, one key finding from our work is that no branch of service maintains a complete list of these programs, tracks the development of new programs, or has appropriate resources in place to direct servicemembers and their families to the full array of programs that best meet their needs. As we note in Chapter One, existing resources, such as the National Resource Directory, the DCoE T2WRL, and the DCoE Clearinghouse, have only partial listings of programs. Directors of psychological health for each of the services do not have readily available information on all programs offered within their service. There is also no centralized responsibility for authorizing the development of new programs or for tracking them in any way over the course of their efforts. Finally, programs may be initiated in a number of different ways, including centrally by an OSD component, by a branch of service, or based on the interests of a small number of individuals at a single installation, further complicating efforts to identify and track programs over time.

A Typology of Program Activities

To better understand the types of services provided, we grouped programs based on their missions, goals, and activities to develop a typology that can be used to describe *what programs do*. As a result of these efforts, we identified three broad areas along the prevention, identification, and treatment continuum (Table 5.1), each of which is further categorized by two or more specific themes. Together these encompass 23 key activities in which programs engage. In addition, we describe three additional specific areas of focus (Table 5.2) that are common to some of the programs included in this report, with eight key activities. Providing training, education, or support to servicemembers is not included here because it is the default activity for nearly all programs in this report, except those offering similar services to care providers. The categories in this typology are not mutually exclusive, and many programs are well described by more than one category. A description of how each program included in this report fits into this typology is shown in Appendix D.

As we discussed in Chapter Two, there is no overarching conceptual framework for thinking about psychological health and/or TBI programs within DoD. As a result, the categories we present in this typology were derived post hoc based on the programs we include in this report; a different group of programs would have yielded a different typology.

Program Characteristics

In this section, we describe the characteristics of programs by branch of service, targeted participants, and deployment phase. Appendix A provides a program-by-program listing of the characteristics shown here, enabling the reader to identify individual programs that meet a given set of characteristics, and Appendix B includes detailed descriptions of each program. Further, the RAND website (http://www.rand.org/multi/military/innovative-practices.html) includes a searchable tool that allows the user to identify all programs with a given set of characteristics and to view descriptions of each program. This online tool will support the addition of newly identified programs through 2012. Appendix E provides detailed information describing the terms used in the tables below.

Since programs have multiple characteristics, the tables in this section have rows and columns that are not mutually exclusive and therefore cannot be summed, with the exception of Tables 5.5 and 5.8, which can be summed across each row.

Branch of Service

Each branch of service has a unique set of needs for addressing psychological health and TBI among its servicemembers. Variation in need is related to the relative size of each service, its operational tempo, the types of activities in which its servicemembers engage, and other services that may be available to support servicemembers and their families. As a result, it would be inappropriate to compare numbers or types of programs across branches of service. For example, the prevalence of TBI is likely to be significantly lower in the Air Force than among marines, since airmen have lower exposure to IEDs.

Programs that are described as DoD-wide in this section include those that are not targeted at particular branches of service and are therefore available to participants from all services. As a result, in order to identify all programs that servicemembers from an individual

Table 5.1
Typology of Program Activities: Prevention, Identification, and Care for Psychological Health Problems and Traumatic Brain Injury

Area	Theme	Activities
Preventing problems	Reducing the incidence of psychological health problems and TBI	• Improving resilience and the ability to handle stress among members of the military community • Promoting readiness, increasing combat and operational stress control, and preparing for the psychological health consequences of combat
	Employing public health approaches	• Preventing incidents of domestic violence • Preventing incidents of sexual assault • Reducing the risk of substance abuse • Preventing suicide
Identifying individuals in need and connecting them to care	Providing information, connecting individuals to care, and encouraging help-seeking	• Operating a telephone hotline that provides immediate access to counselors and other resources • Serving as an information hub that provides referrals to care • Reducing barriers associated with seeking help for mental health conditions or TBI and/or providing education regarding specific conditions
	Identifying individuals with mental health concerns or TBI	• Conducting routine screening for mental health problems or TBI in the absence of reported symptoms • Increasing the capacity for early identification of mental health problems outside the health care system, with the goal of referring individuals to care when needed
Caring for servicemembers and families in need	Providing or improving clinical services	• Providing comprehensive care for severe or persistent problems among wounded, ill, and injured servicemembers • Improving transitions between care settings and providers, improving coordination and continuity of care, or providing case management • Providing clinical services for mental health concerns, TBI, or other clinical concerns
	Offering mental health services in nontraditional locations to expand access to care	• Embedding mental health providers in primary care or other non–behavioral health clinical settings, or other initiatives to improve treatment for mental health conditions in primary care settings • Embedding mental health providers within military units
	Nonclinical activities that provide support	• Training servicemembers to provide peer-to-peer support for improving psychological health • Offering complementary and alternative treatment services to help address the consequences of mental health concerns and TBI • Providing spiritual support
	Responding to incidents of concern	• Responding to incidents of domestic violence • Responding to incidents of sexual assault • Responding to substance abuse problems • Engaging in post-suicide response

branch of service can access, it is essential to include both DoD-wide programs and those that specifically address the service in question. Programs offering services exclusively to veterans are not included in this report (see Chapter Three for inclusion and exclusion criteria), though some of the programs that are included offer services to veterans in addition to those offered to servicemembers and their families.

Table 5.3 displays programs by targeted participants, deployment phase, and branch of service. Most programs, regardless of branch of service, focus their efforts on uniformed servicemembers, with some programs offering services to family members and civilian employees.

Table 5.2
Typology of Program Activities: Specific Areas of Program Focus

Theme	Activities
Providing training, education, or support for specific populations	• Providing training, education, or support for health care providers, chaplains, or educators • Providing training, education, or support for military leaders, including officers and noncommissioned officers (NCOs) • Providing training, education, or support for servicemembers' families • Programs that promote psychological health for National Guard, Reserve, or Coast Guard servicemembers
Providing support during times of military transition	• Providing support for servicemembers and their families during transitions between deployment phases • Providing support for servicemembers as they transition to civilian life
Internet-based interventions and the use of new technologies	• Internet-based education or delivery of interventions • Application of new technologies

Table 5.3
Number of Programs by Targeted Participants, Deployment Phase, and Branch of Service

	Targeted Participants				Deployment Phase				
Branch of Service	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase
DoD-wide	62	29	43	22	10	12	18	31	28
Army	63	11	33	18	15	11	20	32	33
Army Reserve	27	7	17	10	7	5	6	14	13
Army National Guard	37	10	26	12	13	11	13	24	16
Air Force	28	7	15	7	6	5	8	12	14
Air Force Reserve	9	2	5	3	3	2	4	5	3
Air National Guard	21	7	16	6	7	6	9	14	8
Navy	29	9	20	12	3	3	3	9	22
Navy Reserve	16	3	10	5	3	3	4	5	12
Marine Corps	32	13	18	12	6	5	6	11	21
Marine Corps Reserve	16	5	8	5	3	4	4	4	10

NOTE: Categories are not mutually exclusive, and therefore numbers of programs cannot be summed across either rows or columns. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report and three additional programs run by the Coast Guard.

Within each branch of service, more programs are typically offered for active-duty servicemembers than for those in the National Guard or Reserve components. The large majority of programs for each branch either focus on multiple deployment phases or are not related to deployment phase, rather than focusing primarily on a single deployment phase.

Table 5.4 shows the domains and approaches employed in programs by each branch of service. Given the focus of this report on psychological health, it is not surprising to find a heavy concentration of programs for each branch of service that emphasizes the psychological aspects of servicemembers' needs, with fewer programs focusing on the biological, social, spiritual, and holistic needs of members of the military community. Large numbers of programs focus on education/training and/or prevention/resilience; though not shown in the table, a subset of these programs emphasizes the early identification of mental health concerns and subsequent referral to appropriate care. Many programs also provide clinical services or emphasize outreach.

In Table 5.5, we describe the scale of the programs included in this report. One program had not yet been implemented at the time of our interview but was planning to begin service delivery during the period of our study. DoD-wide programs, not surprisingly, were more likely to be active across multiple services or the entire DoD, though a number of programs based at a single installation were also open to servicemembers across DoD. Programs serv-

Table 5.4
Number of Programs by Domain, Approach, and Branch of Service

	Domain					Approach			
Branch of service	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/ Training	Prevention/ Resilience	Outreach
DoD-wide	24	59	38	13	23	31	44	39	30
Army	20	58	42	16	24	34	41	51	22
Army Reserve	5	21	14	7	9	13	22	18	13
Army National Guard	8	33	23	8	11	13	34	28	21
Air Force	6	28	18	5	7	15	25	24	9
Air Force Reserve	0	10	5	1	1	2	9	7	6
Air National Guard	0	23	13	2	2	2	20	17	16
Navy	7	29	17	6	11	16	27	24	13
Navy Reserve	1	15	9	3	4	4	16	13	9
Marine Corps	9	32	20	5	12	15	28	28	12
Marine Corps Reserve	2	15	10	3	2	5	14	13	8

NOTE: Categories are not mutually exclusive, and therefore numbers of programs cannot be summed across either rows or columns. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report and three additional programs run by the Coast Guard.

Table 5.5
Number of Programs by Scale and Branch of Service

	Scale of Implementation				
Branch of Service	Primarily at One Installation	At More Than One Installation but Not Across an Entire Service	Across an Entire Service	Across Multiple Services or the Entire DoD	Not Implemented at Time of Interview
DoD-wide	21	11	1	23	1
Army	25	20	14	1	0
Army Reserve	9	4	9	1	0
Army National Guard	14	7	13	2	0
Air Force	10	8	7	2	0
Air Force Reserve	2	0	5	2	0
Air National Guard	6	2	12	3	0
Navy	6	10	9	3	0
Navy Reserve	2	3	9	1	0
Marine Corps	7	9	10	4	0
Marine Corps Reserve	0	2	10	2	0

NOTE: Categories for branch of service are not mutually exclusive, and therefore numbers of programs cannot be summed across different branches of service. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report (for one of which no interview occurred), three additional programs run by the Coast Guard, and 24 programs for which no interview occurred and descriptions included in this report were prepared from publicly available information.

ing the Army and Air Force were somewhat more likely to operate primarily at one installation than those serving the Navy and Marine Corps, which were slightly more likely to operate across their entire service; this may reflect a number of organizational factors within the branches of service that affect the most effective and efficient way for them to offer programs to their servicemembers.

Table 5.6 shows the clinical issues addressed by the programs included in this report. Because multiple mental health issues may occur simultaneously and because TBI is frequently associated with accompanying mental health issues, programs typically address more than one clinical issue. In general, though, fewer programs focus on TBI than on issues associated with mental health—including depression, PTSD, substance use, suicide prevention, and general psychological health.

Table 5.6
Number of Programs by Clinical Issues Addressed and Branch of Service

	Clinical Issues Addressed					
Branch of Service	Depression	PTSD	Substance Use	Suicide Prevention	Traumatic Brain Injury	General Psychological Health
DoD-wide	28	36	15	14	26	42
Army	30	39	17	30	14	40
Army Reserve	13	18	7	11	6	17
Army National Guard	18	22	13	16	10	24
Air Force	12	14	8	10	9	16
Air Force Reserve	5	5	2	3	3	8
Air National Guard	11	10	8	9	7	15
Navy	6	10	9	7	4	14
Navy Reserve	3	3	4	4	0	9
Marine Corps	8	13	9	7	5	16
Marine Corps Reserve	3	4	4	4	0	9

NOTE: Categories are not mutually exclusive, and therefore numbers of programs cannot be summed across either rows or columns. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report and three additional programs run by the Coast Guard.

Table 5.7 depicts the nonclinical issues addressed by programs. Many programs focus on issues related to deployment, families and/or children, postdeployment and reintegration, resilience, and stress reduction. The "Other" category includes a wide variety of nonclinical services, each provided by one or a small number of programs, such as programs addressing unit cohesion, parenting skills, employment, or nonclinical support services (such as those related to managing finances or relocation).

Based on the information reported to us during our interviews, DoD-wide programs and those in the Army report being more likely to employ evidence-based interventions than programs serving the Air Force, Navy, and Marine Corps (see Table 5.8). Programs with evidence-based interventions have activities and/or interventions that have been evaluated and shown to be effective in one or more research studies or evaluations. We did not assess the strength of the evidence base employed, so it remains possible that these differences reflect varying perceptions of the individuals interviewed rather than actual differences in empirical support for the programs. It is also possible that there is differential availability of an adequate evidence base for the particular programs of interest to each of the services. Overall, six in ten programs (60.3 percent) report including an evidence-based intervention in their efforts, and 22.8 percent report having an outcome evaluation conducted in the past 12 months. Slightly more than

Table 5.7
Number of Programs by Nonclinical Issues Addressed and Branch of Service

	Nonclinical Issues Addressed									
Branch of Service	Deployment-Related	Domestic Violence	Family and/or Children	Legal	Postdeployment and Reintegration	Relationships	Resilience	Spiritual	Stress Reduction	Other
DoD-wide	28	8	23	4	29	18	29	7	29	22
Army	26	11	28	5	28	24	41	15	35	32
Army Reserve	12	5	11	4	10	10	18	9	15	17
Army National Guard	18	8	17	6	19	17	25	12	21	21
Air Force	10	5	12	1	11	8	15	4	10	7
Air Force Reserve	1	0	3	1	6	1	5	1	4	3
Air National Guard	6	3	9	5	14	8	11	4	8	7
Navy	6	4	15	4	9	7	14	6	10	11
Navy Reserve	2	3	10	3	4	4	7	3	5	7
Marine Corps	8	2	10	1	10	8	13	3	9	12
Marine Corps Reserve	5	1	5	1	5	3	7	2	4	7

NOTE: Categories are not mutually exclusive, and therefore numbers of programs cannot be summed across either rows or columns. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report and three additional programs run by the Coast Guard.

three-quarters (76.1 percent) of all programs report currently collecting process data, while far fewer (45.1 percent) report currently collecting outcome data.

Targeted Participants

This section characterizes programs based on their targeted participants—those who the program is designed to serve. While only those programs that target active-duty, National Guard, and Reserve component servicemembers and/or their families are included in this report, many of these programs also serve veterans and/or civilians (including DoD employees and private-sector clinicians who care for servicemembers).

Table 5.9 displays the domains and approaches by targeted participants. As above, many programs focus on the psychological aspects of servicemembers' needs and use an education/training and/or prevention/resilience approach.

Table 5.10 shows the clinical issues addressed by programs and the programs' targeted participants. As above, there are more programs related to psychological health than to TBI.

Table 5.11 describes the nonclinical issues addressed by programs and the programs' targeted participants. As above, many programs address issues related to deployment, families and/or children, postdeployment and reintegration, resilience, and stress reduction. As in

Table 5.8
Number of Programs by Evidence Base, Evaluation, Data Collection, and Branch of Service

Branch of Service	Includes Evidence-Based Intervention	Outcome Evaluation Conducted in Past 12 Months	Type of Data Currently Collected by Program	
			Process Data	Outcome Data
DoD-wide	43	15	43	24
Army	40	19	50	40
Army Reserve	12	3	19	12
Army National Guard	17	4	31	18
Air Force	16	7	20	17
Air Force Reserve	5	2	7	4
Air National Guard	7	2	18	7
Navy	17	3	23	14
Navy Reserve	7	1	14	4
Marine Corps	17	7	23	15
Marine Corps Reserve	7	4	13	6

NOTE: Categories for branch of service are not mutually exclusive, and therefore numbers of programs cannot be summed across different branches of service. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report, three additional programs run by the Coast Guard, and 24 programs for which no interview occurred and descriptions included in this report were prepared from publicly available information. Only programs that have conducted outcome evaluations within the past 12 months are included here; a small number of programs conducted evaluations at an earlier time period.

Table 5.9
Number of Programs by Domain, Approach, and Targeted Participants

Targeted Participants	Domain					Approach			
	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/ Training	Prevention/ Resilience	Outreach
Servicemembers	48	176	110	36	56	80	139	136	84
Veterans	17	59	40	17	26	30	47	45	35
Family members	25	111	80	24	36	41	91	93	73
Civilians	15	60	36	17	19	21	53	48	37

NOTE: Categories are not mutually exclusive, and therefore numbers of programs cannot be summed across either rows or columns. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report.

Table 5.10
Number of Programs by Clinical Issues Addressed and Targeted Participants

	Clinical Issues Addressed					
Targeted Participants	Depression	PTSD	Substance Use	Suicide Prevention	Traumatic Brain Injury	General Psychological Health
Servicemembers	75	98	52	61	49	115
Veterans	31	37	23	23	26	44
Family members	46	52	33	40	31	76
Civilians	17	24	15	18	9	40

NOTE: Categories are not mutually exclusive, and therefore numbers of programs cannot be summed across either rows or columns. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report.

Table 5.11
Number of Programs by Nonclinical Issues Addressed and Targeted Participants

	Nonclinical Issues Addressed									
Targeted Participants	Deployment-Related	Domestic Violence	Family and/or Children	Legal	Postdeployment and Reintegration	Relationships	Resilience	Spiritual	Stress Reduction	Other
Servicemembers	66	32	70	20	81	60	96	31	83	79
Veterans	23	11	24	7	29	22	32	14	29	19
Family members	51	22	64	15	58	49	62	22	54	52
Civilians	23	6	26	4	25	18	31	13	28	25

NOTE: Categories are not mutually exclusive, and therefore numbers of programs cannot be summed across either rows or columns. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report.

Table 5.7, the "Other" category includes nonclinical services that are each provided by one or a small number of programs.

Deployment Phase

This section describes programs based on the deployment phases for which they provide services. Programs that are accessible to their participants and provide similar services or activi-

ties regardless of deployment phase, such as the Real Warriors Campaign, were determined to be unrelated to deployment. In contrast, if all four deployment phases are indicated, then the program has distinct activities for each deployment phase. This is relevant for such programs as the Yellow Ribbon Reintegration Program, which has separate activities for members of the military community in each of the four deployment phases. If fewer than four deployment phases are indicated, the program has activities targeted toward participants in each of the listed phases.

In Table 5.12, we show programs by the domain they emphasize and the approach they take. In general, regardless of deployment phase, the programs we identified are highly likely to focus on the psychological aspects of servicemembers' needs. Postdeployment programs are somewhat more likely than those emphasizing other phases of the deployment cycle to focus on the social aspects of the experiences of servicemembers and their families. Regardless of which phase of deployment they emphasize, programs are highly likely to use education/training and/or prevention/resilience as their primary approaches.

Table 5.13 depicts the clinical issues addressed by programs and the deployment phase that is emphasized. Similar to what we show above, comparatively few programs focus on TBI, regardless of deployment phase.

Finally, Table 5.14 displays programs by the nonclinical issues they address and the deployment phase that is emphasized. Regardless of deployment phase, many programs address issues related to deployment, families and/or children, postdeployment and reintegration, resilience, and stress reduction.

Table 5.12
Number of Programs by Domain, Approach, and Deployment Phase

	Domain					Approach			
Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/ Training	Prevention/ Resilience	Outreach
Predeployment	9	39	28	8	16	10	35	34	23
Deployment	8	37	23	6	12	9	32	29	21
Redeployment	13	57	40	12	20	17	46	46	34
Postdeployment	22	85	61	15	35	35	70	67	45
Not related to deployment phase	26	89	52	22	22	41	69	72	43

NOTE: Categories are not mutually exclusive, and therefore numbers of programs cannot be summed across either rows or columns. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report.

Table 5.13
Number of Programs by Clinical Issues Addressed and Deployment Phase

	Clinical Issues Addressed					
Deployment Phase	Depression	PTSD	Substance Use	Suicide Prevention	Traumatic Brain Injury	General Psychological Health
Predeployment	20	23	15	16	12	37
Deployment	17	22	14	16	12	34
Redeployment	34	39	22	23	21	50
Postdeployment	48	65	29	30	38	67
Not related to deployment phase	29	32	27	32	12	48

NOTE: Categories are not mutually exclusive, and therefore numbers of programs cannot be summed across either rows or columns. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report.

Table 5.14
Number of Programs by Nonclinical Issues Addressed and Deployment Phase

	Nonclinical Issues Addressed									
Deployment Phase	Deployment-Related	Domestic Violence	Family and/or Children	Legal	Postdeployment and Reintegration	Relationships	Resilience	Spiritual	Stress Reduction	Other
Predeployment	30	12	23	8	34	25	31	10	30	17
Deployment	32	11	21	7	31	24	29	8	28	15
Redeployment	35	16	35	11	49	33	42	14	38	26
Postdeployment	43	20	42	16	67	44	59	19	48	38
Not related to deployment phase	23	11	33	5	16	20	36	14	33	41

NOTE: Categories are not mutually exclusive, and therefore numbers of programs cannot be summed across either rows or columns. We identified a total of 211 programs. We exclude from this table two programs that themselves comprise more than one program included in this report.

Program Development and Implementation

Interviews with program representatives revealed considerable diversity in the processes by which programs are developed and initiated; program size, scope, and implementation

approaches; and the means by which programs are sustained and supported. To better reflect the diversity represented by the programs included in this report, in this section we focus on a small subset of programs to provide further detail regarding their implementation processes. These descriptions are presented to illustrate issues related to program implementation and do not focus on program effectiveness.

We selected five programs for these case studies to represent a variety of the themes discussed in the typology of program activities shown in Tables 5.1 and 5.2. We also selected programs that reflect the diversity of programs on other dimensions, including branch of service, size, and other factors. Additional information on the programs described here is available in Appendix B.

Operational Stress Control and Readiness

Description. The Operational Stress Control and Readiness (OSCAR) program is a large scale program within the Marine Corps intended to prevent, identify, and manage combat and operational stress problems as early as possible. In its current form, the OSCAR program includes three types of staff members: (1) OSCAR mentors, who are willing to assist and mentor other marines with combat and operational stress problems and are charged with early identification of marines with psychological health concerns; (2) OSCAR extenders, non–mental health clinicians and chaplains who bridge the gap between mentors and mental health personnel; and (3) mental health personnel embedded within Marine Corps units. These three groups work together to raise awareness about psychological health issues, identify at-risk personnel, and assist those marines in need of mental health services.

How the Program Was Implemented. In the 1990s, mental health services for Marine Corps members were positioned as external services. Obtaining mental health services required a concerted effort to obtain care, further complicated by existing stigma surrounding the receipt of such services. In an effort to make mental health services more accessible to marines, 2d Marine Division developed the first iteration of the OSCAR program, which embedded mental health service providers within each division.

After several years, the Marine Corps leadership recognized that the need for mental health services was more extensive than could be served by one provider per division. However, with few resources available to provide additional personnel and lingering issues of stigma surrounding mental health services, a creative solution was required. In 2009, the Assistant Commandant of the Marine Corps directed the extension of OSCAR capabilities down to the infantry battalion and company levels. Rather than immediately embedding additional mental health personnel, this directive allowed for training to support the development of mentors and extenders from existing personnel to assist in the identification of marines in need and connect them with appropriate mental health personnel. Mentors—typically senior NCOs—also provide peer support to help marines handle day-to-day stress and encourage them to seek help when needed.

The Marine Corps Combat and Operational Stress Control (COSC) program contracted for the development of a comprehensive training program that would prepare OSCAR mentors and extenders for their new roles. This was initially a two-day training, but after early efforts it became apparent that two days was neither feasible nor sustainable because heavy scheduling in the predeployment phase posed a significant logistical barrier. The training was subsequently condensed into a single day, which has proven to be much more feasible as OSCAR has continued to expand.

Because the program has met with significant enthusiasm from Marine leadership, it has rapidly expanded well beyond its initial scope. At the onset, OSCAR was intended to target primarily infantry battalions, but it has subsequently been extended to logistics and air wing battalions. Because of its rapid large scale growth, the development of program-specific infrastructure has been a challenge. For example, it was difficult to meet the need for qualified trainers for OSCAR mentors and extenders. The Marine Corps focused resources on implementing a train-the-trainer program to substantially increase the number of individuals capable of delivering the OSCAR program. This measure has been successful in increasing the number of qualified personnel who can deliver the OSCAR training and has allowed rapid expansion of program activities.

As OSCAR continues to spread throughout the Marine Corps, a large scale evaluation is being conducted by RAND to determine the effects of the program on stigma, psychological well-being, and mission readiness. Should the program prove to be effective, it may be adapted and expanded on an even larger scale.

Table 5.15 provides additional detail on program characteristics.

Where the Program Fits in Our Typology of Program Activities (see Tables 5.1 and 5.2). Preventing problems: Reducing the incidence of psychological health problems:

- Promoting readiness, increasing combat and operational stress control, and preparing for the psychological health consequences of combat

Identifying individuals in need and connecting them to care: Identifying individuals with mental health concerns:

- Increasing the capacity for early identification of mental health problems outside the health care system, with the goal of referring individuals to care when needed

Table 5.15
Operational Stress Control and Readiness Program Characteristics

Characteristic	Description
Branch of service	Marine Corps, Marine Corps Reserve
Targeted participants	Servicemembers
Deployment phase	Not related to deployment phase
Domain	Psychological, social
Approach	Clinical, education and/or training, prevention and/or resilience, and outreach
Clinical and nonclinical issues addressed	PTSD, general psychological health, deployment-related issues, postdeployment and reintegration, resilience, and stress reduction
Evidence-based interventions	This program does include evidence-based interventions.
Outcome evaluation	This program has conducted an outcome evaluation in the past 12 months.
Process data	This program does not currently collect process data.
Outcome data	This program does not currently collect outcome data.

