THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 28 2009

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

Dear Mr. Chairman:

Section 741 of the National Defense Authorization Act for Fiscal Year 2007 required the Department of Defense to develop pilot-projects to evaluate the efficacy of promising approaches to improving the "early diagnosis and treatment of post-traumatic stress disorder (PTSD) and other mental health conditions."

The Department has worked diligently to create programs that address the growing behavioral health needs of the Service members, veterans, and their families. The following programs are part of that effort as each program provides a unique opportunity to improve mental health care access and reduce barriers to care.

Afterdeployment.org provides internet-based mental health care tools for Service members and families. "Re-Engineering Systems for the Primary Care Treatment of Depression and PTSD in the Military" increases accessibility to behavioral health care through training primary care providers. The Navy Reserve Psychological Health Outreach Program provides a safety net outreach program for the post-deployment Navy Reserve population. The enclosed report discusses these programs.

Thank you for your continued support of the Military Health System and its beneficiaries.

Sincerely,

Ward

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 28 2009

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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The Honorable John M. McHugh
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
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HEALTH AFFAIRS

APR 28 2009

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

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cc:
The Honorable Thad Cochran
Vice Chairman

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 28 2009

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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cc:
The Honorable Jerry Lewis
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 28 2009

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

Dear Mr. Chairman:

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The Honorable Lindsey O. Graham
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 28 2009

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madame Chairwoman:

Section 741 of the National Defense Authorization Act for Fiscal Year 2007 required the Department of Defense to develop pilot-projects to evaluate the efficacy of promising approaches to improving the "early diagnosis and treatment of post-traumatic stress disorder (PTSD) and other mental health conditions."

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As stated

cc:
The Honorable Joe Wilson
Ranking Member

COMPREHENSIVE PLAN ON PILOT PROJECTS ON EARLY DIAGNOSIS AND TREATMENT OF POST-TRAUMATIC STRESS DISORDER AND OTHER MENTAL HEALTH CONDITIONS AMONG MEMBERS OF THE ARMED FORCES AND THEIR FAMILIES

REPORT TO CONGRESS

NATIONAL DEFENSE AUTHORIZATION ACT
FOR FISCAL YEAR 2007

SECTION 741

TABLE OF CONTENTS

1. Introduction

Section 741 of the John Warner National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2007, required the Department of Defense (DoD) to develop pilot projects to evaluate the efficacy of promising approaches to improving the early diagnosis and treatment of post-traumatic stress disorder (PTSD) and other mental health (MH) conditions. As requested in Section 1634(a)(2) of the NDAA for FY 2008, the Secretary of Defense submitted a report in August 2008 describing the progress in implementing the requirements of Section 741 of the NDAA for FY 2007. The August 2008 report introduced 3 pilot-projects:

- **Afterdeployment.org** provides internet-based delivery of behavioral health tools providing outreach and resources for Service Members and their families and psycho-educational tools for health care providers in the military and civilian health care systems on early diagnosis and treatment of PTSD and other MH conditions.

- **Re-Engineering Systems for the Primary Care Treatment of Depression and PTSD in the Military** (RESPECT-Mil) increases accessibility to behavioral health care, and promotes early identification and treatment of PTSD by introducing screening and treatment into the primary care setting.

- **Navy Reserve Psychological Health Outreach Program** provides a "safety net" outreach program for the post-deployment Navy Reserve population, improving accessibility and the utilization of services, and to facilitate reporting and referral in the Navy Reserve Component (RC).

Each program provides a unique and promising practice to decrease the social stigma associated with seeking MH care and to tear down additional barriers that may prevent Service members and their families across DoD from receiving the psychological services they need. DoD has worked diligently to create programs that address the growing behavioral health needs of the Services. In response to Section 741 of the NDAA for FY 2007, this is the final report regarding the 3 innovative pilot projects above.

Over the past year, the Department has piloted innovative approaches to combat the effects of traumatic brain injury and to improve the Psychological Health (PH) of our Service members. DoD has aggressively looked for scientific, relevant, and sustainable advances to ensure the readiness and quality of life of our soldiers, sailors, marines, and airmen. DoD also has shown considerable dedication to the health and well being of their families who endure a unique burden.