Caring for servicemembers and families in need: Offering mental health services in nontraditional locations to expand access to care:

- Embedding mental health providers within military units

Focusing on specific populations:

- Providing training, education, or support for military leaders

Key Lessons Learned. OSCAR highlights the possibility of implementing alternative approaches to providing mental health services within military units by training leaders with nonclinical backgrounds to initiate assistance for servicemembers in need and using a train-the-trainer approach to support rapid, widespread implementation.

Fort Hood Resilience and Restoration Center's Warrior Combat Stress Reset Program

Description. The Fort Hood Resilience and Restoration Center's Warrior Combat Stress Reset Program (WCSRP) is a staged multimodal comprehensive Army treatment program for soldiers with clinical PTSD diagnoses. The treatment phases include a three-week intensive day-treatment immersion program followed by approximately ten weeks of individualized follow-up. The day-treatment phase employs standard psychological treatments, such as group therapy focused on cognitive restructuring, as well as skills training designed to lower physiological arousal (e.g., relaxation training, biofeedback). A selection of complementary and alternative therapies (e.g., acupuncture, yoga, Reiki) is used to augment the focus on reduced stress reactivity, increased relaxation, and pain management. The follow-up phase includes individualized treatment plans for individual and group psychotherapy (usually at least PTSD group treatment), continued self-care, and complementary and alternative therapies.

How the Program Was Implemented. WCSRP was initially modeled after a similar residential program that was developed at Fort Bliss for the treatment of PTSD. When the Fort Bliss Restoration and Resilience Center was launched, the Behavioral Health Department at Fort Hood was tasked with the creation of a similar holistic treatment program for soldiers with PTSD. A task force studied the Fort Bliss program, conducted a review of available literature, and determined that a multimodal intensive outpatient program that incorporated psychotherapy and complementary and alternative therapies would best meet the needs of the soldiers at Fort Hood. Initially the complementary and alternative therapy components of the program were viewed with some trepidation, as holistic and alternative approaches were not generally in widespread use on Army bases. With time and advocacy, however, both the enrolled soldiers and their commanding officers accepted these as essential components of the program.

One of the key elements that staff feel has contributed to the program's efforts was the involvement of highly qualified alternative care providers. Because of Fort Hood's location in central Texas, the program was able to benefit from the existence of an extensive local network of experienced alternative care providers, many of whom were familiar with the military environment through personal and family experiences. The combination of experienced complementary and alternative care providers and mental health professionals with military knowledge proved instrumental in providing services tailored to soldiers with PTSD. Because the program relies on the synergy between traditional psychotherapy and complementary and alternative modalities, it is also essential that the clinicians delivering treatment be supportive of a holistic approach. Several clinicians initially involved with the program did not have prior

expertise or interest in holistic therapies, so the program instituted an informal, individualized training process to assess the skills of incoming staff, capitalize on their strengths, and fortify weaknesses.

As a program still under development, one of the most difficult challenges has been the lack of ability to make midcourse adjustments to the program's core features. Funds and staff are not easily transferable from one area of the program to another, which is particularly challenging as the program continues to assess the need for certain services. The available budget distribution can be revisited only during the annual budget and contracting process, which means that change occurs slowly and may lag behind existing need. For example, although there was a budget shortfall for one treatment modality and a surplus in others, the annual contracting process did not allow resources to be readily transferred to address this imbalance.

Despite the challenges and slow pace of change, the WCSRP team expects their program to continue to grow. Their ongoing collection of outcome data indicates a positive and significant change in symptoms of physiological arousal, depression, anxiety, and PTSD indicators, and participant satisfaction has been consistently high. These data have been helpful to the team in demonstrating that the program provides an important service to soldiers, and the team believes that this will be essential in securing future funding and support. Over a dozen intensive outpatient programs of similar design are being developed around the military, with Fort Hood providing guidance.

Table 5.16 provides additional details.

Where the Program Fits in Our Typology of Program Activities (see Tables 5.1 and 5.2). Caring for servicemembers and families in need: Providing or improving clinical services:

- Providing comprehensive care for severe or persistent problems among wounded, ill, and injured servicemembers

Caring for servicemembers and families in need: Providing or improving clinical services:

Table 5.16
Warrior Combat Stress Reset Program Characteristics

Characteristic	Description
Branch of service	Army, Army Reserve, Army National Guard
Targeted participants	Servicemembers
Deployment phase	Postdeployment
Domain	Biological, psychological, social, holistic
Approach	Clinical, education and/or training
Clinical and nonclinical issues addressed	PTSD
Evidence-based interventions	This program does include evidence-based interventions.
Outcome evaluation	This program has conducted an outcome evaluation in the past 12 months.
Process data	This program currently collects process data.
Outcome data	This program currently collects outcome data.

- Providing clinical services for mental health concerns, TBI, or other clinical concerns

Caring for servicemembers and families in need: Nonclinical activities that provide support:

- Offering complementary and alternative treatment services to help address the consequences of mental health concerns

Key Lessons Learned. WCSRP demonstrates that multimodal comprehensive treatment programs that include complementary and alternative therapies can be implemented in a military setting. Because this program differs from more traditional treatment programs, some midcourse adjustments have been necessary, highlighting the challenges posed by administrative processes.

Traumatic Brain Injury: The Journey Home

Description. Traumatic Brain Injury: The Journey Home is a website with interactive components that provides patients and families with information about the causes and treatment of TBI and how to cope with the long-term consequences of TBI. Educational materials, personal testimonies, and multimedia presentations are available, addressing biological, psychological, social, educational, resilience, and outreach needs relevant to TBI survivors and their families.

How the Program Was Implemented. Between 2001 and 2007, the Defense and Veterans Brain Injury Center (DVBIC) reported over 2,000 cases of TBI, but there were few existing patient education materials focused on the unique aspects of military-acquired TBI. As a result, a need for program development in this area was identified, and the Air Force Center of Excellence for Medical Multimedia (CEMM) adopted TBI as a topic for website development.

Staff at CEMM developed a basic outline for the website after consulting with staff at DVBIC. Using a standard CEMM protocol for the development of web content on medical conditions, their initial approach focused on describing brain anatomy and defining TBI, as well as detailing signs and symptoms, diagnosis, treatment, and recovery from a lay perspective. During the program development phase, the team collaborated with the Defense Health Board Traumatic Brain Injury Family Caregiver Panel, which was tasked with developing educational materials for caregivers with family members affected by TBI.

The two teams began by comparing existing content that each had developed and conducting a gap analysis to determine what additional materials would need to be developed to meet the goals of each team. The results of this process revealed that sufficient background materials on TBI had already been developed and that most of the content in need of further development fell in the domain of caregiver support. The final website content was designed to cover both medical information about TBI for the layperson and information about caregiver roles and supports.

To ensure that resources were available online as quickly as possible, the teams decided to launch the website prior to adding the caregiver-specific program content. This content was the most difficult to develop, as little existing work had focused specifically on caregivers for individuals with TBI. Thus, literature on health literacy and caregiving in general needed to be reviewed and adapted to fit with the needs of caregivers for those with military-acquired TBI. The additional caregiver content was added six months after the original program content was launched.

Although the benefits of this complex collaboration were clear, there were also some challenges, one of which was balancing the goals of two teams in the decisionmaking process. As in any collaborative effort, meeting this challenge required communication, compromise, and contributions from both teams in order to develop the final product.

Table 5.17 provides additional details on program characteristics.

Where the Program Fits in Our Typology of Program Activities (see Tables 5.1 and 5.2). Identifying individuals in need and connecting them to care: Providing information, connecting individuals to care, and encouraging help-seeking:

- Reducing barriers associated with seeking help for mental health conditions or TBI and/or providing education regarding specific conditions

Web-based interventions and the use of new technologies:

- Web-based education or delivery or interventions

Key Lessons Learned. Traumatic Brain Injury: The Journey Home demonstrates that websites can be developed to deliver complex medical information designed to educate members of the military community. This website is the result of a collaborative effort between two groups with complementary goals, suggesting that partnering across organizations can be a potentially effective means of meeting multiple goals, avoiding duplication of effort, and providing more complete information and services to the intended population through a single access point.

Families OverComing Under Stress

Description. Families OverComing Under Stress (FOCUS) is a large scale program providing services that augment existing military medical and family support programs in order to target prevention services to support family readiness and wellness and to enhance access

Table 5.17
Traumatic Brain Injury: The Journey Home Program Characteristics

Characteristic	Description
Branch of service	DoD-wide
Targeted participants	Servicemembers, veterans, family members, and civilians
Deployment phase	Not related to deployment phase
Domain	Biological, psychological, social, spiritual, holistic
Approach	Clinical, education and/or training, prevention and/or resilience, and outreach
Clinical and nonclinical issues addressed	TBI
Evidence-based interventions	This program includes evidence-based interventions.
Outcome evaluation	This program has not conducted an outcome evaluation in the past 12 months.
Process data	This program currently collects process data.
Outcome data	This program does not currently collect outcome data.

to a continuum of psychological health services for servicemembers, families, and children. Services provided by FOCUS include direct outreach to family members, outreach to military leaders and providers, educational workshops, skill-building interactive groups, resiliency training, and consultation services for providers and family members.

How the Program Was Implemented. FOCUS was developed in response to increasing documentation that military families were under greater stress and had an increasing incidence of divorce, child abuse, substance abuse, and other problems. The Department of Defense Mental Health Task Force identified high-risk families as an underserved population in need of assistance (see Chapter One for more information on this task force).

To address this need, the Navy Bureau of Medicine and Surgery (BUMED) built a partnership with a team of researchers from the University of California at Los Angeles and Harvard University who had developed a family program to improve resiliency within the civilian population. BUMED and the research team worked together to adapt the program to the specific needs of military families, and the program was initially implemented at seven installations.

Unlike programs that begin as grassroots efforts, FOCUS was developed at the initiative of military leaders, with early buy-in from the chain of command. As a result, the program immediately found support from leadership at the installations where it was implemented. Furthermore, because funding was appropriated well before the implementation phase, program development was able to proceed smoothly without needing to focus substantial time and effort on garnering resources. At the same time, given the large scale of the program's efforts, one of the biggest challenges has been obtaining permanent space at installations to house program activities.

Table 5.18 provides additional details.

Where the Program Fits in Our Typology of Program Activities (see Tables 5.1 and 5.2). Preventing problems: Reducing the incidence of psychological health problems:

- Improving resilience and the ability to handle stress among members of the military community

Table 5.18
Families OverComing Under Stress Program Characteristics

Characteristic	Description
Branch of service	Army, Air Force, Navy, Marine Corps
Targeted participants	Servicemembers, family members, and civilians
Deployment phase	Not related to deployment phase
Domain	Psychological and social
Approach	Clinical, education and/or training, prevention and/or resilience, and outreach
Clinical and nonclinical issues addressed	General psychological health, family and/or children, postdeployment and reintegration, relationships, and resilience
Evidence-based interventions	This program includes evidence-based interventions.
Outcome evaluation	This program has conducted an outcome evaluation in the past 12 months.
Process data	This program currently collects process data.
Outcome data	This program currently collects outcome data.

Focusing on specific populations:

- Providing training, education, or support for servicemembers' families

Key Lessons Learned. The FOCUS program demonstrates the feasibility of implementing a large scale program in military settings when funding is appropriated at the program outset and that existing civilian program content can be adapted to support the psychological health of military families. This program has also been successful at attracting nongovernmental sponsors to support its efforts.

Real Warriors Campaign

Description. The Real Warriors Campaign is a large scale multimedia program designed to promote resilience, facilitate recovery, and support the reintegration of returning servicemembers, veterans, and their families. One of the main goals of the campaign is to reduce stigma and remove barriers that impede the treatment of mental health issues among servicemembers. The campaign includes several types of programming, such as outreach, print materials, a website, and the use of social media.

How the Program Was Implemented. The need for large scale programs to combat stigma and assist servicemembers in reaching out to appropriate mental health services was first identified by the 2007 Department of Defense Mental Health Task Force (Department of Defense Task Force on Mental Health, 2007). As a result of the findings of this task force, the Real Warriors Campaign was established to address these needs among servicemembers. After identifying the basic needs the program would be designed to meet, the services of a contractor were engaged to further develop program content.

Initial program development included a review of existing literature, focus groups with servicemembers representing different segments of the population (e.g., officers, female servicemembers, enlisted personnel), and consultation with experts to determine the most important areas of focus for the program. The final campaign was inspired by the National Institutes of Mental Health campaign "Real Men, Real Depression," which focused on reducing stigma and assisting men in reaching out to access available mental health services. In particular, the "Real Men, Real Depression" campaign used a variety of media, including printed pamphlets, television spots, and video, as well as in-person outreach to raise awareness of the fact that depression is a common problem among men. Similarly, the Real Warriors Campaign focused on developing multimedia tools that would reduce the stigma associated with seeking mental health care, with particular focus on personal accounts from real servicemembers. Thus, the Real Warriors Campaign was able to benefit from program implementation groundwork laid by the "Real Men, Real Depression" campaign while constructing specific content tailored to a military population.

The Real Warriors Campaign website launched in May 2009. Since that time, hits on the website have steadily increased. However, the intended audience for the campaign is very broad, including current servicemembers, veterans, family members, and caregivers, creating a continuing challenge of conducting effective outreach to all of these populations. The program staff has engaged in promotion strategies, including showcasing the website at conferences, cross-listing the website on relevant partner websites, and raising awareness of the website through newsletters and mailing lists. Currently, the campaign is engaging in additional strategies to promote awareness, including new outreach programming that engages former pro-

fessional football players as speakers, with the hope of reaching a broader swath of the target audience.

In addition to increasing outreach efforts, the Real Warriors Campaign is also focused on improving access to its informational material. To this end, the campaign is in the process of developing a mobile version of the website for smartphone access and adding social networking capabilities, and the staff has improved the ease and speed with which informational materials can be obtained by users by incorporating shopping cart technology into the website.

Table 5.19 provides additional details on program characteristics.

Where the Program Fits in Our Typology of Program Activities (see Tables 5.1 and 5.2). Identifying individuals in need and connecting them to care: Providing information, connecting individuals to care, and encouraging help-seeking:

- Reducing barriers associated with seeking help for mental health conditions or TBI and/or providing education regarding specific conditions

Internet-based interventions and the use of new technologies:

- Internet-based education or delivery of interventions

Key Lessons Learned. Although the Real Warriors Campaign is still expanding and adapting, the work conducted thus far suggests that complicated issues, such as reducing barriers to care and decreasing stigma, may be addressed through multimedia campaigns that highlight personal experiences.

Summary

The case studies detailed in this section highlight the diversity of substantive content and implementation processes across programs addressing psychological health and TBI among

Table 5.19
Real Warriors Campaign Program Characteristics

Characteristic	Description
Branch of service	DoD-wide
Targeted participants	Servicemembers, veterans, family members
Deployment phase	Predeployment, deployment, redeployment, postdeployment
Domain	Psychological, social
Approach	Education and/or training, prevention and/or resilience, outreach
Clinical and nonclinical issues addressed	TBI, general psychological health, postdeployment and reintegration
Evidence-based interventions	This program does not include evidence-based interventions.
Outcome evaluation	This program has not conducted an outcome evaluation in the past 12 months.
Process data	This program currently collects process data.
Outcome data	This program does not currently collect outcome data.

members of the military community. Programs included efforts and content initiated by military leadership, researchers, and specialized task forces and encountered a variety of challenges to implementation. The diversity in scope and size also contributed to a broad spectrum of implementation strategies and challenges, including garnering resources, reducing duplication of efforts, and meeting the logistical challenges of widespread implementation. These case studies highlight that a variety of implementation strategies may be effective in initiating and maintaining programs and that no single strategy for implementation will meet the needs of all programs.

How Programs Address Recommendations from Earlier Reports

The reports described in Chapter One, along with two additional reports from the Army (Traumatic Brain Injury Task Force for the Department of the Army, 2007; *Army Health Promotion, Risk Reduction, and Suicide Prevention Report*, 2010), provided a series of recommendations regarding the improvement of services for psychological health and TBI within DoD. Some of these recommendations potentially relate to the programs included in this report. In this section, we summarize a subset of such relevant recommendations by theme and describe how the programs discussed in this report help to address them. This section is not intended to provide a comprehensive review of the recommendations provided in these prior high-level reports, but rather to highlight the ways in which a small number of the programs discussed in this report may complement efforts by clinical care settings and supportive counseling services to address the recommendations of these earlier task force, working group, and commission reports. Further, the programs described here are mentioned for illustrative purposes only and do not represent an endorsement on the part of RAND regarding the effectiveness with which they address these recommendations. More-detailed descriptions of each of the programs mentioned here can be found in Appendix B.

Integrating Mental Health Care into Primary Care Settings

Recommendations from these prior high-level reports include integrating mental health professionals into primary care settings and expanding primary care provider screening of patients for mental health issues. Since such arrangements are not part of routine clinical care and are generally administered as freestanding programs housed within the clinical care system, we include them in this report.

One program that is designed to meet these needs is RESPECT-Mil, an Army program whose goal is to enhance the recognition and management of PTSD and depression among servicemembers in primary care settings. The program involves routine screening for these conditions in primary care settings, the placement of a care facilitator at primary care sites, and enhanced access to behavioral health specialists to support both the care facilitator and the primary care clinician.

Similarly, the Air Force's Behavioral Health Optimization Program (BHOP) includes psychologists and social workers in servicemembers' health care teams, with psychiatrists available in an advisory capacity. Primary care case managers refer servicemembers seen in primary care to psychologists or social workers as needed; these providers see the servicemembers while they are in the clinic for their original primary care appointment and provide immediate or same-day feedback to the primary care manager about the servicemember's needs. At the time

of this report, BHOP mental health providers were integrated into primary care internal medicine, obstetrics/gynecology, and pediatric medical clinics.

Another example is the Navy's Behavioral Health Integration Program, which places mental health providers in primary care facilities to be on hand to ensure continuity of care; serve as consultants to primary care providers; and provide sailors with short, focused assessments, brief interventions, skill training, and behavioral change plans.

Building the Capacity of Leadership to Address Psychological Health Issues

The prior high-level reports also included recommendations addressing the need to build skills among leaders at all levels to prevent, identify, and address psychological health issues, including the development of leadership training programs. For example, the Marine Corps Suicide Prevention Program includes a component with an explicit leadership focus. It includes activities to educate leaders about suicide risk and to incorporate suicide prevention as an expectation of leaders and as part of the Marine Corps culture.

The Navy offers the Navy Operational Stress Control program, with the goal of providing an environment in which sailors and their families can thrive in the midst of stressful situations. A strong focus of the program is helping leaders understand their role in facilitating help-seeking and creating a climate in which leaders' actions serve to increase sailors' resilience. Further, the Army's Master Resiliency Training Program employs a set of techniques taught to officers to enhance the soldiers' ability to cope with stress through positive psychology.

Combat Stigma Associated with Mental Health Problems

Several recommendations from these prior high-level reports focus on the need for efforts to reduce the stigma associated with seeking care for mental health problems. One program that contributes to fulfilling this need is DCoE's Real Warriors Campaign, which has a key goal of removing barriers that prevent servicemembers from obtaining treatment for mental health issues, including but not limited to stigma. The program includes a website and related media campaign materials that feature depictions of real servicemembers who sought treatment while maintaining successful military careers.

Increasing Access to Mental Health Care by Expanding Services

Recommendations in this area from prior high-level reports include embedding mental health professionals within line units in order to improve access to care regardless of a servicemember's location. One program that typifies this approach is the Marine Corps OSCAR program. Among other activities, OSCAR embeds mental health professionals at the division level but extends their efforts down to the battalion level by providing training for chaplains and for health care providers in other specialties. NCOs are also trained, with a particular focus on early identification of mental health problems and referral of marines to a variety of resources.

Another approach to expanding services is represented by inTransition, a program that began in 2010 and which is available to servicemembers across DoD if they are transitioning because of new orders, relocation, a call to active duty, return to civilian status, or other reasons. The program provides coaching by a licensed behavioral health clinician, assistance with referrals to and follow-up with new providers, and connection to other community resources to ensure access to appropriate mental health care and continuation of treatment.

Increasing the Use of Evidence-Based Practices

A number of recommendations from these prior high-level reports focus on increasing the use of evidence-based approaches to caring for servicemembers. One Air Force program in this area, PTSD Provider Training, specifically trains mental health providers in therapeutic approaches that have been demonstrated to help individuals with PTSD. In addition, the program has trained a smaller number of master clinicians to serve as mentors to other providers in order to support their use of evidence-based practices.

Another effort, the Co-Occurring Disorders Program, is a Navy and Marine Corps program to support the use of evidence-based practices among health professionals, mental health specialists, and clergy regarding the provision of integrated treatment services for people with nonsevere psychiatric disorders that co-occur with substance use disorders.

Further, the Center for Deployment Psychology, a component center of DCoE, offers workshops that train military and civilian mental health providers in empirically supported treatment methods for addressing psychological trauma and resilience, including treatment of PTSD and other problematic responses to trauma and deployment.

Programs such as these that seek to increase the use of evidence-based practices primarily focus on improving their use in clinical care settings, which are otherwise excluded from this report. This may be due in part to the fact that there is a comparatively limited evidence base to date for many of the content areas on which included programs focus (e.g., suicide prevention).

Improving Support for Family Members

Enhancing the ability of military families to cope with the stresses of military life, including deployment, was emphasized by several recommendations in these prior high-level reports. For example, FOCUS originated in the Navy and provides family resiliency services to members of the military community.

Another program, the Special Operations Force Resilience Enterprise Program, focuses on the unique psychological needs of family members of special operations forces throughout DoD. Family Strong Hawaii, a program at Tripler Army Medical Center, provides support to family members as they prepare for and experience the departure, absence, and return of soldiers deploying from that installation. Family Strong Hawaii comprises a set of interactive and educational classes that address the coping, emotional, spiritual, financial, transitional, and relational needs of families. The Military and Family Life Consultants program is an additional program aimed at enhancing operational and family readiness and provides short-term counseling services focused on situational issues and problem-solving.[1]

Barriers to Maximizing the Effectiveness of Programs

Despite our identification of programs that directly address one or more of the recommendations from earlier reports that are described above, we also identified a number of potential barriers that must be addressed before programs can fully and efficiently implement those recommendations.

[1] Since this interview was conducted, this program has been renamed Military and Family Life Counselors.

Information Is Highly Decentralized

During our interviews, a number of program representatives noted that they did not know whether others in the DoD community had similar programs or materials they could borrow or learn from, what approaches other programs had used, and whether other programs had been successful in the past. In part as a result of this lack of sharing of knowledge, programs proliferate without utilizing a centralized evidence base or source for materials. This can lead to significant inefficiencies, contradictory information, and duplicative efforts, such as multiple programs developing teaching points and training materials on the same topic or programs with similar objectives using conflicting approaches to supporting psychological health among members of the military community.

Programs Are Developed in Isolation from the Existing Care System

Some programs are designed to encourage the early identification of mental health concerns and to provide appropriate referrals to clinical care where needed. However, relatively few programs are established in partnership with or sustain formal relationships with existing clinical or supportive counseling services, except where such programs are embedded as an inherent part of the existing care system. This lack of linkage and partnership is troubling, leaving programs without a consistent course of action when follow-up care is needed and leaving existing care systems without the ability to predict how new programs are likely to affect referrals to their services and their resultant workload.

Programs Face Common Barriers

The most common barriers to providing services mentioned by our interviewees were

- inadequate funding, resources, or staff capacity to provide services, given the existing demand (mentioned by 22 percent of programs)
- potential participants' concerns about the stigma associated with receiving mental health services, fear of commanders learning about services used, and fear of career repercussions (25 percent)
- lacking the ability to have servicemembers spend adequate amounts of time with the program staff and/or materials because of other obligations on the part of participants or providers (18 percent).

Other barriers were mentioned less frequently, including program logistics (such as hours of operation, transportation, and administrative barriers to participation); a lack of awareness among potential participants about the program and/or its services; and the lack of full support from military leadership. Several programs also reported concerns regarding a lack of continuity of care when servicemembers are deployed or undergo a permanent change of station. While some of these barriers can be ameliorated, others will require that programs employ creative solutions to ensure that they are functioning optimally in the face of those barriers that are not readily amenable to change.

Evaluation Is a Challenge

Programs are evaluated infrequently: Fewer than one-third of programs in any branch of service reported having an outcome evaluation in the past 12 months (see Table 5.8). At the same time, for those programs with an evaluation, the rigor of the evaluation may vary in terms of

whether it was conducted by an independent party or by program staff, whether it had a control group, whether it examined both processes (implementation efforts) and outcomes, and the appropriateness of the metrics used.

With infrequent evaluation and a decentralized evidence base, no means exists to allow successful programs or components of programs to be replicated. There is no method for ensuring that efforts to fund continuation and expansion of programs to address psychological health and TBI focus on those programs that have been demonstrated to be effective. Even programs with a planned evaluation component are sometimes rolled out rapidly prior to evaluation results being available in an effort to meet a perceived need for services. Given the lack of centralized oversight, it is also possible that some programs are incorporating techniques that have been shown to be ineffective or harmful.

Limitations of Our Findings

We note the following limitations of our efforts that affect the ability to interpret our findings:

- The landscape of existing programs is constantly evolving as new programs are established and existing programs are changed, updated, or discontinued. Any effort to describe these programs, including ours, can provide only a point-in-time "snapshot" of these programs.
- We rely on reports by program staff regarding the content and characteristics of each program and have not independently verified the information they shared with us.
- There are many ways to count programs. For example, for programs that share a common name and originate from a common policy or instruction but are independently implemented by each branch of service and therefore differ in their details, we counted the program in each branch of service separately. A different count of programs would be generated by a different set of decision rules.
- Many programs cross categories, making efficient categorization of programs a challenge. For example, many programs care for individuals in multiple branches of service, provide interventions across multiple deployment phases, or address multiple issues related to psychological health.
- Finally, it is possible that we have omitted some locally administered programs, as it was not possible to contact every organizational location in which a program might be housed at every military installation.

CHAPTER SIX

Recommendations and Conclusions

In Chapter Five we summarized key features of existing programs, highlighting those that address one or more of the recommendations made by previous high-level reports regarding psychological health and TBI and the improvement of services within DoD. However, we also summarized barriers and challenges that will need to be addressed in order to fully and efficiently implement those recommendations. In this chapter, we describe our recommendations for overcoming those barriers and identify areas where efforts may be expanded to better support the needs of servicemembers and their families. These recommendations are drawn from both our interviews with program representatives and from the process of identifying these programs, and our assessment suggests several high-level priorities for DoD:

- Take advantage of programs' unique capacity for supporting prevention, resilience, early identification of symptoms, and help-seeking to meet the psychological health and TBI needs of servicemembers and their families.
- Establish clear and strategic relationships between programs and existing mental health and TBI care delivery systems.
- Examine existing gaps in routine service delivery that could be filled by programs.
- Reduce barriers faced by programs.
- Evaluate and track new and existing programs, and use evidence-based interventions to support program efforts.

Take Advantage of Programs' Unique Capacity for Supporting Prevention, Resilience, Early Identification of Symptoms, and Help-Seeking to Meet the Psychological Health and TBI Needs of Servicemembers and Their Families

Our work finds a lack of clarity regarding the role of programs and the unique contribution that they can make to addressing psychological health and TBI among members of the military community. This section offers recommendations regarding how to capitalize on the strengths that programs often possess in order to address these issues.

Recommendation 1.1: Develop Programs' Capacity for Early Identification, Promotion of Help-Seeking, and Referrals to Appropriate Resources for Members of the Military Community with Mental Health Concerns

Efforts are under way to ensure that the clinical resources in use throughout the treatment system are state of the art and readily available. Thus, duplication of these efforts by programs

is unnecessary. However, clinical resources and support services for those facing challenges associated with psychological health or TBI can be accessed only after individuals, their family members, their peers, or their leaders identify a need for assistance. One unique role that programs can potentially fill is in the area of training and education to support early identification of concerns and symptoms, encouraging individuals to seek help, and identifying resources to provide such assistance. Clinicians—even those embedded within military units—have a limited ability to engage in such activities because they may have had limited contact with servicemembers and their families prior to the identification of problems. Programs that provide training can help to fill this gap by building skills among members of the military community to recognize and act in response to concerns related to psychological health or TBI in themselves or others. For such programs to be effective, however, referral processes need to be in place to ensure that follow-up care is available when needed.

Recommendation 1.2: Programs Bring Particular Strength in Focusing on Prevention and Resilience; This Capacity Should Be Further Developed

As is the case with Recommendation 1.1, the clinical care system and most supportive counseling services are not well positioned to improve prevention and resilience because they typically encounter servicemembers and their families only after a problem is identified and help is sought. In contrast, programs provide opportunities to focus on prevention and resilience and to build skills in these areas among servicemembers and their families.

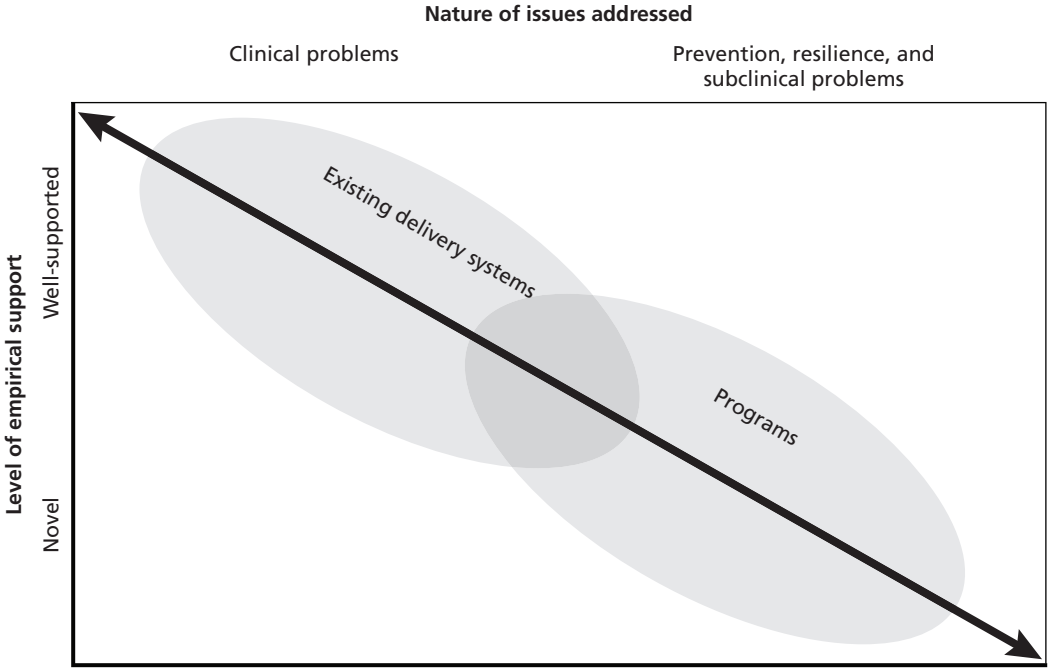
The growth of such programs should emphasize the adoption of evidence-based approaches, which have been described elsewhere for the general area of resilience (Meredith et al., 2011) and for suicide prevention in particular (Ramchand et al., 2011). At the same time, careful attention should be paid to the messages developed as part of these programs. Overemphasis on resilience may have the unintended consequence of increasing stigma, since individuals with symptoms of psychological health problems may feel that help-seeking is a sign that they are not resilient.

Recommendation 1.3: Programs Should Serve as Testbeds for Piloting New and Innovative Approaches to Psychological Health and TBI Care

Figure 6.1 presents an overview of the ideal characteristics of services provided by programs and by the existing delivery system, including clinical care and supportive counseling services. It illustrates where the existing delivery system and programs would each ideally place their primary emphasis. Under this framework, the majority of care provided in existing delivery systems should consist of treatment approaches that are supported by an empirical evidence base, such as cognitive behavioral therapy for depression. Care in these settings may also rely in part on treatment approaches that have mixed or less empirical support. Ideally, novel or unproven treatment approaches would be avoided in this setting, except when explicitly part of a clinical trial or other research project with appropriate protections in place for members of the military community who receive such treatment.

In contrast, programs can serve as a testbed for new and innovative approaches to supporting psychological health and providing care for TBI, and they can provide a mechanism for building the evidence base both for clinical care and for nonclinical approaches, such as programs designed to improve resilience. It is notable that many of the content areas in which programs provide services have a very small available evidence base (e.g., suicide prevention), so allowing for new approaches that have limited existing evidence will be crucial to supporting

Figure 6.1
Ideal Characteristics of Services Provided by Programs and the Existing Delivery System



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innovation. When such new approaches are developed or applied, it is imperative that they be subject to appropriate evaluation to ensure that they are effective (see Recommendation 5.1).

With appropriate research and evaluation to demonstrate their effectiveness, a subset of programs may be scaled up for widespread implementation, or their approaches may become part of routine care when appropriate. Regardless of roles such as these that programs may fill, they will remain an ideal environment in which prevention, resilience, and subclinical problems can be addressed, since the clinical care delivery system will not typically see individuals until they have significant symptoms for which they seek help. Some programs, particularly those that provide services on a more-intensive basis, may also care for servicemembers with clinical problems that cannot be readily addressed in more routine care settings.

Establish Clear and Strategic Relationships Between Programs and Existing Mental Health and Traumatic Brain Injury Care Delivery Systems

In general, few programs have established relationships with the existing care delivery system or formal mechanisms for referring servicemembers or their families for clinical care when needed. Where such mechanisms exist, they are typically built into the structure of the program—for example, they exist because the program embeds mental health providers in military units or in primary care clinics or because the program is housed within a family or community services program that offers supportive counseling services. However, reliable and accessible lines of communication and established referral processes between programs and existing clinical care systems are essential for ensuring that programs can meet their potential

to serve as a means of early identification of clinical and subclinical symptoms, to function as a testbed for new and innovative approaches to care, and to maximize the efficiency of clinical care by allowing programs to address subclinical cases and therefore enable the health care system to focus on those servicemembers with more-severe concerns. Many members of the military community for whom programs provide care will not need follow-up services; when they do, however, established relationships between programs and systems providing routine care are essential to ensure coordination and continuity of care.

Recommendation 2.1: Programs Should Complement or Supplement Existing Services

Programs are not stand-alone substitutes for clinical services. Rather, programs may complement or supplement existing services by focusing on subclinical psychological needs, allowing them to divert some of the burden on the clinical care system and supportive counseling services; by focusing on prevention, resilience, and early identification of problems (see Recommendations 1.1 and 1.2); by embedding mental health providers in nontraditional locations, such as within military units or in primary care settings; or by providing services in coordination with the clinical care system. However, even programs that focus on embedding clinicians within military units will still sometimes need to refer patients to traditional clinical care settings, which highlights the need to ensure appropriate linkages and partnerships with the clinical care system. While there are existing programs that address subclinical psychological needs and those that embed mental health providers in nontraditional settings, this recommendation is intended to suggest the need for increasing and/or expanding those types of programs.

Recommendation 2.2: Ensure That Systems Exist to Support Appropriate Handoffs Between Programs and Other Settings and That Transitions in Care Are Appropriately Coordinated

As in other areas of health care, planning for appropriate referrals and transitions between providers and care settings is essential for ensuring that servicemembers' and family members' needs for care are met, that their care is continuous and coordinated, and that they transition safely between care providers. This focus on continuity of care is particularly important for programs that are focused on early identification of problems and those that provide limited treatment. Every program meeting these criteria should have formal referral and follow-up procedures in place and should ensure that appropriate information regarding available resources for follow-up care is accessible to all who need it.

Recommendation 2.3: Track Referrals From Programs to Existing Clinical Care Systems on a Continual Basis, Including the Volume of Referrals and Rates of Follow-Up on Referrals Received

For individuals to successfully access follow-up care when needed, there must be adequate capacity to provide services in clinical and supportive counseling settings for individuals who are referred from programs. Since a number of programs are designed to help servicemembers and their families identify potential mental health problems in their early phases, it is important to ensure that appropriate resources and follow-up services are available when needed and to understand the extent to which individuals follow through on referrals that are made.

Currently, however, there is no way to estimate the numbers of individuals with mental health problems who are referred to follow-up care after program participation. By systematically tracking referrals from programs to existing systems of clinical care, both programs and

the health care system will be better equipped to address the needs of servicemembers and their families.

Examine Existing Gaps in Routine Service Delivery That Could Be Filled by Programs

Ideally, a report such as this would describe specific gaps in services provided by programs, highlighting content areas, specific populations, and geographic regions where new program development would offer significant benefit. In order to do so, however, we would need information that is not currently available, since few programs begin with a formal needs assessment or an estimation of the numbers of members of the military community in need of assistance. This section therefore first highlights the prerequisite for conducting such a gap analysis: a comprehensive needs assessment.

Recommendation 3.1: Conduct a Comprehensive Needs Assessment Designed to Identify How Many Members of the Military Community Are in Need of Services, What Their Characteristics Are, What Types of Assistance They Need, and Where They Are Located

A formal, comprehensive needs assessment conducted throughout DoD is a fundamental prerequisite for understanding what services are necessary for addressing psychological health and TBI. This needs assessment should go beyond describing the prevalence of such conditions as PTSD, depression, and TBI to establish the magnitude of demand for different types of services, the characteristics of individuals in need, and their geographic locations. Services should be broadly defined to include not only clinical and supportive counseling services but also assess the need for education, outreach, prevention, and efforts to improve resilience.

This analysis would provide a threshold of need against which to later array available services in order to assess their adequacy and should identify the full range of services needed, including the need for clinical services, prevention and resilience training, and nonclinical support services, as well as the magnitude of the existing need. It should also describe the extent to which the routine care system—including clinical services and support services—currently meets those needs and address the Military Health System's Quadruple Aim of improving readiness, population health, and experiences with care while achieving appropriate financial value for the services provided (Dinneen, 2010).

Recommendation 3.2: Following the Needs Assessment, Conduct a Formal Gap Analysis to Identify How Well Programs Are Meeting the Identified Needs, Opportunities That Exist to Improve Current Programs, and Where Need Exists to Develop New Programs

A formal gap analysis would build on the information described in this report to provide an in-depth understanding of the extent to which existing programs meet the needs identified in the needs assessment (see Recommendation 3.1) and where gaps exist that warrant the development of new programs. Prior efforts to conduct gap analyses have been significantly hampered by the absence of a comprehensive needs assessment and thus have had limited ability to identify mismatches between the psychological health needs of members of the military community and the services and information provided by routine care settings, programs, and resources.

Such a gap analysis would compare and contrast existing programs with the identified need for services to assess the types of programs that should be developed, the services they should offer, the approaches they should use, the populations they should serve, where in DoD or the branches of service they should be organizationally housed, and where they should be geographically located (if a physical location is necessary for services to be delivered). This analysis should also consider existing clinical and supportive counseling services, transitions in care between services and programs, and how individuals access care. It should serve as the basis for informing future investments in the development of programs to address psychological health and TBI.

Given the wide array of existing programs and the lack of information regarding the needs of servicemembers and their families, conducting such a gap analysis is not feasible at this time. When appropriate information is available and a gap analysis is conducted at a later date, it will be important to integrate the results of program evaluations (see Recommendation 5.1) to provide details on what types of programs and approaches work best and have the greatest likelihood of being expandable, replicable, or appropriately adapted for use in other settings.

Recommendation 3.3: Adopt a Single, Integrated Conceptual Framework for Psychological Health Across DoD

The multiple conceptual models that exist (discussed in Chapter Two) create significant confusion and ambiguity when attempting to examine psychological health services and programs provided across the branches of service and may be a factor contributing to the duplicative and conflicting program efforts we identified. Without a single overarching conceptual framework, programs cannot consistently be identified or tracked in a comprehensive manner across DoD (see Recommendation 5.5), and any gap analysis will be significantly limited in its ability to identify opportunities to improve the care provided to members of the military community (Recommendation 3.2). Further, the lack of such a framework inhibits the ability to fully describe or categorize programs in a comparable manner across the branches of service and hinders any attempt to consistently assess program effectiveness throughout DoD. Adoption of a single DoD-wide conceptual framework would provide significant benefits by addressing these concerns.

Reduce Barriers Faced by Programs

We found that programs encountered a number of barriers in the course of their efforts. Two of the most frequently mentioned barriers—inadequate resources to support the program and inadequate time spent with servicemembers—are often encountered by many programs, regardless of the types of services they provide. The barriers discussed in this section, however, are particularly notable: stigma as a barrier to servicemembers seeking help, the need to improve the continuity of services over the course of deployment cycles and during transitions associated with permanent change of station, and the need for information about programs to be available to those organizations and individuals who are charged with developing new efforts.

Recommendation 4.1: Continue Widespread Efforts to Reduce Stigma and Institutional Barriers Associated with Seeking Treatment for Mental Health Problems and TBI

In order for programs, as well as clinical care and supportive counseling services, to be maximally effective, efforts to reduce the stigma associated with receiving such care among servicemembers must continue. Some programs, such as the Real Warriors Campaign, are explicitly designed to remove barriers that prevent servicemembers from obtaining treatment and to reduce stigma by providing widespread information about psychological health. Others, such as training programs designed to help servicemembers identify early warning signs of mental health problems, may be well positioned to help reduce the stigma associated with mental health problems and may provide an effective mechanism for increasing available care in the face of existing stigma. To effectively do so, it may be helpful for training messages to focus on mental health problems as part of a range of reactions to combat and operational stress, to emphasize help-seeking as an appropriate response, and to avoid setting unrealistically high expectations for resilience. Further, in order to encourage servicemembers to seek care when needed, it must be evident to them that the career repercussions associated with seeking treatment are limited. There may be opportunities to modify DoD policy to reduce servicemembers' concerns in this area and reduce these institutional barriers to help-seeking.

Recommendation 4.2: Improve Continuity of Services over the Course of the Deployment Cycle and During Transitions Associated with Permanent Change of Station

Mental health concerns and TBI may be of long duration, and servicemembers and their families move frequently as a result of deployment cycles and permanent change of station. For servicemembers or family members participating in a program, continuity of care is important throughout the deployment cycle and across permanent change of station, and programs need a method to ensure such continuity. One model is the inTransition program, which provides coaching and support for servicemembers moving between health care systems or providers.

Recommendation 4.3: Improve the Sharing of Information Across Programs

One common issue that was raised by program representatives was the lack of information they had about other programs that were attempting to accomplish goals similar to theirs. They often did not know what else had been tried, what had worked and what had not, or if any resources were available to help support their program and allow them to avoid developing new materials when others were already available. Recommendations 5.1, 5.2, 5.4, and 5.5 include methods that may help to alleviate this concern.

Evaluate and Track New and Existing Programs, and Use Evidence-Based Interventions to Support Program Efforts

DoD currently lacks centralized mechanisms to enable organizations interested in adopting existing or developing new programs to locate resources, identify what works, follow existing implementation strategies, or access resources to evaluate the effectiveness of programs that have been adapted or implemented in new settings. While some areas of psychological health do have such resources in place—such as the Suicide Prevention and Risk Reduction Committee's Resources for Suicide Prevention website (Suicide Prevention and Risk Reduction Com-

mittee, undated)—these resources are limited to narrowly focused areas and do not encourage the sharing of information across the psychological health spectrum.

This lack of a process to systematically develop, track, and evaluate programs is likely to result in the proliferation of untested programs that are developed without an evidence base, inefficient uses of resources, and added cost and administrative inefficiencies. Further, it raises the potential that some programs—despite the best intentions of their originators—may cause harm or delay entry into the system of care and that such harm would not be identified in a systematic or timely fashion.

Recommendation 5.1: The Evidence Base Regarding Program Effectiveness Needs to Be Developed

Existing programs and those under consideration for future development should be required to embed an ongoing evaluation in their efforts that addresses at least four key questions:

- What works well? This question helps an evaluation focus on identifying aspects of the program that are effective and worthy of replication.
- What are the unanticipated consequences of the program? All programs have unanticipated consequences that are the collateral result of their efforts and can include positive unexpected benefits or negative unexpected consequences that occur, in addition to the intended positive effects of a program. A good evaluation will pay close attention to identifying negative unintended consequences of program design and implementation so as to avoid these consequences in subsequent implementation efforts and provide the potential to improve the current program.
- What are the opportunities for improvement? When implemented in real-world settings, programs rarely fully achieve their goals. This question helps an evaluation focus on challenges and problems encountered in implementing the program in order to improve its results.
- What lessons were learned during program implementation, and what factors will affect the successful transferability of the program to new organizations or locations? The success of a program in one setting does not automatically assure its success in others, and an evaluation can help identify key factors that should be considered when a program is deployed in a new setting.

Where possible and appropriate, evaluations that contribute to this evidence base should draw from a common set of measures to allow for comparability across programs devoted to addressing psychological health and TBI. Further, the evidence base should include an assessment of each program, where appropriate, against the Military Health System's Quadruple Aim (Dinneen, 2010), evaluating how each program contributes to force readiness, population health, and positive experiences of care while ensuring that value is maximized and per capita costs are appropriate.

Recommendation 5.2: The Evidence Base Regarding Program Effectiveness Needs to Be Centralized and Made Accessible Across the Department of Defense

New programs should be built on the existing evidence base wherever possible and should focus on one of three approaches:

- replicating programs that have been evaluated and shown to be effective while employing available evidence regarding lessons learned and transferability (see Recommendation 5.1)
- utilizing evidence-based components of existing programs or other evidence-based approaches to care provision in order to develop new programs, with an evaluation designed as an inherent part of the program before it begins operation
- using new treatments, techniques, or materials that are developed explicitly as pilot programs; incorporating a rigorous, detailed research study as an inherent part of the program before it begins operation; and not replicating or expanding the utilization of these new approaches until research and evaluation have shown them to be effective.

In order for this to occur, the evidence base needs to be accessible across DoD to ensure that organizations that are considering the development of new programs or implementation of existing programs can utilize this information. The evidence base should consist of detailed information regarding program implementation and the results of prior evaluation efforts. Sharing this information across DoD will enable proven programs to be disseminated or transferred to new settings while maintaining fidelity to the original approach, will avoid duplication of effort, and will help ensure that approaches that were previously ineffective are not replicated. The benefits of centralizing such information should supersede concerns regarding different cultures for care provision in the branches of service in order to form a basis for how to best support members of the military community and should serve to create a best practices clearinghouse from which all services can draw.

Recommendation 5.3: Programs That Are Shown to Be Ineffective Should Be Discontinued and Should Not Be Replicated

If an evaluation is sufficiently rigorous and provides adequate evidence that a program is ineffective or is harmful, the program should be discontinued and should not be replicated elsewhere. A willingness to discontinue ineffective programs is one key component of building a DoD-wide portfolio of effective approaches to addressing psychological health and TBI. Without such a policy and its uniform enforcement, DoD runs the continual risk of a poor investment of tax dollars in programs that have been demonstrated to be ineffective, are likely to have unintended consequences, and may harm servicemembers. The decision to continue or discontinue a program would ideally not be made by those responsible for the development and implementation of the program; this is because program staff have an inherent incentive to discount evidence from an evaluation that portrays the program in a negative light. Further, evidence regarding any lack of effectiveness of such programs should be highlighted in the centralized evidence base described in Recommendation 5.2 in order to avoid new programs replicating approaches that have been shown to be ineffective. This policy should be made clear to anyone operating an existing program or proposing a new program.

Recommendation 5.4: A Central Authority Should Set Overall Policies and Establish Guidelines Regarding Programs, Including Guidelines Governing the Proliferation of New Programs

In order to avoid the proliferation of programs without adequate evidence and the duplication of effort across services to identify best practices, DoD should identify a central authority charged with the coordination of programs between branches of service and within OSD, centralization of the evidence base regarding program effectiveness (Recommendation 5.2), and

ongoing tracking of programs (Recommendation 5.5). Similar joint efforts are currently under way at the Medical Education and Training Campus (METC), a tri-service campus located at Fort Sam Houston that provides DoD health care education and trains enlisted personnel. The METC is able to take advantage of best practices and lessons learned from each service. Curriculum and learning modules are jointly developed, and the METC helps to capitalize on the synergy of co-locating and integrating similar service-specific training efforts.

In addition to the METC, there are other models of central authority that may be employed to set overall policies and establish necessary guidelines across DoD:

- **Joint Program Executive Offices.** Through Joint Program Executive Offices, talent and expertise from across the services are leveraged under a single chain of command. The Joint Program Executive Office for Chemical and Biological Defense may serve as one example of this model.
- **DoD Executive Agents.** DoD Executive Agents are authorized by DoD Directive 5101.1 (Department of Defense, 2003). Section 4.1.2 of the directive specifies that a DoD executive agent may be conferred when "DoD resources need to be focused on a specific area or areas of responsibility in order to minimize duplication or redundancy." In this model, one service is designated as the lead executive agency. For example, Directive 5101.13 (Department of Defense, 2006) designates the Secretary of the Army as the DoD Executive Agent for the Unexploded Ordnance Center of Excellence.
- **Centers of Excellence.** DoD may also choose to capitalize on the existing DCoE, modifying or expanding its responsibilities to address the need for a centralized authority.