2. Afterdeployment.org

2.1. Background

One innovative behavioral health tool to improve or augment military and civilian health care systems in providing early diagnosis and treatment of PTSD and other MH conditions is *afterdeployment.org.* It is an internet-based pilot project focusing on psychological health issues that Service members and their families often face during the first 4 months of a combat deployment. In addition, afterdeployment.org provides educational material for Service members, veterans, providers, and families experiencing MH issues.

The Assistant Secretary of Defense for Health Affairs (ASD (HA)) designated the Army to lead the initial *afterdeployment.org* effort. The project has since migrated to the Defense Centers of Excellence (DCoE) for Psychological Health (PH) and Traumatic Brain Injury's Telehealth and Technology directorate. The directorate and the associated National Center for Telehealth and Technology (also part of DCoE) now provide the necessary support.

2.2. Rationale and Development

The need for internet-based PH tools was driven by Service members who resist seeking in-person consultation due to limited provider availability, travel distances, scheduling difficulties, and the social stigma surrounding psychological health care. There are additional layers of stigmatic complexity due to concerns over possible "career impacts" if individuals access MH treatment while on Active Duty.

Online tools provide both discreet (confidential) service delivery and valuable resources to family members and providers. Further, they accommodate constant high-volume access, minimize the challenges of confidentiality, and can either supplement in-person care or function as a stand-alone service. Logging on to a Web site virtually eliminates barriers to care due to stigma. Additionally, there is no need to schedule an appointment, sit in a crowded waiting room, or find a sitter for the children. Online tools have particular applicability to National Guard and Reserve units, who are often physically separated from their units upon redeployment and may be living far from a military medical treatment facility (MTF).

Currently, *afterdeployment.org* contains 12 modules, referred to as programs:

- Adjusting to War Memories;
- Dealing with Depression;
- Handling Stress;

- Improving Relationships;
- Succeeding at Work;
- Overcoming Anger;
- Sleeping Better;
- Controlling Alcohol and Drugs;
- Helping Kids Deal with Deployment;
- Seeking Spiritual Fitness;
- Living with Physical Injuries; and
- Balancing Your Life.

These program areas are designed to reduce or possibly prevent common post-deployment stress reactions, including post-combat stress, relationship or work conflict, and substance abuse. There are program areas to help parents assist children with deployment-related adjustment problems. Materials address concerns about re-connecting with family and friends, and support positive skill-development and resiliency-building in managing stressors at home and in the workplace. Future programs include Mild Traumatic Brain Injury and Warrior Resilience, as well as a variety of special topic areas for women, families, and veterans.

Afterdeployment,org's programs aim to identify populations at risk, track frequently accessed modules, increase information availability, link to other military and health-based sites (reciprocal links), expand the capacity and reach of the MH system, provide a forum for military leadership, and decrease the barriers to seeking care via an anonymous, and thereby stigma-free, environment. In addition to its in-depth repository of behavioral health tools (Appendix A) and links to topical information, the site also provides tutelage for healthcare providers when determining effective approaches to the various MH problems that may be experienced by Service members and their families.

Afterdeployment.org emphasizes multimedia features and interactivity. Each program contains a voluntary self-assessment to generate tailored feedback and recommendations while allowing users to review their work and track progress. Users may create a username (which does not have to be their real name) and password or may access the system anonymously. To measure user satisfaction and system efficacy, all components include a set of brief evaluation questions that the user may answer or skip.

The *afterdeployment* project was initiated in October 2006. The first year's concentration was primarily content development. In September 2007, a pilot of the website was evaluated internally, followed by individual user and focus group feedback. Given the extensive feedback received through these constituencies, the website underwent extensive changes to both the content and access features.

In FY 2008, $7 million were spent on the development of *afterdeployment.org*. FY 2008 funding was devoted entirely to the successful "go live" release of Versions 1.0 and 2.0. Version 1.0 of *afterdeployment.org* began as planned on August 5, 2008, with Version 2.0 encompassing additional content starting in late-September 2008. Implementation of Version 3.0 began in October 2008, with projected releases of new content in July of 2009. Future iterations will include programs on mild traumatic brain injury (concussion) along with Service member and family resilience. The additional content and interaction with other members through blogging will add a sense of community by making them aware that they are not alone and there are others feeling the same way. They can talk with other people on the site (while maintaining anonymity) and find out what they did or are doing to address their condition.