Recommendation 5.5. Both New and Existing Programs Should Be Tracked on an Ongoing Basis by a Single Entity, Preferably the Same Organization That Is Charged with Developing Guidance Regarding Program Proliferation

This report includes a compendium of all programs we were able to identify that meet the inclusion and exclusion criteria shown in Chapter Three. RAND will maintain this compendium in online format and strive to keep it current through 2012 (available at http://www.rand.org/multi/military/innovative-practices.html), adding programs that are identified through passive means, such as newsletters and media coverage. However, in the long run DoD needs to develop an infrastructure to build on this compendium and to ensure that its contents are kept current. One way to accomplish this is to require all ongoing and new programs to register with a centralized database and to provide key pieces of program information, such as program name, target population, point of contact, and key activities. Information should be housed in a single, accessible database with appropriate quality controls. In order to ensure that the compendium is complete, DoD should adopt a single definition of what constitutes a program—the definition included in Chapter Three serves as one potential example—and then ensure that all new and existing programs report standardized information to this centralized resource. One model for such tracking efforts is provided by ClinicalTrials.gov (ClinicalTrials.gov, undated), a clinical trials registry sponsored by the National Institutes of Health that serves as a public information resource. Notably, ClinicalTrials.gov includes trials funded by the National Institutes of Health and by other organizations, including those outside the federal government, and so may provide one model for compiling information across the branches of service.

Conclusions

A recent RAND study estimated that two-year costs resulting from PTSD and major depression for the 1.6 million individuals who had deployed to Iraq and Afghanistan between 2001 and 2007 range between $4.0 and $6.2 billion in 2007 dollars (Eibner et al., 2008). Further, the same study estimated the total cost of deployment-related TBI for the same period to be between $591 and $910 million, again in 2007 dollars.

A variety of factors—including increased news coverage regarding the psychological and cognitive consequences of deployment, the recommendations resulting from the work of highly visible advisory committees, the expanded numbers of mental health providers available in military clinical care settings, and the establishment of DCoE—has created significant motivation and momentum for developing programs to support servicemembers and their families.

While this attention is both necessary and laudable, the proliferation of programs creates a high risk of a poor investment of DoD resources. Our report suggests that there is significant duplication of effort, both within and across branches of service. Without a centralized evidence base, we remain uncertain as a nation about which approaches work, which are ineffective, and which are—despite the best intent of their originators—harmful to servicemembers and their families. Given the financial investment the nation is making in caring for servicemembers with mental health problems and TBI, servicemembers and their families deserve to know what these investments are buying. Strategic planning, centralized coordination, and the sharing of information across branches of service, combined with rigorous evaluation, are imperative for ensuring that these investments will result in better outcomes and will reduce the burden that servicemembers and their families face.

APPENDIX A

Index of Programs

This appendix displays a series of tables that describe the characteristics of every program included in this report. These tables can be used to identify all programs that share specific characteristics, such as programs that share the same target population or that address the same clinical issue, and to subsequently view the extended description of each program that follows in Appendix B. The categories used in this appendix are defined in detail in Appendix E. Some programs may have been known by more than one name; these details are shown in Appendix B.

Table A.1
Programs by Branch of Service

NOTE: To identify all programs that serve an individual branch of service, consult both the column that specifically addresses that branch of service and the DoD-wide column.

	Branch of Service										
Program Name	**DoD-Wide**	**Army**	**Army Reserve**	**Army National Guard**	**Air Force**	**Air Force Reserve**	**Air National Guard**	**Navy**	**Navy Reserve**	**Marine Corps**	**Marine Corps Reserve**
ACE (Ask, Care, Escort)		X			X						
Adaptive Disclosure Training								X		X	
After Deployment	X										
Air Force Special Operations Command Resiliency Program					X						
Air Force Suicide Prevention Program					X	X	X				
Air Force Wounded Warrior Program					X	X	X				
Air National Guard Psychological Health Program							X				
Airman Resilience Training					X	X	X				
Alcohol and Drug Abuse Prevention and Treatment Program					X						
America's Heroes at Work	X										
Are You Listening?										X	
Army Center for Enhanced Performance		X									
Army Confidential Alcohol Treatment and Education Pilot		X									
Army Strong Community Center	X										
Army Substance Abuse Program		X	X	X							
Army Suicide Prevention Program*		X	X	X							
Army Wounded Warrior Program		X	X	X							
Assessing and Managing Suicide Risk					X			X		X	
Automated Behavioral Health Clinic Program		X	X	X							
Automated Tools and Outcome Measures	X										
AXON	X	X			X			X		X	
Battlefield Resiliency Initiative		X									
Battlemind		X	X	X							

Table A.1—Continued

Program Name	Branch of Service										
	DoD-Wide	Army	Army Reserve	Army National Guard	Air Force	Air Force Reserve	Air National Guard	Navy	Navy Reserve	Marine Corps	Marine Corps Reserve
Behavioral Health Integration Program	X							X	X		
Behavioral Health Optimization Program					X						
BrainCheckers Deployment Stress Assessment Tool	X										
Brainline.org	X										
Brigade Resiliency Teams		X									
Buddy-to-Buddy Program				X			X				
Care Coalition		X			X			X		X	
Care for Caregivers		X									
Care Provider Support Program		X	X	X							
Caregiver Occupational Stress Control Program								X	X		
Caregiver Optimization Systems (CAREOPS)		X		X						X	
The Caring Letters Project	X										
Center for Deployment Psychology	X										
Center for Spiritual Leadership		X	X	X							
Child and Youth Behavior Consultants								X	X		
Child, Adolescent and Family Behavioral Health Proponency		X									
Citizen Soldier Support Program			X	X							
Co-Occurring Disorders Program								X	X	X	X
Coast Guard Programs	Coast Guard										
Cognitive Processing Therapy for PTSD		X									
Cognitive-Behavioral Couple Therapy for Combat Stress Reactions and Intimate Relationship Problems		X			X						
Combat and Operational Stress First Aid								X		X	
Combat and Operational Stress Reaction/ Staff Resiliency Program								X	X		
Combat and Operational Stress Control Training Program*								X	X		

Table A.1—Continued

Program Name	Branch of Service										
	DoD-Wide	Army	Army Reserve	Army National Guard	Air Force	Air Force Reserve	Air National Guard	Navy	Navy Reserve	Marine Corps	Marine Corps Reserve
Combat Stress Control Team*		X	X	X							
Comfort for America's Uniformed Services	X										
Community Behavioral Health Services		X									
Community Resiliency Initiative		X									
Comprehensive Combat and Complex Casualty Care Program	X							X			
Comprehensive Soldier Fitness		X	X	X							
Coping with Deployments: Psychological First Aid for Military Families	X										
CREDO								X	X	X	X
Defender's Edge*					X						
Defense and Veterans Brain Injury Center Regional Care Coordination	X										
Defense Stress Management*	X										
Department of Pastoral Ministry Training		X	X	X							
Deployment Health Clinical Center Specialized Care Program	X										
Deployment Transition Center					X	X	X				
DESTRESS-PC (Delivery of Self Training and Education for Stressful Situations—Primary Care)	X										
Domestic Violence Among Returning Servicemembers with PTSD	X										
Drug Demand Reduction Program*	X										
DSTRESS										X	X
Effects of Integrative Restoration (iRest) on Sleep and Perceived Stress		X									
Elmendorf Air Force Base TBI Clinic		X			X					X	
Evolution		X			X						
Families OverComing Under Stress (FOCUS)		X			X			X		X	
Family Advocacy Program (Air Force)					X						

Table A.1—Continued

Program Name	Branch of Service										
	DoD-Wide	Army	Army Reserve	Army National Guard	Air Force	Air Force Reserve	Air National Guard	Navy	Navy Reserve	Marine Corps	Marine Corps Reserve
Family Advocacy Program (Army)		X	X	X							
Family Advocacy Program (Coast Guard)	Coast Guard										
Family Advocacy Program (Marine Corps)										X	X
Family Advocacy Program (Navy)								X	X		
Family Assistance for Maintaining Excellence		X			X						
Family Optimization Systems (FAMOPS)		X		X							
Family Strong Hawaii		X	X	X							
Federal Recovery Coordination Program	X										
Fort Bliss Restoration and Resilience Center		X	X	X							
Fort Hood Resilience and Restoration Center's Warrior Combat Stress Reset Program		X	X	X							
Freedom Restoration Center*	X										X
Healing Heroes*	X										
HeartMath					X			X		X	
Heroes at Home	X										
Installation Suicide Response Team*		X									
Integrated Delivery System					X						
Integrative Pain Center	X										
Integrative Restoration (iRest)	X										
inTransition	X										
LivingWorks Suicide Intervention Training Programs (Applied Suicide Intervention Skills Training, safeTALK, and suicideTALK)	X										
Marine Corps Combat and Operational Stress Control										X	X
Marine Corps Martial Arts Program										X	X
Marine Corps Operational Stress Training Program*										X	
Marine Corps Substance Abuse Program										X	X

Table A.1—Continued

Program Name	Branch of Service										
	DoD-Wide	Army	Army Reserve	Army National Guard	Air Force	Air Force Reserve	Air National Guard	Navy	Navy Reserve	Marine Corps	Marine Corps Reserve
Marine Corps Suicide Prevention Program										X	X
Marine Corps Wounded Warrior Regiment Psychological Health and TBI Clinical Services Staff								X		X	
Master Resiliency Training Program		X									
Medical Soldier Readiness Processing		X			X						
Mild Traumatic Brain Injury (mTBI) Intensive Treatment Program*		X	X	X							
Military and Family Life Consultants	X										
Military Child Education Coalition Living in the New Normal Program		X	X	X				X			
Military Child Education Coalition Student 2 Student Programs		X	X	X				X	X		
Military OneSource	X										
Military Pathways	X										
Mind-Body Skills Groups for the Treatment of War Zone Stress in Military and Veteran Populations	X										
Mind-Body Trauma First Aide		X	X	X							
Mindfulness-Based Mind Fitness Training		X								X	
Mobile Telehealth Program	X										
Mountain Post Wellness Center*		X	X	X							
National Center for Telehealth and Technology Mobile Applications	X										
National Guard Family Programs				X			X				
National Guard Psychological Health Program				X			X				
National Guard Transition Assistance Advisors				X			X				
The National Intrepid Center of Excellence	X										
Navy Alcohol and Drug Abuse Prevention Program*								X	X		
Navy Command Level Suicide Prevention Program								X	X		

Table A.1—Continued

Program Name	Branch of Service										
	DoD-Wide	Army	Army Reserve	Army National Guard	Air Force	Air Force Reserve	Air National Guard	Navy	Navy Reserve	Marine Corps	Marine Corps Reserve
Navy MORE (My Ongoing Recovery Experience) Program								X		X	
Navy Operational Stress Control								X	X		
Navy Safe Harbor								X	X		
Operation BRAVE (Building Resilience and Valuing Empowered) Families		X									
Operation: Military Kids	X										
Operational Stress Control and Readiness (OSCAR)										X	X
Outcomes of Prolonged Exposure and Cognitive Processing Therapy Used in the Treatment of Combat Operational Stress in Deployed Locations	X										
Partners in Care				X			X				
Passport Toward Success				X			X				
Physical Medicine and Integrative Care Services	X										
Post Deployment Open House Program					X	X	X				
Post-Traumatic Stress Residential Rehabilitation Program		X									
Postdeploymenthealth.com	X										
Prevention, Treatment and Outreach				X			X				
Psychiatric Service Dog Society Research	X										
Psychological Health Advocacy Program						X	X				
Psychological Health Pathways Program	X										
PTSD Provider Training*					X	X	X				
PTSD Training Program*		X	X	X							
PTSD Treatment in Primary Care Settings	X										
Randomized Exploratory Study to Evaluate Two Acupuncture Methods for the Treatment of Headaches Associated with TBI	X										
Re-Engineering Healthcare Integration Programs	X	X			X			X			

Table A.1—Continued

Program Name	Branch of Service										
	DoD-Wide	Army	Army Reserve	Army National Guard	Air Force	Air Force Reserve	Air National Guard	Navy	Navy Reserve	Marine Corps	Marine Corps Reserve
Real Warriors Campaign	X										
Recovery Coordination Program	X										
Reserve Psychological Health Outreach Coordinators Program									X		X
Reset		X									
Resilience Training	See listing for Battlemind and see Appendix B for additional information.										
Resiliency Center				X			X				
RESPECT-Mil		X									
Return to Duty Performance Validation Program (TBI Program)		X	X	X	X						
Returning Warrior Workshops									X		X
Road to Reintegration: Systems of Care				X			X				
School Mental Health Training Academy		X									
School-Based Initiative		X									
Scripps Military Brain Injury Rehabilitation Program	X										
Seeking Safety	X										
Semper Fit Health Promotion Program										X	
Sesame Workshop Military Families Initiative	X										
Sexual Assault Prevention and Response Office*	X										
Sexual Assault Prevention and Response Program (Air Force)					X	X	X				
Sexual Assault Prevention and Response Program (Coast Guard)	Coast Guard										
Sexual Assault Prevention and Response Program (Marine Corps)										X	X
Sexual Assault Prevention and Response Program (National Guard)				X			X				
Sexual Assault Prevention and Response Program (Navy)								X	X		

Table A.1—Continued

Program Name	Branch of Service										
	DoD-Wide	Army	Army Reserve	Army National Guard	Air Force	Air Force Reserve	Air National Guard	Navy	Navy Reserve	Marine Corps	Marine Corps Reserve
Sexual Harassment/Assault Response and Prevention Program (Army)		X									
Signs of Suicide*	X										
SimCoach	X										
Soldier 360°*		X									
Soldier Evaluation for Life Fitness		X									
Special Operations Force Resilience Enterprise Program		X			X			X		X	
Special Psychiatric Rapid Intervention Team								X			
Spiritual Warrior Training Program*		X									
STEPS UP (Stepped Enhancement of PTSD Services Using Primary Care)		X									
Stress Gym	X										
Strong Bonds		X	X	X							
Strong Families, Strong Forces	X										
STRONG STAR (South Texas Research Organizational Network Guiding Studies on Trauma and Resilience) Research Consortium	X										
Substance Abuse Rehabilitation Program*								X	X	X	X
Suicide Awareness Voices of Education					X		X			X	
Suicide Reduction Initiatives		X									
TBI Family Caregiver Curriculum	X										
TBI.Consult	X										
Telehealth for Children at Tripler Army Medical Center		X	X	X							
Theater of War	X										
Third Location Decompression								X			
Tragedy Assistance Program for Survivors	X										
Traumatic Brain Injury: The Journey Home	X										
Traumatic Stress Response Team					X	X	X				

Table A.1—Continued

Program Name	Branch of Service										
	DoD-Wide	Army	Army Reserve	Army National Guard	Air Force	Air Force Reserve	Air National Guard	Navy	Navy Reserve	Marine Corps	Marine Corps Reserve
TRICARE Assistance Program	X										
Tripler Army Medical Center School Mental Health Program		X								X	
Tripler Programs in TBI, Pain, Psychological Health, and Telehealth*		X									
Virtual Behavioral Telehealth Pilot at Fort Richardson*		X									
Virtual Behavioral Telehealth Pilot at Tripler Army Medical Center		X									
Virtual Reality and Innovative Technology Applications	X										
Virtual Reality Graded Exposure Therapy with Physiological Monitoring								X		X	
Virtual Reality Iraq/Afghanistan	X										
Virtual Traumatic Brain Injury Clinic	X										
Warrior Adventure Quest		X	X	X							
Warrior and Family Assistance Center			X								
Warrior Mind Training		X						X		X	
Warrior Optimization Systems (WAROPS)		X		X							
Warrior Resilience & Thriving		X	X	X							
Warrior Resiliency Program		X									
Warrior Restoration Center*		X									
Warrior Strengthening Program	X										
Warrior Transition Units*		X	X	X							
Warrior's Huddle		X									
Wellness and Resiliency Assessment—Post-Deployment		X	X	X							
The Wingman Project							X				
Wounded Warrior Call Center										X	X
Wounded Warrior Regiment										X	
Yellow Ribbon Reintegration Program (Air Force)						X	X				

Table A.1—Continued

Program Name	Branch of Service										
	DoD-Wide	Army	Army Reserve	Army National Guard	Air Force	Air Force Reserve	Air National Guard	Navy	Navy Reserve	Marine Corps	Marine Corps Reserve
Yellow Ribbon Reintegration Program (Army)			X	X							
Yellow Ribbon Reintegration Program (Marine Corps)											X
Yellow Ribbon Reintegration Program (National Guard)	X			X			X				
Yellow Ribbon Reintegration Program (Navy)									X		

* No interview was conducted for this program. Our description of the program was developed from publicly available documentation or from documentation provided by the program, and only limited information was available.

Table A.2
Programs by Targeted Participants, Deployment Phase, Domain, and Approach

NOTE: Programs that target civilians (including civilian health care providers) to support them in caring for servicemembers have both "Civilians" and "Servicemembers" marked as their targeted participants.

	Targeted Participants				Deployment Phase					Domain					Approach			
Program Name	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/Training	Prevention/Resilience	Outreach
ACE (Ask, Care, Escort)	X								X		X	X				X	X	
Adaptive Disclosure Training	X							X			X	X		X	X	X	X	
After Deployment	X	X	X				X	X		X	X	X	X	X		X	X	X
Air Force Special Operations Command Resiliency Program	X		X		X	X	X	X			X	X	X			X	X	
Air Force Suicide Prevention Program	X		X	X					X		X	X	X			X	X	X
Air Force Wounded Warrior Program	X	X					X	X			X	X		X		X	X	X
Air National Guard Psychological Health Program	X		X					X			X	X					X	X
Airman Resilience Training	X				X			X			X	X				X	X	
Alcohol and Drug Abuse Prevention and Treatment Program	X								X		X				X	X	X	
America's Heroes at Work	X		X					X				X				X		X
Are You Listening?	X			X					X		X	X				X		X
Army Center for Enhanced Performance	X		X	X					X		X	X		X		X	X	X
Army Confidential Alcohol Treatment and Education Pilot	X		X						X		X	X			X		X	X
Army Strong Community Center	X	X	X						X		X	X					X	X
Army Substance Abuse Program	X		X	X					X		X				X	X	X	
Army Suicide Prevention Program*	X		X	X					X		X	X				X	X	X
Army Wounded Warrior Program	X	X	X	X				X			X	X		X		X	X	X
Assessing and Managing Suicide Risk	X	X	X	X					X		X					X	X	
Automated Behavioral Health Clinic Program	X		X						X		X				X			

Table A.2—Continued

Program Name	Targeted Participants				Deployment Phase					Domain					Approach			
	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/Training	Prevention/Resilience	Outreach
Automated Tools and Outcome Measures	X		X						X		X				X			
AXON	X		X						X	X	X	X	X	X	X	X	X	X
Battlefield Resiliency Initiative	X				X	X					X	X		X			X	
Battlemind	X		X	X	X	X	X	X			X					X	X	
Behavioral Health Integration Program	X	X	X						X	X	X	X		X	X	X	X	
Behavioral Health Optimization Program	X	X	X				X	X			X	X			X	X	X	X
BrainCheckers Deployment Stress Assessment Tool	X					X					X			X	X			
Brainline.org	X	X	X	X					X	X	X	X	X	X		X	X	
Brigade Resiliency Teams	X				X	X	X	X		X	X	X	X	X	X	X	X	X
Buddy-to-Buddy Program		X						X				X		X			X	X
Care Coalition	X		X						X	X	X	X		X	X	X	X	X
Care for Caregivers	X								X	X	X			X		X	X	
Care Provider Support Program	X			X					X	X	X	X	X	X	X	X	X	
Caregiver Occupational Stress Control Program	X	X		X					X		X					X	X	
Caregiver Optimization Systems (CAREOPS)	X				X	X	X	X		X	X	X		X		X	X	
The Caring Letters Project	X	X	X	X					X		X	X			X			X
Center for Deployment Psychology	X			X					X		X					X		
Center for Spiritual Leadership	X							X					X			X	X	
Child and Youth Behavior Consultants			X						X			X				X	X	
Child, Adolescent and Family Behavioral Health Proponency	X	X	X						X		X	X			X		X	X
Citizen Soldier Support Program	X	X		X					X		X					X		X
Co-Occurring Disorders Program	X			X					X		X					X		

Table A.2—Continued

	Targeted Participants				Deployment Phase					Domain					Approach			
Program Name	**Servicemembers**	**Veterans**	**Family Members**	**Civilians**	**Predeployment**	**Deployment**	**Redeployment**	**Postdeployment**	**Not Related to Deployment Phase**	**Biological**	**Psychological**	**Social**	**Spiritual**	**Holistic**	**Clinical**	**Education/Training**	**Prevention/Resilience**	**Outreach**
Coast Guard Programs	X		X	X					X		X						X	
Cognitive Processing Therapy for PTSD	X							X			X				X			
Cognitive-Behavioral Couple Therapy for Combat Stress Reactions and Intimate Relationship Problems	X	X	X					X			X	X			X	X		
Combat and Operational Stress First Aid	X								X		X				X		X	
Combat and Operational Stress Reaction/Staff Resiliency Program	X							X			X				X	X	X	X
Combat and Operational Stress Control Training Program*	X								X									
Combat Stress Control Team*	X		X			X												
Comfort for America's Uniformed Services	X		X					X				X		X			X	
Community Behavioral Health Services	X				X	X	X	X			X	X			X	X	X	X
Community Resiliency Initiative	X		X					X				X					X	
Comprehensive Combat and Complex Casualty Care Program	X	X	X	X					X	X	X	X	X	X	X	X	X	X
Comprehensive Soldier Fitness	This entry includes two or more programs. See Appendix B for additional details.																	
Coping with Deployments: Psychological First Aid for Military Families			X			X		X			X	X				X	X	
CREDO	X		X	X					X		X	X	X	X		X	X	
Defender's Edge*	X					X					X					X	X	
Defense and Veterans Brain Injury Center Regional Care Coordination	X	X	X					X			X				X		X	X
Defense Stress Management*	X																	
Department of Pastoral Ministry Training	X								X				X			X		

Table A.2—Continued

Program Name	Targeted Participants				Deployment Phase					Domain					Approach			
	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/Training	Prevention/Resilience	Outreach
Deployment Health Clinical Center Specialized Care Program	X		X					X		X	X	X		X	X			
Deployment Transition Center	X						X				X	X				X	X	
DESTRESS-PC (Delivery of Self Training and Education for Stressful Situations—Primary Care)	X	X					X	X			X				X			
Domestic Violence Among Returning Servicemembers with PTSD	X	X						X			X	X				X	X	
Drug Demand Reduction Program*	X			X					X	X	X						X	
DSTRESS	X	X	X						X		X	X					X	
Effects of Integrative Restoration (iRest) on Sleep and Perceived Stress		X	X	X					X				X	X			X	
Elmendorf Air Force Base TBI Clinic	X						X	X			X	X			X		X	
Evolution	X					X	X	X		X	X	X	X	X	X	X	X	
Families OverComing Under Stress (FOCUS)	X		X	X					X		X	X			X	X	X	X
Family Advocacy Program (Air Force)	X		X						X		X	X				X	X	X
Family Advocacy Program (Army)	X		X	X					X		X	X			X	X	X	X
Family Advocacy Program (Coast Guard)	X		X						X		X					X	X	
Family Advocacy Program (Marine Corps)	X	X	X						X		X	X			X	X	X	
Family Advocacy Program (Navy)	X		X						X		X	X				X	X	X
Family Assistance for Maintaining Excellence	X		X						X		X				X			
Family Optimization Systems (FAMOPS)			X		X	X	X	X		X	X	X		X		X	X	X
Family Strong Hawaii	X		X		X	X	X	X			X	X				X	X	X

Table A.2—Continued

	Targeted Participants				Deployment Phase					Domain					Approach			
Program Name	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/Training	Prevention/Resilience	Outreach
Federal Recovery Coordination Program	X	X					X	X			X	X		X		X	X	X
Fort Bliss Restoration and Resilience Center	X							X			X				X		X	
Fort Hood Resilience and Restoration Center's Warrior Combat Stress Reset Program	X							X		X	X	X		X	X	X		
Freedom Restoration Center*	X					X												
Healing Heroes*							X	X			X	X				X	X	X
HeartMath	X	X	X	X	X	X		X		X	X			X	X	X	X	
Heroes at Home	X		X	X	X	X	X	X		X	X	X				X	X	
Installation Suicide Response Team*											X							
Integrated Delivery System	X		X		X	X	X	X			X	X					X	
Integrative Pain Center	X	X	X						X	X	X	X	X	X	X	X	X	X
Integrative Restoration (iRest)	X	X	X	X					X	X	X	X	X	X	X	X	X	X
inTransition	X								X		X					X		
LivingWorks Suicide Intervention Training Programs (Applied Suicide Intervention Skills Training, safeTALK, and suicideTALK)	X	X	X	X					X		X	X	X			X	X	X
Marine Corps Combat and Operational Stress Control	X		X		X	X	X	X			X	X				X	X	X
Marine Corps Martial Arts Program	X								X	X	X	X	X			X	X	
Marine Corps Operational Stress Training Program*	X				X	X	X	X			X			X		X	X	X
Marine Corps Substance Abuse Program	X								X	X	X	X			X	X	X	X
Marine Corps Suicide Prevention Program	X								X		X					X	X	
Marine Corps Wounded Warrior Regiment Psychological Health and TBI Clinical Services Staff	X	X	X					X			X				X	X		X

Table A.2—Continued

Program Name	Targeted Participants				Deployment Phase					Domain					Approach			
	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/Training	Prevention/Resilience	Outreach
Master Resiliency Training Program	X								X	X	X	X	X	X			X	
Medical Soldier Readiness Processing	X				X		X	X		X	X	X	X	X	X	X	X	
Mild Traumatic Brain Injury (mTBI) Intensive Treatment Program*	X							X							X			
Military and Family Life Consultants	X		X	X	X	X	X	X			X					X	X	X
Military Child Education Coalition Living in the New Normal Program			X				X				X	X				X	X	X
Military Child Education Coalition Student 2 Student Programs			X						X			X				X		X
Military OneSource	X		X	X	X	X	X	X			X					X		X
Military Pathways	X	X	X						X		X				X	X		X
Mind-Body Skills Groups for the Treatment of War Zone Stress in Military and Veteran Populations	X	X	X						X	X	X	X	X	X	X	X	X	
Mind-Body Trauma First Aide	X	X	X	X					X	X	X	X	X	X	X	X	X	X
Mindfulness-Based Mind Fitness Training	X				X									X		X	X	
Mobile Telehealth Program	X	X	X						X		X				X			
Mountain Post Wellness Center*	X	X	X	X	X		X	X			X	X	X	X	X	X	X	X
National Center for Telehealth and Technology Mobile Applications	X	X	X	X					X	X	X					X	X	
National Guard Family Programs			X		X	X	X	X			X					X	X	X
National Guard Psychological Health Program	X		X		X	X	X	X			X					X		
National Guard Transition Assistance Advisors	X	X	X					X			X	X				X		X
The National Intrepid Center of Excellence	X		X						X	X	X	X	X	X	X	X	X	X

Table A.2—Continued

	Targeted Participants				Deployment Phase					Domain					Approach			
Program Name	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/Training	Prevention/Resilience	Outreach
Navy Alcohol and Drug Abuse Prevention Program*	X								X		X					X	X	
Navy Command Level Suicide Prevention Program	X								X		X					X	X	
Navy MORE (My Ongoing Recovery Experience) Program	X	X	X	X					X		X				X			
Navy Operational Stress Control	X		X		X	X	X	X			X	X	X	X		X	X	X
Navy Safe Harbor	X		X					X			X	X		X		X	X	X
Operation BRAVE (Building Resilience and Valuing Empowered) Families	X		X	X			X	X			X	X			X	X	X	X
Operation: Military Kids	X		X	X					X		X	X		X		X	X	X
Operational Stress Control and Readiness (OSCAR)	X								X		X	X			X	X	X	X
Outcomes of Prolonged Exposure and Cognitive Processing Therapy Used in the Treatment of Combat Operational Stress in Deployed Locations	X					X					X	X			X			
Partners in Care	X		X						X		X	X	X			X	X	X
Passport Toward Success	X		X				X	X			X	X				X	X	
Physical Medicine and Integrative Care Services	X		X					X		X	X			X	X	X	X	
Post Deployment Open House Program	X		X					X			X					X		
Post-Traumatic Stress Residential Rehabilitation Program	X	X							X	X	X	X	X	X	X	X		
Postdeploymenthealth.com	X		X					X			X					X		X
Prevention, Treatment and Outreach	X		X		X	X	X	X			X					X		X
Psychiatric Service Dog Society Research	X							X			X				X			
Psychological Health Advocacy Program	X		X		X	X	X	X			X							X

Table A.2—Continued

Program Name	Targeted Participants				Deployment Phase					Domain					Approach			
	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/Training	Prevention/Resilience	Outreach
Psychological Health Pathways Program	X						X	X		X	X	X	X	X	X	X	X	X
PTSD Provider Training*											X				X	X		
PTSD Training Program*	X								X							X		
PTSD Treatment in Primary Care Settings	X	X					X	X			X				X			
Randomized Exploratory Study to Evaluate Two Acupuncture Methods for the Treatment of Headaches Associated with TBI	X							X		X					X			
Re-Engineering Healthcare Integration Programs	X								X		X				X			
Real Warriors Campaign	X	X	X		X	X	X	X			X	X				X	X	X
Recovery Coordination Program	X		X				X	X			X	X		X		X	X	X
Reserve Psychological Health Outreach Coordinators Program	X		X		X	X	X	X			X					X	X	X
Reset	X	X					X	X			X					X	X	
Resilience Training	See listing for Battlemind and see Appendix B for additional information.																	
Resiliency Center	X		X						X		X						X	
RESPECT-Mil	X								X	X	X	X			X			X
Return to Duty Performance Validation Program (TBI Program)	X				X			X		X	X	X		X	X	X	X	
Returning Warrior Workshops	X			X			X				X	X	X		X	X		X
Road to Reintegration: Systems of Care	X	X	X	X				X			X	X				X		X
School Mental Health Training Academy	X		X	X					X		X					X		
School-Based Initiative	X		X						X		X	X			X		X	
Scripps Military Brain Injury Rehabilitation Program	X	X	X	X	X		X	X		X	X	X	X	X	X	X	X	X
Seeking Safety	X								X		X	X			X		X	

Table A.2—Continued

	Targeted Participants				Deployment Phase					Domain					Approach			
Program Name	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/Training	Prevention/Resilience	Outreach
Semper Fit Health Promotion Program	X	X	X	X					X	X	X	X	X	X		X	X	
Sesame Workshop Military Families Initiative	X	X	X	X	X	X	X	X			X	X		X		X	X	X
Sexual Assault Prevention and Response Office*	X		X	X					X		X					X	X	X
Sexual Assault Prevention and Response Program (Air Force)	X			X					X		X					X	X	X
Sexual Assault Prevention and Response Program (Coast Guard)	X		X	X					X		X	X				X	X	X
Sexual Assault Prevention and Response Program (Marine Corps)	X	X	X	X					X		X					X	X	X
Sexual Assault Prevention and Response Program (National Guard)	X								X		X	X				X	X	X
Sexual Assault Prevention and Response Program (Navy)	X		X	X					X		X					X	X	X
Sexual Harassment/Assault Response and Prevention Program (Army)	X		X	X					X		X						X	X
Signs of Suicide*			X								X					X	X	X
SimCoach	X	X	X						X	X	X	X				X	X	X
Soldier 360°*	X						X	X		X	X	X	X	X		X	X	
Soldier Evaluation for Life Fitness	X						X			X	X	X			X		X	
Special Operations Force Resilience Enterprise Program	X		X	X					X		X	X				X	X	
Special Psychiatric Rapid Intervention Team	X		X	X					X	X	X	X	X	X	X	X	X	X
Spiritual Warrior Training Program*	X				X			X			X	X						
STEPS UP (Stepped Enhancement of PTSD Services Using Primary Care)	X								X	X	X	X			X			
Stress Gym	X							X		X	X	X	X	X	X	X	X	

Table A.2—Continued

Program Name	Targeted Participants				Deployment Phase					Domain					Approach			
	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/Training	Prevention/Resilience	Outreach
Strong Bonds	X		X						X			X	X			X	X	
Strong Families, Strong Forces	X		X		X		X	X			X	X		X			X	
STRONG STAR (South Texas Research Organizational Network Guiding Studies on Trauma and Resilience) Research Consortium	X	X	X	X	X	X	X	X		X	X	X			X	X		
Substance Abuse Rehabilitation Program*	X	X							X		X				X	X	X	
Suicide Awareness Voices of Education	X	X							X		X					X	X	
Suicide Reduction Initiatives	X								X		X				X		X	
TBI Family Caregiver Curriculum	X	X	X					X		X		X				X		
TBI.Consult	X					X				X	X				X	X		
Telehealth for Children at Tripler Army Medical Center	X	X	X						X		X				X		X	
Theater of War	X		X	X				X			X	X					X	
Third Location Decompression	X							X			X	X			X	X	X	
Tragedy Assistance Program for Survivors	X	X	X	X					X		X	X				X	X	X
Traumatic Brain Injury: The Journey Home	X	X	X	X					X	X	X	X	X	X	X	X	X	X
Traumatic Stress Response Team	X	X	X	X					X		X				X	X	X	X
TRICARE Assistance Program	X		X						X		X					X	X	
Tripler Army Medical Center School Mental Health Program			X	X					X	X	X	X			X		X	
Tripler Programs in TBI, Pain, Psychological Health, and Telehealth*									X									
Virtual Behavioral Telehealth Pilot at Fort Richardson	X						X	X			X						X	
Virtual Behavioral Telehealth Pilot at Tripler Army Medical Center	X						X	X			X						X	

Table A.2—Continued

	Targeted Participants				Deployment Phase					Domain					Approach			
Program Name	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/Training	Prevention/Resilience	Outreach
Virtual Reality and Innovative Technology Applications	X	X	X	X					X		X	X			X	X		X
Virtual Reality Graded Exposure Therapy with Physiological Monitoring	X							X		X	X				X	X		
Virtual Reality Iraq/Afghanistan	X	X			X		X	X			X				X			
Virtual Traumatic Brain Injury Clinic	X						X	X		X	X			X	X	X		
Warrior Adventure Quest	X				X			X				X				X	X	
Warrior and Family Assistance Center	X	X	X						X		X			X				X
Warrior Mind Training	X	X	X	X	X	X	X	X			X	X	X	X		X	X	
Warrior Optimization Systems (WAROPS)	X								X	X	X					X	X	
Warrior Resilience & Thriving	X	X	X	X	X	X		X			X		X	X	X	X	X	X
Warrior Resiliency Program	This entry includes two or more programs. See Appendix B for additional details.																	
Warrior Restoration Center*	X						X	X										
Warrior Strengthening Program	X			X					X		X					X		
Warrior Transition Units*	X							X		X	X			X	X	X		
Warrior's Huddle		X						X			X	X	X	X			X	
Wellness and Resiliency Assessment—Post-Deployment	X						X	X			X							X
The Wingman Project	X		X	X					X		X					X	X	X
Wounded Warrior Call Center	X	X	X					X			X	X		X		X	X	X
Wounded Warrior Regiment	X	X	X				X	X			X	X		X		X	X	X
Yellow Ribbon Reintegration Program (Air Force)	X		X		X	X	X	X			X	X				X	X	X
Yellow Ribbon Reintegration Program (Army)	X		X		X	X	X	X			X	X				X	X	X
Yellow Ribbon Reintegration Program (Marine Corps)	X		X	X	X	X	X	X			X	X				X	X	X

Table A.2—Continued

Program Name	Targeted Participants				Deployment Phase					Domain					Approach			
	Servicemembers	Veterans	Family Members	Civilians	Predeployment	Deployment	Redeployment	Postdeployment	Not Related to Deployment Phase	Biological	Psychological	Social	Spiritual	Holistic	Clinical	Education/Training	Prevention/Resilience	Outreach
Yellow Ribbon Reintegration Program (National Guard)	X	X	X	X	X	X	X	X			X	X				X	X	X
Yellow Ribbon Reintegration Program (Navy)	X		X		X	X	X	X			X	X				X	X	X

* No interview was conducted for this program. Our description of the program was developed from publicly available documentation or from documentation provided by the program, and only limited information was available.

Table A.3
Programs by Clinical and Nonclinical Issues Addressed

	Clinical Issues						Nonclinical Issues									
Program Name	**Depression**	**PTSD**	**Substance Use**	**Suicide Prevention**	**Traumatic Brain Injury**	**General Psychological Health**	**Deployment-Related**	**Domestic Violence**	**Family and/or Children**	**Legal**	**Postdeployment and Reintegration**	**Relationships**	**Resilience**	**Spiritual**	**Stress Reduction**	**Other**
ACE (Ask, Care, Escort)				X									X			
Adaptive Disclosure Training		X				X					X		X			X
After Deployment	X	X	X	X	X	X		X	X		X	X	X	X	X	X
Air Force Special Operations Command Resiliency Program	X	X	X	X		X	X	X	X		X	X	X	X	X	
Air Force Suicide Prevention Program*	X	X	X	X		X			X				X	X	X	
Air Force Wounded Warrior Program	X	X			X	X			X		X					X
Air National Guard Psychological Health Program	X	X			X	X			X	X		X				
Airman Resilience Training											X		X			
Alcohol and Drug Abuse Prevention and Treatment Program			X													
America's Heroes at Work																X
Are You Listening?						X										X
Army Center for Enhanced Performance						X			X				X		X	X
Army Confidential Alcohol Treatment and Education Pilot			X			X										
Army Strong Community Center													X			X
Army Substance Abuse Program			X													
Army Suicide Prevention Program				X		X							X			
Army Wounded Warrior Program	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessing and Managing Suicide Risk				X												
Automated Behavioral Health Clinic Program	X	X	X	X			X									X
Automated Tools and Outcome Measures	X	X	X	X		X	X				X		X		X	X
AXON					X											X

Table A.3—Continued

Program Name	Clinical Issues						Nonclinical Issues									
	Depression	PTSD	Substance Use	Suicide Prevention	Traumatic Brain Injury	General Psychological Health	Deployment-Related	Domestic Violence	Family and/or Children	Legal	Postdeployment and Reintegration	Relationships	Resilience	Spiritual	Stress Reduction	Other
Battlefield Resiliency Initiative				X		X	X	X			X	X	X		X	
Battlemind	X	X					X				X		X		X	X
Behavioral Health Integration Program						X										
Behavioral Health Optimization Program	X		X	X	X	X	X	X	X		X	X	X		X	X
BrainCheckers Deployment Stress Assessment Tool					X		X									
Brainline.org					X											
Brigade Resiliency Teams	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Buddy-to-Buddy Program	X	X	X	X	X	X				X	X	X	X			
Care Coalition						X			X							
Care for Caregivers															X	X
Care Provider Support Program	X	X				X	X						X	X	X	X
Caregiver Occupational Stress Control Program						X							X		X	
Caregiver Optimization Systems (CAREOPS)	X	X	X	X	X	X	X	X	X		X	X	X	X	X	
The Caring Letters Project				X		X										
Center for Deployment Psychology	X	X	X	X	X	X	X		X		X		X		X	
Center for Spiritual Leadership		X											X	X		
Child and Youth Behavior Consultants							X		X						X	
Child, Adolescent and Family Behavioral Health Proponency				X		X			X		X		X		X	X
Citizen Soldier Support Program						X										X
Co-Occurring Disorders Program			X			X										
Coast Guard Programs		X		X		X										
Cognitive Processing Therapy for PTSD		X														

Table A.3—Continued

	Clinical Issues						Nonclinical Issues									
Program Name	Depression	PTSD	Substance Use	Suicide Prevention	Traumatic Brain Injury	General Psychological Health	Deployment-Related	Domestic Violence	Family and/or Children	Legal	Postdeployment and Reintegration	Relationships	Resilience	Spiritual	Stress Reduction	Other
Cognitive-Behavioral Couple Therapy for Combat Stress Reactions and Intimate Relationship Problems		X			X							X				
Combat and Operational Stress First Aid						X										X
Combat and Operational Stress Reaction/Staff Resiliency Program	X	X											X			
Combat and Operational Stress Control Training Program*									X				X		X	
Combat Stress Control Team*		X		X		X	X				X		X		X	
Comfort for America's Uniformed Services							X				X		X		X	X
Community Behavioral Health Services	X	X	X	X		X	X	X			X	X	X		X	X
Community Resiliency Initiative													X			
Comprehensive Combat and Complex Casualty Care Program	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Comprehensive Soldier Fitness	This entry includes two or more programs. See Appendix B for additional details.															
Coping with Deployments: Psychological First Aid for Military Families						X	X		X		X	X	X		X	
CREDO									X			X		X	X	X
Defender's Edge*		X				X	X						X		X	
Defense and Veterans Brain Injury Center Regional Care Coordination					X	X							X			X
Defense Stress Management*						X										
Department of Pastoral Ministry Training														X		
Deployment Health Clinical Center Specialized Care Program	X	X					X				X					X
Deployment Transition Center						X					X		X		X	
DESTRESS-PC (Delivery of Self Training and Education for Stressful Situations—Primary Care)	X	X				X									X	

Table A.3—Continued

	Clinical Issues						Nonclinical Issues									
Program Name	**Depression**	**PTSD**	**Substance Use**	**Suicide Prevention**	**Traumatic Brain Injury**	**General Psychological Health**	**Deployment-Related**	**Domestic Violence**	**Family and/or Children**	**Legal**	**Postdeployment and Reintegration**	**Relationships**	**Resilience**	**Spiritual**	**Stress Reduction**	**Other**
Domestic Violence Among Returning Servicemembers with PTSD		X						X								
Drug Demand Reduction Program*			X													
DSTRESS	X	X	X	X		X	X					X				
Effects of Integrative Restoration (iRest) on Sleep and Perceived Stress	X	X	X	X		X	X				X	X	X	X	X	
Elmendorf Air Force Base TBI Clinic	X	X														
Evolution	X	X	X	X	X	X	X	X	X		X	X	X	X	X	
Families OverComing Under Stress (FOCUS)						X			X		X	X	X			
Family Advocacy Program (Air Force)								X	X			X	X			
Family Advocacy Program (Army)	X	X				X		X	X	X		X	X		X	X
Family Advocacy Program (Coast Guard)								X								
Family Advocacy Program (Marine Corps)								X	X			X				
Family Advocacy Program (Navy)								X	X			X				
Family Assistance for Maintaining Excellence							X		X							X
Family Optimization Systems (FAMOPS)	X	X	X	X	X	X	X		X		X	X	X		X	X
Family Strong Hawaii		X				X	X		X			X	X		X	X
Federal Recovery Coordination Program		X			X	X					X					
Fort Bliss Restoration and Resilience Center		X														X
Fort Hood Resilience and Restoration Center's Warrior Combat Stress Reset Program		X														X
Freedom Restoration Center*							X						X		X	
Healing Heroes*					X	X	X				X		X			
HeartMath		X	X		X	X	X				X	X	X		X	

Table A.3—Continued

	Clinical Issues						Nonclinical Issues									
Program Name	Depression	PTSD	Substance Use	Suicide Prevention	Traumatic Brain Injury	General Psychological Health	Deployment-Related	Domestic Violence	Family and/or Children	Legal	Postdeployment and Reintegration	Relationships	Resilience	Spiritual	Stress Reduction	Other
Heroes at Home						X	X		X		X	X				X
Installation Suicide Response Team*	X	X		X		X										
Integrated Delivery System						X	X		X		X	X				
Integrative Pain Center	X	X	X		X								X			X
Integrative Restoration (iRest)	X	X		X	X	X	X		X		X	X	X	X	X	
inTransition																X
LivingWorks Suicide Intervention Training Programs (Applied Suicide Intervention Skills Training, safeTALK, and suicideTALK)				X												
Marine Corps Combat and Operational Stress Control	X	X				X	X				X		X		X	
Marine Corps Martial Arts Program																X
Marine Corps Operational Stress Training Program*	X	X				X	X				X	X	X		X	
Marine Corps Substance Abuse Program			X			X										
Marine Corps Suicide Prevention Program				X												
Marine Corps Wounded Warrior Regiment Psychological Health and TBI Clinical Services Staff	X	X			X						X					
Master Resiliency Training Program	X					X							X		X	X
Medical Soldier Readiness Processing	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X
Mild Traumatic Brain Injury (mTBI) Intensive Treatment Program*					X											
Military and Family Life Consultants						X	X		X		X	X	X		X	X
Military Child Education Coalition Living in the New Normal Program									X							
Military Child Education Coalition Student 2 Student Programs									X							X

Table A.3—Continued

	Clinical Issues						Nonclinical Issues									
Program Name	**Depression**	**PTSD**	**Substance Use**	**Suicide Prevention**	**Traumatic Brain Injury**	**General Psychological Health**	**Deployment-Related**	**Domestic Violence**	**Family and/or Children**	**Legal**	**Postdeployment and Reintegration**	**Relationships**	**Resilience**	**Spiritual**	**Stress Reduction**	**Other**
Military OneSource						X			X		X	X			X	X
Military Pathways	X	X	X			X										X
Mind-Body Skills Groups for the Treatment of War Zone Stress in Military and Veteran Populations	X	X			X	X	X		X		X	X	X	X	X	
Mind-Body Trauma First Aide	X	X	X	X		X	X	X	X		X	X	X	X	X	X
Mindfulness-Based Mind Fitness Training													X		X	
Mobile Telehealth Program	X	X	X	X		X	X								X	
Mountain Post Wellness Center*						X	X		X		X		X	X	X	
National Center for Telehealth and Technology Mobile Applications		X				X	X						X		X	
National Guard Family Programs	X		X	X		X	X	X	X	X	X	X	X	X	X	
National Guard Psychological Health Program	X	X	X	X	X	X	X	X	X		X	X	X		X	X
National Guard Transition Assistance Advisors	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Navy Alcohol and Drug Abuse Prevention Program*			X													
The National Intrepid Center of Excellence		X			X	X										
Navy Command Level Suicide Prevention Program				X												
Navy MORE (My Ongoing Recovery Experience) Program			X													
Navy Operational Stress Control	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X
Navy Safe Harbor						X			X	X	X					
Operation BRAVE (Building Resilience and Valuing Empowered) Families	X	X				X	X	X	X		X	X	X		X	X
Operation: Military Kids						X	X		X		X	X	X		X	X
Operational Stress Control and Readiness (OSCAR)		X				X	X				X		X		X	X

Table A.3—Continued

	Clinical Issues						Nonclinical Issues									
Program Name	Depression	PTSD	Substance Use	Suicide Prevention	Traumatic Brain Injury	General Psychological Health	Deployment-Related	Domestic Violence	Family and/or Children	Legal	Postdeployment and Reintegration	Relationships	Resilience	Spiritual	Stress Reduction	Other
Outcomes of Prolonged Exposure and Cognitive Processing Therapy Used in the Treatment of Combat Operational Stress in Deployed Locations	X	X				X	X						X		X	
Partners in Care						X	X		X		X	X		X		X
Passport Toward Success									X		X	X	X		X	X
Physical Medicine and Integrative Care Services	X	X			X						X		X		X	X
Post Deployment Open House Program	X	X			X	X					X					
Post-Traumatic Stress Residential Rehabilitation Program	X	X	X		X	X										X
Postdeploymenthealth.com	X	X	X		X	X			X		X					
Prevention, Treatment and Outreach			X													
Psychiatric Service Dog Society Research		X														
Psychological Health Advocacy Program				X		X					X					X
Psychological Health Pathways Program	X	X	X		X	X	X			X	X		X		X	X
PTSD Provider Training*						X										
PTSD Training Program*	X	X														
PTSD Treatment in Primary Care Settings	X	X				X	X				X		X		X	
Randomized Exploratory Study to Evaluate Two Acupuncture Methods for the Treatment of Headaches Associated with TBI	X	X			X											X
Re-Engineering Healthcare Integration Programs	X	X		X												
Real Warriors Campaign					X	X					X					
Recovery Coordination Program	X	X				X	X		X		X	X	X		X	
Reserve Psychological Health Outreach Coordinators Program				X		X					X		X			X

Table A.3—Continued

Program Name	Clinical Issues						Nonclinical Issues									
	Depression	PTSD	Substance Use	Suicide Prevention	Traumatic Brain Injury	General Psychological Health	Deployment-Related	Domestic Violence	Family and/or Children	Legal	Postdeployment and Reintegration	Relationships	Resilience	Spiritual	Stress Reduction	Other
Reset		X														
Resilience Training	See listing for Battlemind and see Appendix B for additional information.															
Resiliency Center													X			
RESPECT-Mil	X	X		X									X			X
Return to Duty Performance Validation Program (TBI Program)	X	X		X	X	X	X						X		X	
Returning Warrior Workshops	X	X		X		X			X		X		X	X		X
Road to Reintegration: Systems of Care											X					
School Mental Health Training Academy						X			X							
School-Based Initiative	X			X		X	X		X		X	X	X		X	X
Scripps Military Brain Injury Rehabilitation Program	X	X	X		X	X	X	X	X		X	X	X	X	X	
Seeking Safety	X	X	X	X		X	X	X	X	X		X	X		X	
Semper Fit Health Promotion Program			X	X		X									X	X
Sesame Workshop Military Families Initiative		X			X	X	X		X		X	X	X		X	
Sexual Assault Prevention and Response Office*						X										
Sexual Assault Prevention and Response Program (Air Force)						X										X
Sexual Assault Prevention and Program (Coast Guard)																X
Sexual Assault Prevention and Response Program (Marine Corps)																X
Sexual Assault Prevention and Response Program (National Guard)																X
Sexual Assault Prevention and Response Program (Navy)																X
Sexual Harassment/Assault Response and Prevention Program (Army)																X