2.3. Efficacy

The anticipated user population of *afterdeployment.org* is generally young and without advanced formal education. The National Center for Telehealth and Technology conducted a survey examining soldiers' knowledge of, and attitudes toward, using technology to access MH care. Respondents had high levels of experience using most technologies (e.g., email, and downloading files). A significant plurality expressed comfort with computer-assisted treatment. In addition, as many as one-third of respondents stated that they were unwilling to obtain in-person counseling but were willing to access care and information anonymously through technology. A related study by the same researchers also revealed that participants undergoing Internet-based treatment showed fewer symptoms than control groups. The success of *afterdeployment's* unique tools suggests that it will serve as an exemplary laboratory for assessing the efficacy of online MH resources. Bi-weekly use data have been collected since the launch on August 5, 2008.

Site activity on *afterdeployment.org* (with the most frequented modules being: Adjusting to War Memories, Improving Relationships, Dealing with Depression, and Sleeping Better) is consistent with study findings identifying the highest frequency of post-deployment problems for Service members to be in these areas.

Field-testing will be repeated to evaluate ease of use and content validity. Overall feedback so far is positive, with a majority of respondents rating the site at eight out of ten with ten being best. Many respondents asserted that the site had succeeded in meeting post-deployment challenges, and nearly two-thirds stated that they were likely or very likely to either return or recommend the site. Ongoing outreach efforts should continue to increase the value and use of the site. The *afterdeployment* project team, housed in the National Center for Telehealth and Technology, and *afterdeployment* project partners at the Department of Veterans Affairs' National Center for PTSD will phase-in outcome measures during 2009, with research on self-care workshops, a built-in

program evaluation and a standardized protocol to support supplemental usage with in-person clinical services.

2.4. Future Directions

Development of *afterdeployment.org* continues to be an iterative process. Therefore, immediate legislative or administrative actions are not indicated. However, *afterdeployment.org* has set forth a number of project initiatives with new content development projected through January 2010 under award of a new development contract.

- Review and refresh all current content. Usability testing will continue.
- Develop new programs on mild traumatic brain injury (TBI) (commonly referred to as concussion), Service member and family resilience, veterans' concerns, partner and domestic issues, and other important subject areas.
- Add design enhancements to the World Wide Web, including improved user interactivity and expanded social networking capabilities.
- Expand outreach efforts to include the production and release of public service announcements on Armed Forces Network, solicitation of video testimonials, and introduction into new venues including kiosks in clinical settings, National Guard and Reserve Centers, and VA facilities.
- Expand materials targeting families, children, and parenting though new content and affiliations with family-programming organizations.
- Initiate outcome studies. In addition to a partnership with the University of Minnesota, there has been discussion with Washington & Jefferson College, Washington, PA, on the Combat Stress Intervention Program to survey the MH needs of Service members deployed to Operation Enduring Freedom/Operation Iraqi Freedom, National Guard and Reserve members returning to rural areas in Southwestern Pennsylvania.
- Develop standardized training protocols, especially for underserved communities and providers who are less trained, with potential credit as continuing education units.

- Organize targeted e-Learning site content to provide users with e-Learning opportunities, creating more readily identifiable paths to support (e.g. leaders could encourage their personnel to work through *afterdeployment's* standardized stress management, anger management, or conflict resolution protocols and to demonstrate completion via completion certificate).

- Establish a leadership forum to provide users with up-to-date information on military MH issues.

3. Re-Engineering the Primary Care-Based Treatment (of Depression and PTSD) in the Military

3.1. Background

According to a 2004 *New England Journal of Medicine* study by an Army psychiatrist, nearly 20 percent of returning Service members (including Active Duty, Reservist, and National Guard) are assessed positive for a major mental disorder. Of these, 78 percent acknowledge the need for support and assistance, yet only about 25 percent of those assessed as positive of a major MH disorder pursue MH care. Service members assessed positive for mental conditions that require treatment are twice as likely to perceive barriers (e.g., career effects, stigma, poor access to specialty care and mistrust) to seeking support from a MH provider. Therefore, the delivery of MH services within a primary care environment has the potential to reduce the stigmatic barriers to mental health care and increase the likelihood of treating the patient early. With nearly 90 percent of Service members accessing primary care annually (average of 3.5 visits per Service member, per year), MH assessment and care in this setting would improve the accessibility to MH services, promote early intervention, and reduce stigma.