Table A.3—Continued

	Clinical Issues						Nonclinical Issues									
Program Name	Depression	PTSD	Substance Use	Suicide Prevention	Traumatic Brain Injury	General Psychological Health	Deployment-Related	Domestic Violence	Family and/or Children	Legal	Postdeployment and Reintegration	Relationships	Resilience	Spiritual	Stress Reduction	Other
Signs of Suicide*	X			X					X							
SimCoach	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Soldier 360°*		X		X		X	X		X		X	X	X	X		
Soldier Evaluation for Life Fitness	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X
Special Operations Force Resilience Enterprise Program							X		X				X			X
Special Psychiatric Rapid Intervention Team			X	X									X	X	X	X
Spiritual Warrior Training Program*						X										
STEPS UP (Stepped Enhancement of PTSD Services Using Primary Care)	X	X		X							X				X	
Stress Gym	X	X	X	X	X	X		X	X		X	X		X	X	X
Strong Bonds									X			X	X	X		X
Strong Families, Strong Forces	X	X				X	X		X		X	X	X		X	
STRONG STAR (South Texas Research Organizational Network Guiding Studies on Trauma and Resilience) Research Consortium	X	X	X			X	X		X		X	X	X		X	
Substance Abuse Rehabilitation Program*			X			X			X				X			
Suicide Awareness Voices of Education	X	X	X	X												
Suicide Reduction Initiatives				X												
TBI Family Caregiver Curriculum					X				X							
TBI.Consult					X											
Telehealth for Children at Tripler Army Medical Center	X			X		X			X				X		X	
Theater of War		X		X		X					X		X			
Third Location Decompression	X	X	X	X		X		X	X	X	X	X	X	X	X	
Tragedy Assistance Program for Survivors						X			X							

Table A.3—Continued

Program Name	Clinical Issues						Nonclinical Issues									
	Depression	PTSD	Substance Use	Suicide Prevention	Traumatic Brain Injury	General Psychological Health	Deployment-Related	Domestic Violence	Family and/or Children	Legal	Postdeployment and Reintegration	Relationships	Resilience	Spiritual	Stress Reduction	Other
Traumatic Brain Injury: The Journey Home					X											
Traumatic Stress Response Team	X	X											X		X	
TRICARE Assistance Program		X				X	X	X	X			X			X	X
Tripler Army Medical Center School Mental Health Program									X							
Tripler Programs in TBI, Pain, Psychological Health, and Telehealth*						X										
Virtual Behavioral Telehealth Pilot at Fort Richardson*	X	X	X	X		X					X	X	X		X	
Virtual Behavioral Telehealth Pilot at Tripler Army Medical Center	X	X	X	X		X					X	X	X		X	X
Virtual Reality and Innovative Technology Applications	X	X				X										
Virtual Reality Graded Exposure Therapy with Physiological Monitoring		X											X			
Virtual Reality Iraq/Afghanistan	X	X				X							X		X	
Virtual Traumatic Brain Injury Clinic					X											
Warrior Adventure Quest						X					X	X	X		X	X
Warrior and Family Assistance Center	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Warrior Mind Training		X				X	X		X		X		X	X	X	X
Warrior Optimization Systems (WAROPS)															X	
Warrior Resilience & Thriving	X	X		X		X	X				X	X	X		X	
Warrior Resiliency Program	This entry includes two or more programs. See Appendix B for additional details.															
Warrior Restoration Center*		X			X						X					
Warrior Strengthening Program		X														
Warrior Transition Units*		X			X	X										X
Warrior's Huddle	X	X	X	X	X	X	X		X		X	X	X	X	X	

Table A.3—Continued

	Clinical Issues						Nonclinical Issues									
Program Name	**Depression**	**PTSD**	**Substance Use**	**Suicide Prevention**	**Traumatic Brain Injury**	**General Psychological Health**	**Deployment-Related**	**Domestic Violence**	**Family and/or Children**	**Legal**	**Postdeployment and Reintegration**	**Relationships**	**Resilience**	**Spiritual**	**Stress Reduction**	**Other**
Wellness and Resiliency Assessment—Post-Deployment	X	X	X	X		X					X	X	X		X	X
The Wingman Project				X												
Wounded Warrior Call Center																X
Wounded Warrior Regiment	X	X		X	X	X			X	X	X	X	X			
Yellow Ribbon Reintegration Program (Air Force)	X	X	X	X	X	X	X		X	X	X	X	X		X	
Yellow Ribbon Reintegration Program (Army)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Yellow Ribbon Reintegration Program (Marine Corps)						X	X		X	X	X		X			
Yellow Ribbon Reintegration Program (National Guard)						X	X				X					
Yellow Ribbon Reintegration Program (Navy)						X		X	X	X		X				X

* No interview was conducted for this program. Our description of the program was developed from publicly available documentation or from documentation provided by the program, and only limited information was available.

Table A.4
Programs by Evidence Base, Evaluation Status, and Data Collected

Program Name	Includes Evidence-Based Intervention	Outcome Evaluation Conducted in Past 12 Months	Type of Data Currently Collected by Program	
			Process Data	Outcome Data
ACE (Ask, Care, Escort)	X		X	X
Adaptive Disclosure Training	X	X	X	X
After Deployment	X		X	
Air Force Special Operations Command Resiliency Program				
Air Force Suicide Prevention Program	X	X		X
Air Force Wounded Warrior Program			X	X
Air National Guard Psychological Health Program				
Airman Resilience Training	X	X		
Alcohol and Drug Abuse Prevention and Treatment Program	X			
America's Heroes at Work			X	
Are You Listening?			X	
Army Center for Enhanced Performance	X	X	X	X
Army Confidential Alcohol Treatment and Education Pilot			X	
Army Strong Community Center			X	
Army Substance Abuse Program			X	
Army Suicide Prevention Program*				
Army Wounded Warrior Program			X	
Assessing and Managing Suicide Risk	X		X	
Automated Behavioral Health Clinic Program	X		X	
Automated Tools and Outcome Measures	X			
AXON			X	X
Battlefield Resiliency Initiative			X	
Battlemind	X		X	X
Behavioral Health Integration Program	X		X	
Behavioral Health Optimization Program	X		X	X
BrainCheckers Deployment Stress Assessment Tool	X			
Brainline.org	X		X	
Brigade Resiliency Teams			X	X
Buddy-to-Buddy Program			X	

Table A.4—Continued

Program Name	Includes Evidence-Based Intervention	Outcome Evaluation Conducted in Past 12 Months	Type of Data Currently Collected by Program	
			Process Data	Outcome Data
Care Coalition				X
Care for Caregivers			X	X
Care Provider Support Program	X		X	X
Caregiver Occupational Stress Control Program			X	
Caregiver Optimization Systems (CAREOPS)	X		X	X
The Caring Letters Project	X	X	X	X
Center for Deployment Psychology	X			
Center for Spiritual Leadership				
Child and Youth Behavior Consultants			X	
Child, Adolescent and Family Behavioral Health Proponency	X		X	
Citizen Soldier Support Program			X	
Co-Occurring Disorders Program	X		X	X
Coast Guard Programs	X			
Cognitive Processing Therapy for PTSD	X	X	X	X
Cognitive-Behavioral Couple Therapy for Combat Stress Reactions and Intimate Relationship Problems	X	X	X	X
Combat and Operational Stress First Aid				
Combat and Operational Stress Reaction/Staff Resiliency Program			X	
Combat and Operational Stress Control Training Program*				
Combat Stress Control Team*				
Comfort for America's Uniformed Services			X	X
Community Behavioral Health Services	X	X	X	X
Community Resiliency Initiative				
Comprehensive Combat and Complex Casualty Care Program	X		X	X
Comprehensive Soldier Fitness	This entry includes two or more programs. See Appendix B for additional details.			
Coping with Deployments: Psychological First Aid for Military Families			X	
CREDO			X	X
Defender's Edge*				

Table A.4—Continued

Program Name	Includes Evidence-Based Intervention	Outcome Evaluation Conducted in Past 12 Months	Type of Data Currently Collected by Program	
			Process Data	Outcome Data
Defense and Veterans Brain Injury Center Regional Care Coordination			X	
Defense Stress Management*				
Department of Pastoral Ministry Training			X	
Deployment Health Clinical Center Specialized Care Program	X		X	X
Deployment Transition Center	X		X	X
DESTRESS-PC (Delivery of Self Training and Education for Stressful Situations—Primary Care)	X	X	X	X
Domestic Violence Among Returning Servicemembers with PTSD	X	X	X	X
Drug Demand Reduction Program*				
DSTRESS			X	
Effects of Integrative Restoration (iRest) on Sleep and Perceived Stress			X	X
Elmendorf Air Force Base TBI Clinic				
Evolution	X	X	X	X
Families OverComing Under Stress (FOCUS)	X	X	X	X
Family Advocacy Program (Air Force)	X		X	
Family Advocacy Program (Army)			X	X
Family Advocacy Program (Coast Guard)				
Family Advocacy Program (Marine Corps)				
Family Advocacy Program (Navy)	X			
Family Assistance for Maintaining Excellence	X		X	X
Family Optimization Systems (FAMOPS)	X		X	X
Family Strong Hawaii			X	X
Federal Recovery Coordination Program		X		
Fort Bliss Restoration and Resilience Center	X		X	X
Fort Hood Resilience and Restoration Center's Warrior Combat Stress Reset Program	X	X	X	X
Freedom Restoration Center*				
Healing Heroes*				
HeartMath	X			
Heroes at Home	X		X	

Table A.4—Continued

Program Name	Includes Evidence-Based Intervention	Outcome Evaluation Conducted in Past 12 Months	Type of Data Currently Collected by Program	
			Process Data	Outcome Data
Installation Suicide Response Team*				
Integrated Delivery System			X	X
Integrative Pain Center	X	X	X	
Integrative Restoration (iRest)	X	X		X
inTransition			X	
LivingWorks Suicide Intervention Training Programs (Applied Suicide Intervention Skills Training, safeTALK, and suicideTALK)			X	
Marine Corps Combat and Operational Stress Control				
Marine Corps Martial Arts Program				
Marine Corps Operational Stress Training Program*				
Marine Corps Substance Abuse Program	X	X	X	X
Marine Corps Suicide Prevention Program	X	X	X	X
Marine Corps Wounded Warrior Regiment Psychological Health and TBI Clinical Services Staff			X	
Master Resiliency Training Program	X	X	X	
Medical Soldier Readiness Processing		X	X	X
Mild Traumatic Brain Injury (mTBI) Intensive Treatment Program*				
Military and Family Life Consultants	X			
Military Child Education Coalition Living in the New Normal Program	X		X	X
Military Child Education Coalition Student 2 Student Programs				
Military OneSource	X			
Military Pathways	X	X	X	
Mind-Body Skills Groups for the Treatment of War Zone Stress in Military and Veteran Populations	X			
Mind-Body Trauma First Aide	X			X
Mindfulness-Based Mind Fitness Training	X	X	X	X
Mobile Telehealth Program	X		X	
Mountain Post Wellness Center*				
National Center for Telehealth and Technology Mobile Applications	X		X	

Table A.4—Continued

Program Name	Includes Evidence-Based Intervention	Outcome Evaluation Conducted in Past 12 Months	Type of Data Currently Collected by Program	
			Process Data	Outcome Data
National Guard Family Programs			X	
National Guard Psychological Health Program			X	
National Guard Transition Assistance Advisors			X	
The National Intrepid Center of Excellence	X		X	X
Navy Alcohol and Drug Abuse Prevention Program*				
Navy Command Level Suicide Prevention Program				
Navy MORE (My Ongoing Recovery Experience) Program	X		X	
Navy Operational Stress Control	X		X	X
Navy Safe Harbor			X	
Operation BRAVE (Building Resilience and Valuing Empowered) Families	X		X	
Operation: Military Kids	X		X	
Operational Stress Control and Readiness (OSCAR)	X	X		
Outcomes of Prolonged Exposure and Cognitive Processing Therapy Used in the Treatment of Combat Operational Stress in Deployed Locations	X	X	X	X
Partners in Care			X	
Passport Toward Success			X	X
Physical Medicine and Integrative Care Services	X		X	X
Post Deployment Open House Program			X	
Post-Traumatic Stress Residential Rehabilitation Program	X	X	X	X
Postdeploymenthealth.com	X	X	X	X
Prevention, Treatment and Outreach			X	X
Psychiatric Service Dog Society Research				X
Psychological Health Advocacy Program			X	
Psychological Health Pathways Program	X		X	X
PTSD Provider Training*	X			
PTSD Training Program*	X			
PTSD Treatment in Primary Care Settings	X	X	X	X

Table A.4—Continued

Program Name	Includes Evidence-Based Intervention	Outcome Evaluation Conducted in Past 12 Months	Type of Data Currently Collected by Program	
			Process Data	Outcome Data
Randomized Exploratory Study to Evaluate Two Acupuncture Methods for the Treatment of Headaches Associated with TBI	X			
Re-Engineering Healthcare Integration Programs	X	X	X	X
Real Warriors Campaign			X	
Recovery Coordination Program				
Reserve Psychological Health Outreach Coordinators Program		X	X	X
Reset	X	X		
Resilience Training	See listing for Battlemind and see Appendix B for additional information.			
Resiliency Center	X			
RESPECT-Mil	X	X	X	X
Return to Duty Performance Validation Program (TBI Program)			X	X
Returning Warrior Workshops	X		X	
Road to Reintegration: Systems of Care				
School Mental Health Training Academy	X		X	X
School-Based Initiative	X	X	X	X
Scripps Military Brain Injury Rehabilitation Program	X	X	X	X
Seeking Safety	X	X	X	X
Semper Fit Health Promotion Program	X	X	X	X
Sesame Workshop Military Families Initiative				X
Sexual Assault Prevention and Response Office*	X			
Sexual Assault Prevention and Response Program (Air Force)			X	
Sexual Assault Prevention and Response Program (Coast Guard)			X	
Sexual Assault Prevention and Response Program (Marine Corps)	X		X	X
Sexual Assault Prevention and Response Program (National Guard)	X		X	X
Sexual Assault Prevention and Response Program (Navy)	X		X	
Sexual Harassment/Assault Response and Prevention Program (Army)	X		X	X

Table A.4—Continued

Program Name	Includes Evidence-Based Intervention	Outcome Evaluation Conducted in Past 12 Months	Type of Data Currently Collected by Program	
			Process Data	Outcome Data
Signs of Suicide*	X			
SimCoach			X	
Soldier 360°*	X			
Soldier Evaluation for Life Fitness	X		X	
Special Operations Force Resilience Enterprise Program				X
Special Psychiatric Rapid Intervention Team	X			X
Spiritual Warrior Training Program*				
STEPS UP (Stepped Enhancement of PTSD Services Using Primary Care)	X			
Stress Gym	X	X	X	X
Strong Bonds	X	X	X	X
Strong Families, Strong Forces			X	
STRONG STAR (South Texas Research Organizational Network Guiding Studies on Trauma and Resilience) Research Consortium	X			
Substance Abuse Rehabilitation Program*	X			
Suicide Awareness Voices of Education				
Suicide Reduction Initiatives	X	X	X	X
TBI Family Caregiver Curriculum	X		X	
TBI.Consult	X			
Telehealth for Children at Tripler Army Medical Center	X			
Theater of War				
Third Location Decompression			X	X
Tragedy Assistance Program for Survivors	X		X	
Traumatic Brain Injury: The Journey Home	X		X	
Traumatic Stress Response Team	X		X	X
TRICARE Assistance Program			X	X
Tripler Army Medical Center School Mental Health Program	X		X	X
Tripler Programs in TBI, Pain, Psychological Health, and Telehealth*				
Virtual Behavioral Telehealth Pilot at Fort Richardson*				

Table A.4—Continued

Program Name	Includes Evidence-Based Intervention	Outcome Evaluation Conducted in Past 12 Months	Type of Data Currently Collected by Program	
			Process Data	Outcome Data
Virtual Behavioral Telehealth Pilot at Tripler Army Medical Center	X	X	X	X
Virtual Reality and Innovative Technology Applications	X		X	X
Virtual Reality Graded Exposure Therapy with Physiological Monitoring	X			
Virtual Reality Iraq/Afghanistan	X	X	X	X
Virtual Traumatic Brain Injury Clinic	X		X	
Warrior Adventure Quest		X	X	X
Warrior and Family Assistance Center			X	
Warrior Mind Training	X		X	X
Warrior Optimization Systems (WAROPS)	X	X	X	X
Warrior Resilience & Thriving	X		X	X
Warrior Resiliency Program	This entry includes two or more programs. See Appendix B for additional details.			
Warrior Restoration Center*				
Warrior Strengthening Program	X		X	X
Warrior Transition Units*				
Warrior's Huddle			X	
Wellness and Resiliency Assessment—Post-Deployment	X		X	
The Wingman Project			X	
Wounded Warrior Call Center			X	
Wounded Warrior Regiment			X	
Yellow Ribbon Reintegration Program (Air Force)			X	
Yellow Ribbon Reintegration Program (Army)			X	
Yellow Ribbon Reintegration Program (Marine Corps)			X	
Yellow Ribbon Reintegration Program (National Guard)			X	
Yellow Ribbon Reintegration Program (Navy)			X	

* No interview was conducted for this program. Our description of the program was developed from publicly available documentation or from documentation provided by the program, and only limited information was available.

APPENDIX B

Program Descriptions

Because of the length of this appendix, it is provided on the CD at the end of the printed edition of this report. The CD document begins with a clickable table of contents that allows the user to jump directly to any program description. The same information is also included in searchable format on the Innovative Practices for Psychological Health and Traumatic Brain Injury online database on the RAND website, located at http://www.rand.org/multi/military/innovative-practices.html. Programs identified after this report was written will be added to this database, which RAND will maintain and strive to keep current through 2012, adding programs that are identified through passive means, such as newsletters and media coverage.

This appendix includes descriptions of every program that we identified and for which we were able to either (a) complete an interview or (b) identify adequate information from publicly available documents to develop an appropriate description. More-limited descriptions are included for those programs for which we relied on publicly available documents. Programs for which we were not able to complete an interview and for which inadequate information was available are listed in Appendix C.

Inclusion and exclusion criteria, describing in more detail what is included in this appendix, can be found in Chapter Three. The data collection methods are described in Chapter Four. Definitions of the terms used to describe the programs can be found in Appendix E.

Where possible, we identified the ways in which programs had organizational ties to one another at the time of the interview. These linkages are indicated in the individual program descriptions, and we include information only on linkages to other programs that are included in this report. Programs that address the same topic or that are housed within the same organization are not described as being related to one another.

All interviews took place between December 2009 and August 2010. The information presented here was correct as of the time of the interview. RAND staff have not independently verified information reported to us by the program representatives.

APPENDIX C

Excluded Entities

This appendix contains a list of entities we identified but were unable to interview for a variety of reasons: Some did not have publicly accessible information describing the program, and no contact information for a program representative was available; for others we were unable to schedule an interview during the specified data collection period (December 2009–August 2010) despite repeated attempts; and a small number refused our request for an interview. Also shown below are entities we excluded from this report because they did not meet the inclusion criteria listed in Chapter Three. Since we did not interview all entities listed in this appendix, the names shown reflect the best information available to us at the time this report was written.

Entities Not Included in This Report Because Adequate Information Was Not Available (n=27)

- Army Reserve Pre-Command Course—Suicide Prevention Training for Company, Battalion, and Brigade Commanders
- Battlefield Acupuncture (Air Force)
- Battle Trail Break (Army)
- Cadet Counseling Unit (Army)
- Changing Culture Campaign (Army)
- Clinical Pastoral Care Evidence-Based Practice for Traumatic Brain Injury/Post Traumatic Stress Disorder—Walter Reed Army Medical Center
- Forward/Rear Deployed Mild Traumatic Brain Injury Centers (Navy)
- Future Immersive Training Environment
- Health Promotion and Prevention Initiatives Program (Army)
- Injured Soldiers Family Support Group (Army)
- Life Skills Training (Army)
- Marine Corps Family Team Building
- Mild Traumatic Brain Injury Intensive Treatment Program (Army)
- No Soldier Left in Need
- One Shot . . . One Kill (Air Force)
- Project Armor (DoD–wide)
- Psychiatry Emergency and Consultation Team (Army)
- Ready Good to Go
- Self Help Medical Center (Army)
- Small Site Staffing

- TBI Program at Tripler Army Medical Center
- Traumatic Brain Injury Program (Walter Reed Army Medical Center)
- TRICARE Management Activity Behavioral Health Initiatives
- TRICARE Telemental Health Services
- United States Corps of Cadets Sexual Harassment and Sexual Assault Prevention Response Program (Army)
- Walter Reed Army Medical Center School–Based Counseling Advocacy Prevention Services
- Wounded, Injured, and Ill Program (Navy)

Entities for Which Information Was Available but Which Were Excluded from This Report (n=174)

These entities do not meet the inclusion criteria that we used to define what constitutes a program and are grouped by the reason for their exclusion. The lists below consist of entities that were identified as ineligible after an interview was conducted (n=80) and those entities that were identified as research or a resource without an interview (n=94).

The following entities did not directly address psychological health or TBI issues and/or were categorized as routine clinical care or support services. Many of these interviews were used to inform the contents of Chapter Three.

- Airman Family Readiness Center
- Army Family Action Plan
- Army Substance Abuse Program Intensive Outpatient Program
- Beneficiary Counseling Assistance Coordinators (Army)
- Better Opportunities for Single Soldiers (Army)
- Child and Youth Services (Air Force)
- Child and Youth Services (Army)
- Child and Youth Services (Army Reserve)
- Child and Youth Services (Navy)
- Consolidated Substance Abuse and Counseling Center (Marine Corps)
- Deployment Support Program (Army Child and Youth Services)
- Employer Support for Guard and Reserve (DoD-wide)
- Fleet and Family Support Clinical Counseling Program (Navy)
- Heroes to Hometowns Program (DoD-wide)
- Kids Included Together (Navy)
- Marine & Family Services
- Military Impacted School Association (DoD-wide)
- Navy Exceptional Family Member Program Respite Care Program
- New Parent Support Program (Marine Corps)
- Single Marine Program
- Soldier and Family Assistance Center (Army)
- Substance Abuse and Rehabilitation Program (Navy) (This is a clinical service and is therefore out of scope for this report. In contrast, the Navy Alcohol and Drug Abuse Pre-

vention Program meets the inclusion criteria for this study and is included in Appendix B.)
- Survivor Outreach Service Provider (Army)

The following entities did not receive DoD funding:

- American Veterans with Brain Injuries
- Bowling Green State University Spiritual Resilience Program
- Brain Injury Association of America
- Military to Medicine Institute
- Project Welcome Home Troops

The following entities are offices, centers, or other organizations that may oversee programs that are included in this report, but they are not programs themselves:

- Air Force Warrior and Survivor Care Office
- Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention
- Army National Guard Psychological Health Programs
- Army Public Health Command, Health Promotions Operations
- Behavioral Health Program (Army)
- Center for Traumatic Stress
- Child and Youth Services (Office of the Secretary of Defense)
- Community Action Information Board (Air Force)
- Defense and Veterans Brain Injury Center
- Family Advocacy Program (DoD-wide)
- Health Promotion and Wellness Program (Army)
- National Guard Bureau Child and Youth Program
- Naval Special Warfare Command Family Support Program
- Navy Center for Combat and Operational Stress Control
- Office of Naval Research
- Proponency Office for Rehabilitation and Reintegration (Army)
- Sexual Assault Prevention and Response Program (DoD-wide)
- Traumatic Brain Injury Clinical Standards of Care Directorate at DCoE
- Work and Family Life Program (Navy)

These entities were not providing services during our data collection period:

- Acupuncture for PTSD trial
- Army ThriveSphere
- Battle Rhythm and Beyond
- Bootcamp Survival Training for Navy Recruits—A Prescription & Strategies to Assist Navy Recruits' Success

These entities did not specifically target U.S. active-duty military, National Guard, Reserves, or their family members:

- Corporate Athlete Course

- Deployment Safety and Resiliency Team
- Employment Readiness Program
- Full Engagement Program
- Promoting Alternative Thinking Strategies
- Trauma Risk Management System

These entities were excluded because they were identified to be research projects or centers or offices that conduct research, as defined by the exclusion criteria in Chapter Three. Research was excluded if it did not involve an intervention (such as research designed to assess the prevalence of clinical conditions or utilization of services) or where the intervention was a clinical trial of a drug, treatment, or device. This is not a comprehensive list of existing research projects, as it includes only research and research centers that were identified incidental to our efforts to locate programs.

The following entities were interviewed and then excluded because they are research projects or offices. In some cases, these interviews were conducted to identify other potential programs.

- Community Capacity Building for Military Families
- Leadership Evaluation at Fort Hood
- Marine Resilience Study
- National Center for PTSD, Dissemination and Training, Randomized Controlled Trial of Web-Based Training for Mental Health Providers
- Project CAPS: Child Adjustment to Parental Supervision
- Uniformed Services University of the Health Sciences Projects
- U.S. Marine Corps Health Assessment Project/Recruit Assessment Program
- Virtual Reality Pain Research (Army)

The following entities were identified as research projects or offices, and no interview took place; they are excluded from this report:

- Department of Defense Blast Injury Research Program Coordinating Office
- The Deployment Life Study: A Longitudinal Investigation of the Family Experience
- The Human Dimension Study
- Hyperbaric Oxygen Therapy
- Military Health Advisory Teams
- Military Sexual Trauma study
- Preventive Psychological Health Demonstration Project
- Psychological Health/Traumatic Brain Injury Registry
- Samueli Institute—The Family Needs Assessment at Fort Bliss

The following entities were excluded because they were identified as resources based on our exclusion criteria. A resource is an entity that only provides one-way passive transmission of information without an intervention designed to affect a particular outcome. The entities we identified as resources were further categorized as websites; routine reporting, databases, and registries; CDs, videos, books, and other media; guides and checklists; messaging themes; policies; task forces and committees; and conferences. This is not a comprehensive list of exist-

ing resources, as it includes only those resources that were identified incidental to our efforts to locate programs.

The following entities were interviewed and then excluded because they are resources:

- Commander's Dashboard (Air Force)
- Department of Defense Suicide Event Report
- Infantry Immersion Trainer (Marine Corps)
- Military Youth Deployment Support Video Program
- Neurocognitive Assessment Tool at Theater Medical Information Program
- Post-Deployment Health Reassessment Survey (Air Force)
- Special Needs Identification Assignment Coordination program (Air Force)
- T2 Mood Tracker application

The following entities were identified as resources and no interview took place; they are excluded from this report:

- A Different Kind of Courage
- Air Force Annual Suicide Lessons Learned Report
- Air Force CrossRoads Predeployment Guide
- Air Force Readiness EDGE
- Air Force Suicide Prevention Training CD
- Air Force Suicide Prevention Working Group
- Airmen Under Investigation Informational Pamphlets
- America Supports You (DoD-wide)
- ARFP e-Training Center
- Army Campaign for Health Promotion
- Army Medical Department Behavioral Health Campaign Plan
- Army National Guard Decade of Health
- Army Suicide Prevention Task Force
- Ask Care Treat
- Brain Waves "Gray Team"
- CNS Vital Signs (Navy)
- Coalition of Iraq and Afghanistan Veterans
- Cognitive Stability Index Headminders
- Combat Trauma Registry Deployment Health Database
- Combat Yoga Fitness
- Commander's At-Risk Matrix (Army)
- Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Web Portal
- Department of Defense Suicide Prevention and Risk Reduction Committee
- Deployment Cycle Support
- Deployment Cycle Support (redeployment phase timeline modification)
- Deployment Cycle Support Program
- Deployment Cycle Support/Reachback
- Deployment Health and Family Readiness Library
- Family Assistance Centers (Army)

- Family Care Plans (Army)
- Finding My Way
- G–1 Suicide Prevention Website (Army)
- Health Information Technology System
- HOMEFRONTConnections
- Hometown Links
- Hooah4health
- Information and Referral
- Inter-Service Family Assistance Committee
- Kenner Post-Deployment Health Screening Program
- Leader's Guide to Managing Personnel in Distress (Marine Corps)
- Leader's Resources to Support Psychological Health
- Leadership Messages and Newsletters About Suicide Prevention
- Lifelines Services Network page on Deployment
- Marine Corps Awareness Marketing
- Marine Corps Community Services
- Marine Corps Deployment Support
- Marine Corps Warrior Transition Videos
- Medical Evaluation Board Processing Centers (Army)
- MilitaryHOMEFRONT
- MilitaryINSTALLATIONS
- Military Severely Injured Center
- Military Youth Coping with Separation
- National Registry of Evidence-Based Programs and Practices
- National Resource Directory
- Navy Family Outreach Working Group
- Navy Preparedness Alliance
- Navy Suicide Prevention Cross Functional Teams
- Network of Care
- Office of Transition Policy and Care Coordination
- Operational Problems in Behavioral Sciences Symposium Training (Air Force)
- Our Survivors
- Outreach
- Post-Deployment Health Assessment and Post-Deployment Health Reassessment Programs
- Post-Deployment Health Reassessment Survey (active-duty Navy)
- Post-Deployment Health Reassessment Survey (Army)
- Post-Deployment Health Reassessment Survey (Army Office of the Surgeon General)
- Post-Deployment Health Reassessment Survey (Army Reserve)
- Post-Deployment Health Reassessment Survey (Coast Guard)
- Post-Deployment Health Reassessment Survey (Marine Corps)
- Post-Deployment Health Reassessment Survey (Navy Reserve)
- Post-Deployment Health Toolbox
- Psychological Health Task Force
- REALLifelines
- Red Ribbon Campaign

- School Quest
- Senior Commander's Executive Council for Health Promotion, Risk Reduction and Suicide Prevention
- Soldier Wellbeing Program
- TBI Training DVD
- United States Army Public Health, U.S. Army Center for Health Promotion and Preventive Medicine Army Knowledge Online Suicide Prevention Website
- Warfighter Diaries
- Warriorcare.mil
- Warrior Support Within Guard
- Warrior Transition Briefs (Marine Corps)
- Web-Based Neuropsychological Screening

The following entities were excluded because they were part of another program included in this report:

- Counseling Advocacy Prevention Services is part of the Family Advocacy Program (Navy).
- The Family Advocacy Program at Twentynine Palms is part of the Family Advocacy Program (Marine Corps).
- Frontline Supervisor Training (Air Force) and Assessing and Managing Suicide Risk Training for Mental Health Clinical Staff are part of the Air Force Suicide Prevention Program.
- The Military Family Life Consultant Program (Air Force) and the Military Family Life Consultant Program (Army) are part of the Military and Family Life Consultants program.
- Virtual Reality —T2 and Virtual Reality Exposure Therapy are part of Virtual Reality and Innovative Technology Applications.

APPENDIX D

Mapping Programs to Our Typology of Program Activities

We identified three broad areas along the prevention/identification/treatment continuum into which programs may be classified, each of which is further categorized by two or three more-specific themes, together encompassing 21 key activities in which programs engage. We also describe three additional themes common to programs included in this report, with nine key activities. These are shown below, with lists of all programs in this report that fit these descriptions.

The information presented here highlights the key defining characteristics of the programs in this report and displays the programs according to this categorization but is not intended to describe all of a program's activities. For example, a large proportion of the programs in this report provide some type of education, training, or support to one or more specific populations, though here we list only programs for which the provision of these activities is among their primary goals. Despite our emphasis on the primary activities and goals of programs, many programs are best described by a combination of these categories and are therefore listed more than once in this appendix.

Preventing Problems

Reducing the Incidence of Psychological Health Problems and TBI

Improving resilience and the ability to handle stress among members of the military community:

- Air Force Special Operations Command Resiliency Program
- Airman Resilience Training
- Army Center for Enhanced Performance
- Army Strong Community Center
- Battlefield Resiliency Initiative
- Battlemind
- Brigade Resiliency Teams
- Caregiver Optimization Systems (CAREOPS)
- Comprehensive Soldier Fitness
- Defender's Edge
- Deployment Transition Center
- Families OverComing Under Stress (FOCUS)
- Family Strong Hawaii
- Freedom Restoration Center
- HeartMath

- Master Resiliency Training Program
- Mind-Body Trauma First Aide
- Mindfulness-Based Mind Fitness Training
- Mountain Post Wellness Center
- Operation BRAVE (Building Resilience and Valuing Empowered) Families
- Special Operations Force Resilience Enterprise Program
- Stress Gym
- Traumatic Stress Response Team
- Warrior Adventure Quest
- Warrior Optimization Systems (WAROPS)
- Warrior Resilience & Thriving
- Warrior Resiliency Program

Promoting readiness, increasing combat and operational stress control, and preparing for the psychological health consequences of combat:

- Air National Guard Psychological Health Program
- Battlemind
- Combat and Operational Stress Control Training Program
- Combat and Operational Stress First Aid
- Combat and Operational Stress Reaction/Staff Resiliency Program
- Combat Stress Control Team
- Marine Corps Combat and Operational Stress Control
- Marine Corps Martial Arts Program
- Marine Corps Operational Stress Training Program
- Navy Operational Stress Control
- Operational Stress Control and Readiness (OSCAR)
- Reset
- Warrior Mind Training

Employing Public Health Approaches

Preventing incidents of domestic violence:

- Domestic Violence Among Returning Servicemembers with PTSD
- Family Advocacy Program (Air Force)
- Family Advocacy Program (Army)
- Family Advocacy Program (Coast Guard)
- Family Advocacy Program (Marine Corps)
- Family Advocacy Program (Navy)
- Heroes at Home

Preventing incidents of sexual assault:

- Sexual Assault Prevention and Response Office
- Sexual Assault Prevention and Response Program (Air Force)
- Sexual Assault Prevention and Response Program (Coast Guard)
- Sexual Assault Prevention and Response Program (Marine Corps)
- Sexual Assault Prevention and Response Program (National Guard)
- Sexual Assault Prevention and Response Program (Navy)

- Sexual Harassment/Assault Response and Prevention Program (Army)

Reducing the risk of substance abuse:
- Alcohol and Drug Abuse Prevention and Treatment Program
- Army Substance Abuse Program
- Drug Demand Reduction Program
- Marine Corps Substance Abuse Program
- Navy Alcohol and Drug Abuse Prevention Program
- Prevention, Treatment and Outreach

Preventing suicide:
- ACE (Ask, Care, Escort)
- Air Force Suicide Prevention Program
- Army Suicide Prevention Program
- Assessing and Managing Suicide Risk
- The Caring Letters Project
- Coast Guard Programs
- LivingWorks Suicide Intervention Training Programs (Applied Suicide Intervention Skills Training, safeTALK, and suicideTALK)
- Marine Corps Suicide Prevention Program
- Navy Command Level Suicide Prevention Program
- Signs of Suicide
- Suicide Awareness Voices of Education
- Suicide Reduction Initiative
- The Wingman Project

Identifying Individuals in Need and Connecting Them to Care

Providing Information, Connecting Individuals to Care, and Encouraging Help-Seeking

Operating a telephone hotline that provides immediate access to counselors and other resources:
- DSTRESS
- Military OneSource
- Military Pathways
- Wounded Warrior Call Center

Serving as an information hub that provides referrals to care:
- Army Strong Community Center
- Community Behavioral Health Services
- Military OneSource
- Partners in Care
- Prevention, Treatment and Outreach
- Psychological Health Advocacy Program
- TRICARE Assistance Program
- Wounded Warrior Call Center

Reducing barriers associated with seeking help for mental health conditions or TBI and/or providing education regarding specific conditions:

- Brainline.org
- Cognitive-Behavioral Couple Therapy for Combat Stress Reactions and Intimate Relationship Problems
- Military Pathways
- Navy Operational Stress Control
- Postdeploymenthealth.com
- Real Warriors Campaign
- Soldier Evaluation for Life Fitness
- TBI Family Caregiver Curriculum
- Theater of War
- Traumatic Brain Injury: The Journey Home

Identifying Individuals with Mental Health Concerns or TBI

Conducting routine screening for mental health problems or TBI in the absence of reported symptoms:

- Alcohol and Drug Abuse Prevention and Treatment Program
- Automated Behavioral Health Clinic Program
- Automated Tools and Outcome Measures
- Behavioral Health Optimization Program
- BrainCheckers Deployment Stress Assessment Tool
- Comprehensive Soldier Fitness
- Medical Soldier Readiness Processing
- Military Pathways
- RESPECT-Mil
- Soldier Evaluation for Life Fitness
- STEPS UP (Stepped Enhancement of PTSD Services Using Primary Care)
- Virtual Behavioral Telehealth Pilot at Fort Richardson
- Virtual Behavioral Telehealth Pilot at Tripler Army Medical Center
- Wellness and Resiliency Assessment—Post-Deployment

Increasing the capacity for early identification of mental health problems outside the health care system, with the goal of referring individuals to care when needed:

- Are You Listening?
- Army Confidential Alcohol Treatment and Education Pilot
- Army Suicide Prevention Program
- Battlefield Resiliency Initiative
- Buddy-to-Buddy Program
- Combat and Operational Stress First Aid
- Operational Stress Control and Readiness (OSCAR)
- Post Deployment Open House Program
- Reserve Psychological Health Outreach Coordinators Program
- Traumatic Stress Response Team
- Wellness and Resiliency Assessment—Post-Deployment

Caring for Servicemembers and Families in Need

Providing or Improving Clinical Services

Providing comprehensive care for severe or persistent problems among wounded, ill, and injured servicemembers:

- Air Force Wounded Warrior Program
- Army Wounded Warrior Program
- AXON
- Care Coalition
- Comprehensive Combat and Complex Casualty Care Program
- Deployment Health Clinical Center Specialized Care Program
- Evolution
- Federal Recovery Coordination Program
- Fort Bliss Restoration and Resilience Center
- Fort Hood Resilience and Restoration Center's Warrior Combat Stress Reset Program
- Mild Traumatic Brain Injury (mTBI) Intensive Treatment Program
- The National Intrepid Center of Excellence
- Navy Safe Harbor
- Post-Traumatic Stress Residential Rehabilitation Program
- Scripps Military Brain Injury Rehabilitation Program
- Warrior Restoration Center
- Warrior Transition Units
- Wounded Warrior Regiment

Improving transitions between care settings and providers, improving coordination and continuity of care, or providing case management:

- Air Force Wounded Warrior Program
- Army Wounded Warrior Program
- Behavioral Health Integration Program
- Behavioral Health Optimization Program Care Coalition
- Comprehensive Combat and Complex Casualty Care Program
- Defense and Veterans Brain Injury Center Regional Care Coordination
- Federal Recovery Coordination Program
- inTransition
- Marine Corps Wounded Warrior Regiment Psychological Health and TBI Clinical Services Staff
- National Guard Transition Assistance Advisors
- The National Intrepid Center of Excellence
- Navy Safe Harbor
- Psychological Health Pathways Program
- Recovery Coordination Program
- Scripps Military Brain Injury Rehabilitation Program
- Warrior and Family Assistance Center
- Warrior Transition Units
- Wounded Warrior Regiment

Providing clinical services for mental health concerns, TBI, or other clinical concerns:

- Cognitive Processing Therapy for PTSD
- Elmendorf Air Force Base TBI Clinic
- Evolution
- Fort Bliss Restoration and Resilience Center
- Fort Hood Resilience and Restoration Center's Warrior Combat Stress Reset Program
- Integrative Pain Center
- Mild Traumatic Brain Injury (mTBI) Intensive Treatment Program
- Mind-Body Skills Groups for the Treatment of War Zone Stress in Military and Veteran Populations
- Mobile Telehealth Program
- The National Intrepid Center of Excellence
- Post-Traumatic Stress Residential Rehabilitation Program
- Randomized Exploratory Study to Evaluate Two Acupuncture Methods for the Treatment of Headaches Associated with TBI
- Return to Duty Performance Validation Program (TBI Program)
- Scripps Military Brain Injury Rehabilitation Program
- Seeking Safety
- Tripler Programs in TBI, Pain, Psychological Health, and Telehealth
- Virtual Reality Graded Exposure Therapy with Physiological Monitoring
- Virtual Reality Iraq/Afghanistan
- Virtual Traumatic Brain Injury Clinic
- Warrior Restoration Center
- Warrior Strengthening Program
- Warrior Transition Units

Offering Mental Health Services in Nontraditional Locations to Expand Access to Care

Embedding mental health providers in primary care or other non–behavioral health clinical settings, or other initiatives to improve treatment for mental health conditions in primary care settings:

- Behavioral Health Integration Program
- Behavioral Health Optimization Program
- PTSD Treatment in Primary Care Settings
- Re-Engineering Healthcare Integration Programs
- RESPECT-Mil
- STEPS UP (Stepped Enhancement of PTSD Services Using Primary Care)
- Tripler Programs in TBI, Pain, Psychological Health, and Telehealth

Embedding mental health providers within military units:

- Community Behavioral Health Services
- Operational Stress Control and Readiness (OSCAR)

Nonclinical Activities That Provide Support

Training servicemembers to provide peer-to-peer support for improving psychological health:

- Buddy-to-Buddy Program
- Care Coalition

Offering complementary and alternative treatment services to help address the consequences of psychological health concerns and TBI:

- Comfort for America's Uniformed Services
- Effects of Integrative Restoration (iRest) on Sleep and Perceived Stress
- Fort Bliss Restoration and Resilience Center
- Fort Hood Resilience and Restoration Center's Warrior Combat Stress Reset Program
- HeartMath
- Integrative Pain Center
- Integrative Restoration (iRest)
- Mind-Body Skills Groups for the Treatment of War Zone Stress in Military and Veteran Populations
- Mind-Body Trauma First Aide
- Mindfulness-Based Mind Fitness Training
- Physical Medicine and Integrative Care Services
- Randomized Exploratory Study to Evaluate Two Acupuncture Methods for the Treatment of Headaches Associated with TBI
- Warrior Restoration Center

Providing spiritual support:

- Center for Spiritual Leadership
- CREDO
- Department of Pastoral Ministry Training
- Partners in Care
- Spiritual Warrior Training Program

Responding to Incidents of Concern

Responding to incidents of domestic violence:

- Domestic Violence Among Returning Servicemembers with PTSD
- Family Advocacy Program (Air Force)
- Family Advocacy Program (Army)
- Family Advocacy Program (Coast Guard)
- Family Advocacy Program (Marine Corps)
- Family Advocacy Program (Navy)

Responding to incidents of sexual assault:

- Sexual Assault Prevention and Response Office
- Sexual Assault Prevention and Response Program (Air Force)
- Sexual Assault Prevention and Response Program (Coast Guard)
- Sexual Assault Prevention and Response Program (Marine Corps)
- Sexual Assault Prevention and Response Program (National Guard)
- Sexual Assault Prevention and Response Program (Navy)
- Sexual Harassment/Assault Response and Prevention Program (Army)

Responding to substance abuse problems:

- Alcohol and Drug Abuse Prevention and Treatment Program

- Army Confidential Alcohol Treatment and Education Pilot
- Army Substance Abuse Program
- Co-Occurring Disorders Program
- Drug Demand Reduction Program
- Navy MORE (My Ongoing Recovery Experience) Program
- Seeking Safety
- Substance Abuse Rehabilitation Program

Engaging in post-suicide response:
- Air Force Suicide Prevention Program
- Coast Guard Programs
- Installation Suicide Response Team
- Navy Command Level Suicide Prevention Program

Providing Training, Education, or Support for Specific Populations

Providing training, education, or support for health care providers, chaplains, or educators:
- Air Force Suicide Prevention Program
- Assessing and Managing Suicide Risk
- Care for Caregivers
- Care Provider Support Program
- Caregiver Occupational Stress Control Program
- Caregiver Optimization Systems (CAREOPS)
- Center for Deployment Psychology
- Center for Spiritual Leadership
- Citizen Soldier Support Program
- Cognitive-Behavioral Couple Therapy for Combat Stress Reactions and Intimate Relationship Problems
- Combat and Operational Stress Control Training Program
- Combat and Operational Stress Reaction/Staff Resiliency Program
- Co-Occurring Disorders Program
- Department of Pastoral Ministry Training
- LivingWorks Suicide Intervention Training Programs (Applied Suicide Intervention Skills Training, safeTALK, and suicideTALK)
- Military Child Education Coalition Living in the New Normal Program
- Psychological Health Pathways Program
- PTSD Provider Training
- PTSD Training Program
- School Mental Health Training Academy
- TBI.Consult

Providing training, education, or support for military leaders, including officers and noncommissioned officers:
- Air Force Suicide Prevention Program

- Army Substance Abuse Program
- Army Suicide Prevention Program
- Battlefield Resiliency Initiative
- Combat and Operational Stress Reaction/Staff Resiliency Program
- Marine Corps Operational Stress Training Program
- Marine Corps Suicide Prevention Program
- Military and Family Life Consultants
- Navy Alcohol and Drug Abuse Prevention Program
- Navy Command Level Suicide Prevention Program
- Operational Stress Control and Readiness (OSCAR)
- Resiliency Center
- Soldier 360°
- Special Operations Force Resilience Enterprise Program
- Warrior Adventure Quest

Providing training, education, or support for servicemembers' families:

- Army Strong Community Center
- Child and Youth Behavior Consultants
- Child, Adolescent and Family Behavioral Health Proponency
- Cognitive-Behavioral Couple Therapy for Combat Stress Reactions and Intimate Relationship Problems
- Coping with Deployments: Psychological First Aid for Military Families
- Families OverComing Under Stress (FOCUS)
- Family Advocacy Program (Air Force)
- Family Advocacy Program (Army)
- Family Advocacy Program (Coast Guard)
- Family Advocacy Program (Marine Corps)
- Family Advocacy Program (Navy)
- Family Assistance for Maintaining Excellence
- Family Optimization Systems (FAMOPS)
- Family Strong Hawaii
- Heroes at Home
- Military and Family Life Consultants
- Military Child Education Coalition Living in the New Normal Program
- Military Child Education Coalition Student 2 Student Programs
- Military Pathways
- National Guard Family Programs
- Operation BRAVE (Building Resilience and Valuing Empowered) Families
- Operation: Military Kids
- Partners in Care
- Passport Toward Success
- Postdeploymenthealth.com
- Psychological Health Advocacy Program
- Resiliency Center
- Returning Warrior Workshops
- School-Based Initiative

- Sesame Workshop Military Families Initiative
- Signs of Suicide
- Special Operations Force Resilience Enterprise Program
- Strong Bonds
- Strong Families, Strong Forces
- TBI Family Caregiver Curriculum
- Telehealth for Children at Tripler Army Medical Center
- Tragedy Assistance Program For Survivors
- Tripler Army Medical Center School Mental Health Program
- Warrior and Family Assistance Center
- Yellow Ribbon Reintegration Program (Air Force)
- Yellow Ribbon Reintegration Program (Army)
- Yellow Ribbon Reintegration Program (Marine Corps)
- Yellow Ribbon Reintegration Program (National Guard)
- Yellow Ribbon Reintegration Program (Navy)

Programs that promote psychological health for National Guard, Reserve, or Coast Guard servicemembers:

- Air National Guard Psychological Health Program
- Coast Guard Programs
- National Guard Family Programs
- National Guard Psychological Health Program
- National Guard Transition Assistance Advisors
- Reserve Psychological Health Outreach Coordinators Program
- Resiliency Center
- Returning Warrior Workshops
- Road to Reintegration: Systems of Care

Providing Support During Times of Military Transition

Providing support for servicemembers and their families during transitions between deployment phases:

- Deployment Transition Center
- Family Strong Hawaii
- Integrated Delivery System
- Marine Corps Operational Stress Training Program
- Medical Soldier Readiness Processing
- Psychological Health Advocacy Program
- Returning Warrior Workshops
- Road to Reintegration: Systems of Care
- Soldier Evaluation for Life Fitness
- Strong Families, Strong Forces
- Third Location Decompression
- Warrior Adventure Quest

- Warrior and Family Assistance Center
- Warrior Mind Training
- Wellness and Resiliency Assessment—Post-Deployment
- Yellow Ribbon Reintegration Program (Air Force)
- Yellow Ribbon Reintegration Program (Army)
- Yellow Ribbon Reintegration Program (Marine Corps)
- Yellow Ribbon Reintegration Program (National Guard)
- Yellow Ribbon Reintegration Program (Navy)

Providing support for servicemembers as they transition to civilian life:

- Air Force Wounded Warrior Program
- Air National Guard Psychological Health Program
- America's Heroes at Work
- Buddy-to-Buddy Program
- Warrior and Family Assistance Center

Internet-Based Interventions and the Use of New Technologies

Internet-based education or delivery of interventions:

- After Deployment
- Battlemind
- Brainline.org
- DESTRESS-PC (Delivery of Self Training and Education for Stressful Situations—Primary Care)
- Healing Heroes
- Military OneSource
- Military Pathways
- Navy MORE (My Ongoing Recovery Experience) Program
- Postdeploymenthealth.com
- Real Warriors Campaign
- Resiliency Center
- SimCoach
- Stress Gym
- TBI.Consult
- Traumatic Brain Injury: The Journey Home

Application of new technologies:

- BrainCheckers Deployment Stress Assessment Tool
- HeartMath
- Mobile Telehealth Program
- National Center for Telehealth and Technology Mobile Applications
- SimCoach
- Telehealth for Children at Tripler Army Medical Center
- TRICARE Assistance Program
- Tripler Programs in TBI, Pain, Psychological Health, and Telehealth

- Virtual Behavioral Telehealth Pilot at Fort Richardson
- Virtual Behavioral Telehealth Pilot at Tripler Army Medical Center
- Virtual Reality and Innovative Technology Applications
- Virtual Reality Graded Exposure Therapy with Physiological Monitoring
- Virtual Reality Iraq/Afghanistan
- Virtual Traumatic Brain Injury Clinic

Other

A small number of programs did not fit well into any of the previous categories:

- Adaptive Disclosure Training
- Community Resiliency Initiative
- Defense Stress Management
- Outcomes of Prolonged Exposure and Cognitive Processing Therapy Used in the Treatment of Combat Operational Stress in Deployed Locations
- Psychiatric Service Dog Society Research
- Semper Fit Health Promotion Program
- Special Psychiatric Rapid Intervention Team
- STRONG STAR (South Texas Research Organizational Network Guiding Studies on Trauma and Resilience) Research Consortium
- Warrior's Huddle

APPENDIX E

Terms and Definitions

This appendix describes in detail terms and definitions that are specific to this report and are used to describe programs in Chapter Five and Appendix B.

approach

Program approaches correspond to four key functions at DCoE: provision of clinical care; education or training regarding psychological health and/or TBI, including the provision of information regarding these conditions, activities to prevent psychological health problems or TBI or increase resilience in the face of potential psychological health challenges, and outreach to connect members of the military community to needed services.

clinical and nonclinical issues

Programs focus on a wide variety of clinical issues, including one of more of the following: depression, PTSD, substance use, suicide prevention, TBI, and general psychological health. In addition, they may focus on one or more of the following nonclinical issues: deployment-related issues, domestic violence, family and/or children, legal, postdeployment reintegration, relationships, resilience, spiritual, stress reduction, or other issues.

costs to participants

Many programs offer services at no cost to participants, while some may require participants to pay for services or their participation costs may be covered by TRICARE or another source.

deployment phase

Programs that are accessible to their participants and provide similar content throughout all deployment phases, such as the Real Warriors Campaign, are listed as "not related to deployment." In contrast, if all four deployment phases are listed, the program has separate activities for each phase. This is relevant for such programs as the Yellow Ribbon Reintegration Program, which has separate workshops for servicemembers and family members during the four deployment phases. If fewer than four deployment phases are listed, the program has some activities targeted toward participants in each of the indicated phases.