3.2. Rationale and Development

The RESPECT-Mil program provides additional mental health care training for primary care providers so that they can quickly recognize and address mental health care issues. Based on the Three Component Model, RESPECT-Mil combines the efforts of primary care clinicians, care managers, and MH professionals. It is provided in the primary care setting that has much less stigma and is more likely to be accessed. A clinical quality improvement program also seeks to improve the management of behavioral health problems in the primary care environment by changing the primary care system of care. The program relies heavily on care management strategies. A RESPECT-Mil Care Facilitator is a Registered Nurse, who has systematic telephonic or in person contact with patients, during which s/he monitors their response to treatment, using structured tools, assesses treatment adherence, problem solves difficulties, and assesses the patient's progress with self-management strategies. The three components of

RESPECT-Mil are: 1) effective training and the availability of clinical and educational tools and resources; 2) the strategic utilization of care management resources with structured, systematic treatment monitoring by a care facilitator; and 3) an enhanced specialty care interface. This refers to systematic communication among care facilitators, and behavioral health specialists to adjust treatment in a timely way based on patient response or lack thereof to treatment.

Advantages of this approach include early identification and treatment, improved quality of care, reduced stigma, greater collaboration among primary care and behavioral care professionals, and enhanced support for conditions requiring long-term, sustained interventions. Such systematic follow-up helps prevent patients from being "under-treated" or getting lost in a complex system.

RESPECT-Mil was initially piloted (and found to be effective) within the Army at Fort Bragg in 2005-2006. As a result, on January 1, 2007, the Army Surgeon General issued an order directing:

- the establishment of a RESPECT-Mil Center of Excellence (COE) at Fort Bragg to oversee Army-wide implementation;
- universal primary care provider training in PTSD and depression, using the RESPECT-Mil model for all Army primary care providers; and
- a 24-month roll-out of RESPECT-Mil to 15 high operational tempo, Bases (3 in Europe and 12 in the United States) at a cost of approximately $2 million per year. Implementation of this order began February 2007.

The RESPECT-Mil COE is comprised of a Program Director, Deputy Director, Primary Care and Behavioral Health Champions, Program Administrator, Senior Care Facilitator/Trainer, an Administrative Assistant, and RESPECT-Mil civilian consultants from Dartmouth and Duke Universities. The COE provides training, resources, and consultation to RESPECT-Mil sites and oversees their implementation.

3.3. Efficacy

Preliminary analysis on the implementation of RESPECT-Mil:

- Primary Care Champions and Behavioral Health Champions at all 15 sites have been trained to lead in implementing the program at the local level.

- All 15 sites are participating (either preparing or already Implemented). Sites that have recently trained champions or who are about to have champions trained, are engaged in site preparation activities.

- Fourteen sites have full teams, with implementation at a total of 31 clinics and 13 posts.

- More than 100,000 primary care visits, 56 percent of all visits to participating clinics have included screening for depression and PTSD.

- Expansion continues. Data through September 2007 reveals an average of about 13,000 MH screenings per month for the past four months.

- Fourteen percent of screened visits yielded indications of depression, PTSD, or both (with about one-third revealed as false positive on further assessment).

- Approximately 3,600 Service members (about 3.4 percent of screenings) lead to referrals for additional care.

- About one out of every 33 Service members screened has been identified as having mental healthcare needs which were previously undetected.

One of the major benefits associated with the implementation of RESPECT-Mil is an increase in the safety and well-being of our Service members. Through August 2008, 787 Service members (0.8 percent of all Service members screened in the RESPECT-Mil program) have reported either passive or active suicidal ideation at the time of their primary care visit. To date, there are no known completed suicides or attempts among the RESPECT-Mil-identified Service members with some level of suicidal ideation or among any other Service members participating in the RESPECT-Mil program.

A significant number of Service members in need of mental health care for PTSD or depression are now effectively screened, assessed, and treated. A December 2007 independent review by the DoD Military Health System Clinical Quality Management Program (MHS-CQM) revealed marked improvements in quality indicators for clinics implementing RESPECT-Mil compared to a control primary care clinic at Fort Bragg not implementing the program. The investigators concluded that RESPECT-Mil is "an effective program for screening, evaluation, referral, and treatment for mental illness in a primary care setting…(and) warrants expansion to other MTF sites….consider extension among other military community members." This study is available at the MHS-CQM Web site, www.mhs.cqm.info/open/education. The MHS-CQM Phase II program evaluation is slated for completion in calendar year 2009. It will evaluate RESPECT-Mil performance at multiple clinics, and compare program outcomes with MHS control

clinics, in an effort to characterize program benefits systematically. Measured outcomes will include indicators of care quality and safety.

The RESPECT-Mil COE has partnered with military social work leaders and a civilian company (Previdence Behavioral Risk Management System) to develop a Web-based care management tracking system for care facilitators to use when working with RESPECT-Mil patients. The software beta testing at several RESPECT-Mil sites is complete and training for the personnel who will use it has occurred successfully. Final launch approval is expected soon for a system, known as FIRST-STEPS, which will help increase care facilitator adherence to the RESPECT-Mil protocol and offer real-time program evaluation and benchmarking. This will greatly improve overall capacity to monitor program related quality of care and manage the program at participating sites. Password protection systems, state of the art computer security measures, and prescribed level of information access tailored to an individual's program role will insure that personal health information remains tightly controlled and highly protected.

The RESPECT-Mil contract requires training for all primary care providers regarding effective strategies to screen, assess, and manage depression and PTSD in a primary care setting. In FY 2008, the program expended $420,000 toward the development of a Web-based, interactive training product that was released in November 2008.

3.4. Future Directions

In early 2008, DoD approved funding for RESPECT-Mil's expansion to 17 additional sites and an assessment of potential integration into 12 of the Army's Service member Transition Units. A joint RESPECT-Mil implementation team is projected for 2009. The intent will be to move forward on the approved expansion throughout the Army, as well as showing how this model compares to other primary care models for possible expansion across DoD. Due to slower than expected hiring of Army site implementation teams during the first program implementation year, we have extended the original 15-site Army RESPECT-Mil implementation to a third year beginning in January 2009.

4. Navy Reserve Psychological Health Outreach Program

4.1. Background

Navy RC Service members returning from deployment in support of the contingency operations face increased stress and deployment-related injuries, including PH and TBI. Friends, families, and colleagues may not understand deployment or combat experiences. The common phrase heard from returning combat veterans is, "If

you weren't standing next to me, you don't know what I've been through. You weren't there."

Navy RC Service members also bear the burden of deployment as individuals, apart from their units. Firefighters, police officers, and Service members who have been through traumatic events recover more effectively (emotionally) when they are kept with their units. Conversely, those who experience combat with a unit and subsequently return to their home, base, or station individually (either as combat wounded or individual augmentee) are at greater risk of struggling when dealing with combat memories.

Even when Service members return to their Reserve units, they will drill once a month and 2 weeks per year. As a result of the reserve drilling schedule, their leaders and medical staff will see them only on a quarterly basis at best, which may not be often enough to recognize a MH problem. RC Service members also face challenges in accessing care. While they are on Active Duty they have the medical benefits accorded to all Active Duty military members. However, when they return to reserve status, they no longer qualify for treatment in the military MTF unless they can demonstrate service association. Therefore, their MH concerns may not be indentified as readily or they may be less apt to access care for their MH concerns.

4.2. Rationale and Development

The Navy Reserve Psychological Health Outreach Program pilot project supports Navy RC Service members and their Families establishing a noninstallation-based program that addresses unique circumstances of RC members and their families. Improvement in overall psychological health is achieved by identifying members with stress disorders, helping them secure appropriate, timely care, identifying long-term strategies to improve PH services, and providing PH education and training. As part of the Navy Reserve PH Outreach Project, each of the five Navy Reserve Regional Reserve Component Commands now includes two outreach coordinators and one outreach support team. The work of outreach coordinators includes:

- Clinically assessing RC Service members upon referral (from primary care provider, leadership or self-referral);
- Contacting all RC Service members who returned from deployment within 6 months to determine the need (if any) for further psychological assessment;
- Assisting RC Service members with Line of Duty (did the injury result from and within the line of duty) determination processing;
- Facilitating appropriate care for Service members from referral to resolution; and

- Providing periodic leadership briefs, at Navy Mobilization Processing Sites and Navy Operational Support Center (NOSC) sites, presenting on operational stress control and the identification of stress-related issues.

The work of the outreach support team includes:

- Conducting outreach visits to each NOSC to provide psychological health outreach and education services;
- Helping unit members identify stress injuries, and assisting members identified as needing referrals in securing care;
- Providing outreach and assessment services to larger RC populations at risk for psychological health issues, and assisting members who require referrals; and
- Providing psychological support and assessment of RC Service members and their families who experience psychological trauma because of a natural disaster, terrorist attack, or other emergency.