DoD-wide programs and branch of service

Programs that are described as "DoD-wide" are available to targeted participants from all branches of service. A small number of DoD-wide programs are located at a single installation but serve participants from across DoD. Programs that serve an individual branch of service or multiple branches of service (e.g., Navy, Marine Corps) are listed as such.

To identify all programs that serve an individual branch of service, consult both the column that specifically addresses that branch of service and the DoD-wide column.

domain

The description of program domain is based an expanded biopsychosocial model that includes programs that focus on biological, psychological, social, spiritual, and/or holistic aspects of the experiences of servicemembers and their families.

evidence-based interventions

Programs with evidence-based interventions have activities and/or interventions that have been evaluated and shown to be effective in one or more research studies or evaluations. This information was supplied by the interviewees; RAND did not independently assess the strength of the evidence base for the programs.

funding source

Our inclusion criteria require that a program be sponsored or funded by DoD, including funding through any DoD office, activity, agency, service, or command; the VA/DoD Joint Incentive Fund; a DoD memorandum of understanding or memorandum of agreement; or by one of the branches of service. Some lines of funding we identified include Program Objective Memorandum (POM)/Defense Health Program, LOA-2 (see Chapter One), government contracts, and government grants.

impetus or motivation

The impetus or motivation section describes why the program was started, including any task force recommendations, authorizations under the National Defense Authorization Act in a particular year, or other circumstances that motivated the creation and implementation of the program. When applicable, this includes information about any formal military doctrine, policy, or instruction that authorizes or mandates the existence of the program.

installation

Some programs provide services at one or more individual installations. If applicable, the program descriptions in Appendix B include information reflecting the installations on which the program was operating at the time of interview.

mode of service delivery

The mode of service delivery describes the manner in which the program provides services to participants. Common delivery modes include in a classroom, face to face in a group setting; face to face individually; services provided through the Internet; the distribution of outreach or educational materials; and service delivery via telephone and/or video teleconference. Many programs employ more than one mode of delivery.

No interview was conducted; this information was developed from publicly available documentation.

The 24 programs that include this statement were those that we were unable to interview but for which were able to develop a description of the program from publicly available documentation, primarily obtained via the Internet.

outreach

Outreach describes the efforts of a program to reach its target population and inform them of the program's objectives and activities. Common marketing methods include flyers, the Internet, mailings, physician referral, posters, and word of mouth. Many programs employ more than one approach.

pilot program

A pilot program is an activity planned as a test or a trial before a decision is made about whether it should be broadly implemented.

potential barriers to participation

Program barriers can be related to problems implementing or sustaining a program, such as not having leadership support or lacking adequate resources. Barriers can also affect the target audience's ability to participate in the program, such as having a schedule that precludes participation in the program's activities.

program staff's effort to assess success

Assessment of success includes current monitoring, assessment, or evaluative efforts by program staff to measure or understand program effectiveness. This should not be confused with the description of evidence-based interventions, which describes the extent to which the content of the program is based on material that has been shown to be effective in the past, rather than the program's efforts to assess its own success.

RAND analysis

Detailed definitions for this section can be found in Table 4.2.

relationship to other programs

Many of the programs in Appendix B are related to other programs in this report in a variety of ways, including programs in different branches of service that originate from the same DoD policy and those that have related content and use the same program materials.

staffing

Information on program staffing includes information on clinical, nonclinical, and administrative staff who contribute to the program's activities.

targeted participants

Our inclusion criteria require that all programs include active-duty, National Guard, and/or Reserve component servicemembers and/or their family members as their target population. In addition, many programs also serve veterans and/or civilians. Programs that target civilians (including civilian health care providers) to support them in caring for servicemembers have both "civilians" and "servicemembers" marked as their targeted participants.

References

American Association for Public Opinion Research, *Standard Definitions: Final Dispositions of Case Codes and Outcome Rates for Surveys*, Deerfield, Ill.: The American Association for Public Opinion Research, 2008.

American Psychiatric Association, *Treatment of Patients With Major Depressive Disorder, Third Edition*, Washington, D.C.: American Psychiatric Publishing, 2010. As of February 3, 2011: http://www.psychiatryonline.com/pracGuide/pracGuideChapToc_7.aspx

American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members, *The Psychological Needs of U.S. Military Service Members and Their Families: A Preliminary Report*, American Psychological Association, 2007. As of January 20, 2011: http://www.apa.org/about/governance/council/policy/military-deployment-services.pdf

Armed Forces Health Surveillance Center, "Ambulatory Visits Among Members of the Active Component, U.S. Armed Forces, 2009," *Medical Surveillance Monthly Report (MSMR),* Vol. 17, No. 4, 2010a, pp. 10–15.

Armed Forces Health Surveillance Center, "Hospitalizations Among Members of the Active Component, U.S. Armed Forces, 2009," *Medical Surveillance Monthly Report (MSMR)*, Vol. 17, No. 4, 2010b, pp. 3–9.

Army Health Promotion, Risk Reduction, and Suicide Prevention Report, July 29, 2010. As of May 9, 2011: http://usarmy.vo.llnwd.net/e1/HPRRSP/HP-RR-SPReport2010_v00.pdf

Bliese PD and Castro CA, "The Solider Adaptation Model (SAM): Applications to Peacekeeping Research," in TW Britt and AB Adler, eds., *The Psychology of the Peacekeeper*, Westport, Conn.: Praeger, 2003.

Booz Allen Hamilton, *Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Environmental Scan and Opportunities Analysis*, unpublished report, September 15, 2009.

Burnam AM, Meredith LS, Helmus T, Burns RM, Cox RA, D'Amico E, Martin LT, Vaiana ME, Williams KM, and Yochelson MR, "Systems of Care: Challenges and Opportunities to Improve Access to High-Quality Care," in Terri Tanielian and Lisa H. Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, Calif.: RAND Corporation, MG-720-CCF, 2008. As of January 11, 2011: http://www.rand.org/pubs/monographs/MG720.html

Chandra A, Hawkins SA, Martin LT, and Richardson A, "The Impact of Parental Deployment on Child Social and Emotional Functioning: Perspectives of School Staff," *Journal of Adolescent Health*, Vol. 46, No. 3, 2010, pp. 218–223.

Chandra A, Lara-Cinisomo S, Jaycox LH, Tanielian T, Han B, Burns RM, and Ruder T, *Views from the Homefront: The Experiences of Youth and Spouses from Military Families*, Santa Monica, Calif.: RAND Corporation, TR-913-NMFA, 2011. As of January 24, 2011: http://www.rand.org/pubs/technical_reports/TR913.html

ClinicalTrials.gov website, undated. As of April 3, 2011: http://clinicaltrials.gov/

Commission on Chronic Illness, *Chronic Illness in the United States (Vol. 1)*, Cambridge, Mass.: Harvard University Press, 1957.

DCoE—*see* Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.

Deb, S., I. Lyons, C. Koutzoutkis, I. Ali, and G. McCarthy, "Rate of Psychiatric Illness 1 Year After TBI," *American Journal of Psychiatry*, Vol. 156, March 1999, pp. 374–378.

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, "Resilience_Continuum.jpg," undated[a]. As of January 21, 2011:
http://www.dcoe.health.mil/Content/navigation/images/resilience_continuum.jpg

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, "Who We Are: Component Centers," undated[b]. As of January 21, 2011:
http://www.dcoe.health.mil/WhoWeAre/ComponentCenters.aspx

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, "Who We Are: Directorates," undated[c]. As of January 21, 2011:
http://www.dcoe.health.mil/WhoWeAre/Directorates.aspx

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, "Air National Guard Creates Psychological Health Positions," *DCoE in Action*, Vol. 3, No. 11, 2010, p. 3. As of January 18, 2011:
http://www.dcoe.health.mil/Content/navigation/newsletters/dcoe%20in%20action/DCoE_In_Action_Vo3No11.pdf

Defense Health Board Task Force on Mental Health, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health*, Falls Church, Va.: Defense Health Board, 2007. As of January 18, 2011:
http://www.health.mil/dhb/mhtf/mhtf-report-final.pdf

Department of the Army, *Army Health Promotion, Risk Reduction, and Suicide Prevention Report 2010*, Washington, D.C.: HQ, Department of the Army, 2010. As of January 21, 2011:
http://www.army.mil/-news/2010/07/28/42934-army-health-promotion-risk-reduction-and-suicide-prevention-report/index.html

Department of Defense, *Department of Defense Directive 1010.4, Change 1, Drug and Alcohol Abuse by DoD Personnel*, January 11, 1999. As of January 22, 2011:
http://www.dtic.mil/whs/directives/corres/pdf/101004p.pdf

Department of Defense, *Department of Defense Directive 5101.1, DoD Executive Agent*, Section 4.1.2, May 9, 2003. As of April 6, 2011:
http://www.dscp.dla.mil/subs/ea/docs/d51011p.pdf

Department of Defense, *Department of Defense Directive 6400.1, Family Advocacy Program*, August 23, 2004. As of January 22, 2011:
http://www.dtic.mil/whs/directives/corres/pdf/640001p.pdf

Department of Defense, *Department of Defense Directive 5101.13, DoD Executive Agent for the Unexploded Ordnance Center of Excellence (UXOCOE)*, March 2, 2006. As of April 6, 2011:
http://www.dtic.mil/whs/directives/corres/pdf/510113p.pdf

Department of Defense, *Department of Defense Instruction 6495.02, Change 1, Sexual Assault Prevention and Response Program Procedures*, November 13, 2008. As of January 22, 2011:
http://www.dtic.mil/whs/directives/corres/pdf/649502p.pdf

Department of Defense, *Profile of the Military Community*, Washington, D.C.: Department of Defense, 2009a.

Department of Defense, *Department of Defense Instruction 6490.06, Counseling Services for DoD Military, Guard and Reserve, Certain Affiliated Personnel, and Their Family Members*, April 21, 2009b. As of January 22, 2011:
http://www.dtic.mil/whs/directives/corres/pdf/649006p.pdf

Department of Defense, *Department of Defense Instruction 1015.10, Military Morale, Welfare, and Recreation (MWR) Programs*, July 6, 2009c. As of January 22, 2011:
http://www.dtic.mil/whs/directives/corres/pdf/101510p.pdf

Department of Defense, *Quadrennial Defense Review Report*, Washington, D.C.: U.S. Department of Defense, 2010a. As of January 21, 2011:
http://www.defense.gov/qdr/images/QDR_as_of_12Feb10_1000.pdf

Department of Defense, "DoD Appoints New Director of the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury," News Release No. 1068-10. November 18, 2010b. As of January 24, 2011:
http://www.defense.gov/Releases/Release.aspx?ReleaseID=14077

Department of Defense Task Force on Mental Health, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health*, Falls Church, Va.: Defense Health Board, 2007. As of January 22, 2011:
http://www.health.mil/dhb/mhtf/mhtf-report-final.pdf

Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives*, August 2010. As of January 22, 2011:
http://www.health.mil/dhb/downloads/
Suicide%20Prevention%20Task%20Force%20final%20report%208-23-10.pdf

Deployment Health Clinical Center, *Deployment Support*, 2011. As of January 25, 2011:
http://www.pdhealth.mil/dcs/default.asp

Dinneen M, "MHS Strategic Imperatives—Applying Them to Your Organization," presentation at the *2010 Military Health System Conference*, National Harbor, Md., January 26, 2010. As of January 25, 2011:
http://www.health.mil/Libraries/2010_MHS_Conference_Presentations_-_Jan_26/W21_M_Dinneen.pdf

Eibner C, Ringel JS, Kilmer B, Pacula RL, and Diaz C, "The Cost of Post-Deployment Mental Health and Cognitive Conditions," in Terri Tanielian and Lisa H. Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, Calif.: RAND Corporation, MG-720-CCF, 2008. As of January 11, 2011:
http://www.rand.org/pubs/monographs/MG720.html

Foa EB, Keane TM, Friedman MJ, and Cohen JA, eds., *Effective Treatments for PTSD—Practice Guidelines from the International Society for Traumatic Stress Studies, 2nd Edition*, New York: Guilford Press, 2008.

Glod M, "Coping with Their Parents' War: Multiple Deployments Compound Strain for Children of Service Members," *Washington Post*, July 17, 2008. As of January 27, 2011:
http://www.washingtonpost.com/wp-dyn/content/article/2008/07/16/AR2008071602878.html

Hawley, C. A., and S. Joseph, "Predictors of Positive Growth After TBI: A Longitudinal Study," *Brain Injury*, Vol. 22, No. 5, 2008, pp. 427–435.

Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, and Koffman RL, "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *New England Journal of Medicine*, Vol. 351, No. 1, 2004, pp. 13–22.

Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center, *Rebuilding the Trust*, April 2007. As of January 27, 2011:
http://www.npr.org/documents/2007/apr/walter_reed/executive.pdf

Jonas WB, O'Connor F, Deuster P, and Macedonia C, "Total Force Fitness for the 21st Century: A New Paradigm," *Military Medicine,* Vol. 175 (Supplement), August 2010a.

Jonas WB, O'Connor FG, Deuster P, Peck J, Shake C, and Frost SS, "Why Total Force Fitness?" *Military Medicine,* Vol. 175 (Supplement), August 2010b, pp. 6–13.

Karney BR, Ramchand R, Osilla KC, Caldarone LB, and Burns RM, "Predicting the Immediate and Long-Term Consequences of Post-Traumatic Stress Disorder, Depression, and Traumatic Brain Injury in Veterans of Operation Enduring Freedom and Operation Iraqi Freedom," in Terri Tanielian and Lisa H. Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, Calif.: RAND Corporation, MG-720-CCF, 2008. As of January 11, 2011:
http://www.rand.org/pubs/monographs/MG720.html

Koffman R, "Operational Stress Control: Conserving the Force," Navy Bureau of Medicine and Surgery, Deployment Health Directorate, March 28, 2008. As of February 3, 2011:
www.nmcphc.med.navy.mil/downloads/stress/cosc_core_info.ppt

Koffman RL, "Review: MHAT IV OIF Commentary," *Traumatology,* Vol. 13, No. 4, 2007, pp. 37–39.

Lew, H. L., J. D. Otis, C. Tun, R. D. Kerns, M. E. Clark, and D. X. Cifu, "Prevalence of Chronic Pain, Posttraumatic Stress Disorder, and Persistent Postconcussive Symptoms in OIF/OEF Veterans: Polytrauma Clinical Triad," *Journal of Rehabilitation Research and Development*, Vol. 46, 2009, pp. 697–702.

Litz BT, Stein N, Delaney E, Lebowitz L, Nash WP, Silva C, and Maguen S, "Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy," *Clinical Psychology Review*, Vol. 29, No. 8, 2009, pp. 695–706.

McGinn GH, "Prepared Statement Before the Senate Armed Services Committee Subcommittee on Personnel," April 29, 2009. As of January 21, 2011:
http://armed-services.senate.gov/statemnt/2009/April/McGinn%2004-29-09.pdf

Mental Health Advisory Team II, *Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report*, January 30, 2005. As of February 3, 2011:
http://www.armymedicine.army.mil/reports/mhat/mhat_ii/OIF-II_REPORT.pdf

Mental Health Advisory Team III, *Mental Health Advisory Team (MHAT-III) Operation Iraqi Freedom 04-06 Report*, May 29, 2006. As of February 3, 2011:
http://www.armymedicine.army.mil/reports/mhat/mhat_iii/MHATIII_Report_29May2006-Redacted.pdf

Mental Health Advisory Team IV, *Mental Health Advisory Team (MHAT) IV Operation Iraqi Freedom 05-07 Final Report*, November 17, 2006. As of February 3, 2011:
http://www.armymedicine.army.mil/reports/mhat/mhat_iv/MHAT_IV_Report_17NOV06.pdf

Mental Health Advisory Team V, *Mental Health Advisory Team (MHAT) V Operation Iraqi Freedom 06-08: Iraq Operation Enduring Freedom 8: Afghanistan*, February 14, 2008. As of February 3, 2011:
http://www.armymedicine.army.mil/reports/mhat/mhat_v/Redacted1-MHATV-4-FEB-2008-Overview.pdf

Mental Health Advisory Team VI, *Mental Health Advisory Team (MHAT) VI Operation Iraqi Freedom 07-09*, May 8, 2009a. As of February 3, 2011:
http://www.armymedicine.army.mil/reports/mhat/mhat_vi/MHAT_VI-OIF_Redacted.pdf

Mental Health Advisory Team VI, *Mental Health Advisory Team (MHAT) 6 Operation Enduring Freedom 2009 Afghanistan*, November 6, 2009b. As of February 3, 2011:
http://www.armymedicine.army.mil/reports/mhat/mhat_vi/MHAT_VI-OEF_Redacted.pdf

Meredith LS, Sherbourne CD, Gaillot SJ, Hansell L, Ritschard HV, Parker AM, and Wrenn G, *Promoting Psychological Resilience in the U.S. Military*, Santa Monica, Calif.: RAND Corporation, MG-996-OSD, 2011. As of July 12, 2011:
http://www.rand.org/pubs/monographs/MG996.html

MHAT—*see* Mental Health Advisory Team.

Mrazek PJ and Haggerty RJ, eds., *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*, Washington D.C.: National Academy Press, 1994.

Mullen MG, "CJCS Guidance for 2009–2010," December 21, 2009. As of February 15, 2011:
http://www.jcs.mil/content/files/2009-12/122109083003_CJCS_Guidance_for_2009-2010.pdf

National Resource Directory website, undated. As of March 29, 2011:
http://www.nationalresourcedirectory.gov/

Powell, T., A. Ekin-Wood, and C. Collin, "Post-Traumatic Growth After Head Injury: A Long-Term Follow-up," *Brain Injury*, Vol. 21, No. 1, January 2007, pp. 31–38.

President's Commission on Care for America's Wounded Warriors, *Serve, Support, Simplify*, Washington, D.C.: President's Commission on Care for America's Wounded Warriors, 2007. As of January 27, 2011:
http://www.veteransforamerica.org/wp-content/uploads/2008/12/presidents-commission-on-care-for-americas-returning-wounded-warriors-report-july-2007.pdf

Priest D and Hull A, "Soldiers Face Neglect, Frustration at Army's Top Medical Facility," *The Washington Post*, February 18, 2007.

Public Law 109-163, National Defense Authorization Act for Fiscal Year 2006, Title VII, Health Care Provisions, Subtitle C, Mental Health-Related Provisions, Sec. 723, Department of Defense Task Force on Mental Health, January 06, 2006. As of April 12, 2011:
http://www.gpo.gov/fdsys/pkg/PLAW-109publ163/pdf/PLAW-109publ163.pdf

Public Law 110-181, National Defense Authorization Act, Division A, Title XVI and XVII for Fiscal Year 2008, January 28, 2008. As of January 11, 2011:
http://www.govtrack.us/congress/bill.xpd?bill=h110-4986

Public Law 110-417, Duncan Hunter National Defense Authorization Act for Fiscal Year 2009, Sec. 733, Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, October 14, 2008. As of April 12, 2011:
http://www.gpo.gov/fdsys/pkg/PLAW-110publ417/pdf/PLAW-110publ417.pdf

Ramchand R, Acosta J, Burns RM, Jaycox LH, and Pernin CG, *The War Within: Preventing Suicide in the U.S. Military*. Santa Monica, Calif.: RAND Corporation, MG-953-OSD, 2011. As of February 18, 2011:
http://www.rand.org/pubs/monographs/MG953.html

Resnik, L. J., and S. M. Allen, "Using International Classification of Functioning, Disability and Health to Understand Challenges in Community Reintegration of Injured Veterans," *Journal of Rehabilitation Research and Development*, Vol. 44, 2007, pp. 991–1006.

Sandberg, Mark A., Shane S. Bush, and Thomas Martin, "Beyond Diagnosis: Understanding the Healthcare Challenges of Injured Veterans Through the Application of the International Classification of Functioning, Disability and Health (ICF)," *The Clinical Neuropsychologist*, Vol. 23, No. 8, 2009, pp. 1416–1432.

Schell T and Marshall G, "Survey of Individuals Previously Deployed for OEF/OIF," in Terri Tanielian and Lisa H. Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, Calif.: RAND Corporation, MG-720-CCF, 2008. As of January 11, 2011:
http://www.rand.org/pubs/monographs/MG720.html

Suicide Prevention and Risk Reduction Committee's Resources for Suicide Prevention website, undated. As of April 4, 2011:
http://www.suicideoutreach.org/

Sutton LK, *Statement of Brigadier General Loree K. Sutton, MD, Director, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, Subject: Department of Defense and Suicide Prevention*, February 24, 2010. As of January 21, 2011:
http://www.tricare.mil/planning/congress/downloads/2010225/DoD-%20HVAC-%20Mental%20Health-%20Sutton%20-%20FINAL.pdf

Tanielian T and Jaycox LH, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* Santa Monica, Calif.: RAND Corporation, MG-720-CCF, 2008. As of January 11, 2011:
http://www.rand.org/pubs/monographs/MG720.html

Task Force on Returning Global War on Terror Heroes, *Task Force Report to the President*, April 19, 2007. As of January 27, 2011:
http://www.va.gov/op3/Docs/GWOTTaskForce/GWOT_TF_Report_042407.pdf

Traumatic Brain Injury Task Force for the Department of the Army, *Report to the Surgeon General*, May 15, 2007. As of January 28, 2011:
http://www.armymedicine.army.mil/reports/tbi/TBITaskForceReportJanuary2008.pdf

U.S. Department of Veterans Affairs Office of Public Health and Environmental Hazards, "Analysis of VA Health Care Utilization Among Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans," presentation citing the CTS Deployment File Baseline Report, from the Defense Manpower Data Center, provided to the Environmental Epidemiology Service of the U.S. Department of Veterans Affairs Office of Public Health and Environmental Hazards by the Armed Force Health Surveillance Center, December 6, 2010.

U.S. Marine Corps and U.S. Navy, *Combat and Operational Stress Control*, MCRP 6-11C/NTTP 1-15M, Quantico, Va.: Marine Corps Combat Development Command, 2010.

U.S. Navy, "Navy Medicine Keeps Focus on Neurological Assessments," Story Number NNS100813-06, August 13, 2010. As of January 28, 2011:
http://www.navy.mil/search/display.asp?story_id=55283

U.S. Navy Chief of Naval Operations, *Operational Stress Control (OSC) Awareness Brief*, undated. As of February 3, 2011:
http://www.nmcphc.med.navy.mil/downloads/stress/osc_awareness_brief.pdf

Veterans Health Administration, *Implementation of New National Clinical Reminder, "The Afghan and Iraq Post-Deployment Screen,"* VHA Directive 2004-015, Washington, D.C.: Department of Veterans Affairs, 2004.

White, B., S. Driver, and A. Warren, "Considering Resilience in the Rehabilitation of People with Traumatic Disabilities," *Rehabilitation Psychology*, Vol. 53, No. 1, 2008, pp. 9–17.

The White House, *Strengthening Our Military Families: Meeting America's Commitment*, Washington, D.C., January 2011. As of June 8, 2011:
http://www.defense.gov/home/features/2011/0111_initiative/strengthening_our_military_january_2011.pdf

World Health Organization, *International Classification of Functioning, Disability, and Health*, Geneva, Switzerland, 2001.