Outreach coordinators and outreach support team members also serve as facilitators for Returning Service member Workshops. The workshops are weekend MH retreats initiated by the Navy Reserve to facilitate reintegration of the Service member back into the community.

4.3. Efficacy

The Navy Reserve Psychological Health Outreach Project was launched in September 2008 and early qualitative data suggests that it is effective at helping Service members to reintegrate into the community. As the services under the outreach program have increased each month, the number of RC Service members referred to the outreach coordinators has increased (e.g., from 6 in September 2008 to 40 in October, and to 56 in November. The number of referrals to psychological health providers has increased to more than 360 during the month of February 2009. We expect these numbers to continue to rise as the program gains visibility throughout the Navy Reserve community.

Outreach team members have started visiting Navy NOSCs where they provide outreach services directly to unit members along with Operational Stress Control awareness briefs and other psychological health information. To date, visits to 15 NOSCs are complete with the awareness briefs and outreach and assessment services provided to more than 1200 RC Service members. NOSC visits and other pre- and post-mobilization briefs will continue to increase each month, especially as commanding officers become aware of the service and request the visits. The outreach coordinators and team members have facilitated at five returning Warrior Workshops thus far, and will support another 14 through the end of FY 2009.

4.4 Future Direction

The Department plans to expand the outreach program to the U.S. Marine Corps Reserve community. Contracting for this expansion is underway with contract award expected in August 2009.

5. Conclusion

DoD worked diligently to create programs that address the growing behavioral health needs of the Services. The DoD established three pilot-projects to address that need: *afterdeployment.org*, RESPECT-Mil, and the Navy Reserve Psychological Health Outreach Program. The pilot projects cover Active Duty Service members, families, the National Guard, and the Reserve Component. Each of these projects has uniquely, effectively, and significantly worked to lower barriers, decrease the stigma associated with seeking psychological healthcare and identify those who need psychological healthcare. These efforts will continue and increase in quality, effectiveness, and outreach.

Appendix A: Sample of Behavioral Health Tools on *afterdeployment.org*

Afterdeployment.org is an in-depth repository of behavioral health tools. Although this list cannot capture the full spectrum and wealth of tools available on the Web site, the following is a sample of the tools contained on the site.

Each of the 12 program areas contains seven interactive elements. These include:

- Take a Self-Check: A user can take a brief assessment and receive feedback and recommendations regarding their current functioning in the various subject matter areas (i.e. depression, stress, and parenting).

- How Much Do You Know? This area contains interactive quizzes, allowing a user to test their knowledge and receive immediate feedback for each question.

- Expert Advice: A subject matter expert introduces this comprehensive e-library.

- Just the Facts: The user can review or print out quick-to-read, basic facts about the program topics.

- Go Interactive: Game-simulations provide an engaging, interactive learning experience based on the program materials.

- Personal Stories: Users can view video-based testimonials from Service members and their families.

- Self-Help Workshop: Narrator-guided experiences, vignettes, and change strategies are tailored to the user's individual needs. In addition, a user has the opportunity to save their work in a data repository and to access/complete subject matter homework assignments (either on or off-line).

In the "Check How You're Doing" section, the user can choose a self-assessment in any of the current 12 program areas. Here, a user can learn more about their personal problems with stress or sleep, or any of the other problem areas. The user is then provided with results and recommendations.

In the "Staying Healthy Where You Live" section, the user learns how to manage barriers to care and is provided with information about knowing when it's time to seek

out a professional, and what type of provider to contact. In addition, they can find resources in their geographical area.

"Links, Books, Blogs & Pods" contains links to external sites, blogs, books, and podcasts to further the user's knowledge in a selected program area.

ADDITIONAL TOOLS

Afterdeployment.org contains a vast number of therapeutic tools. A sample of these tools includes:

- Deep Breathing
- Progressive Muscle Relaxation
- Guided imagery
- Mindfulness exercises
- Utilizing the PLAN Tool
- Identifying "Cognitive Distortions" or "Thinking Errors"
- Thought records
- Steps for problem solving
- Learning active listening
- Building effective communication skills
- Parenting as a team
- Conflict resolution
- Identifying triggers
- Nightmare logs
- Journaling
- Basics of sleep hygiene
- Time management and scheduling
- Identifying and increasing pleasurable activities
- Increasing coping tools/skills
- Talking to children about PTSD/physical injury
- Writing the warrior's story– Hero's Journey
- Topic related homework assignments