



THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

APR 29 2005

The Honorable John W. Warner  
Chairman, Committee on Armed Services  
United States Senate  
Washington, DC 20510-6050

Dear Mr. Chairman:

I am forwarding the enclosed report as requested by House Conference Report 108-622, which accompanied H.R. 4613, Department of Defense Appropriations Act 2005. The report requested the Secretary of Defense to conduct a comprehensive review of mental health services available to military members deployed in combat theaters, and a review of services that may be available to their dependents during and after a military member's deployment.

The enclosed report incorporates reviews by each of the Services of their mental health programs and services, as well as a review of programs conducted at the level of the Office of the Secretary of Defense, and the efforts the Department plans to undertake in the upcoming year. These include suicide prevention, collaborative efforts with the Department of Veterans Affairs to ensure seamless transition of care for Service members separating from active duty, the Military One-Source Program, identification and treatment of Post-Traumatic Stress Disorder, and efforts to reduce the stigma associated with mental health care.

Thank you for your continued interest in and support of the Military Health System.

Sincerely,

A handwritten signature in black ink that reads "William Winkenwerder, Jr.".

William Winkenwerder, Jr., MD

Enclosure:  
As stated

cc:  
Senator Carl Levin

# Report to Congress



Mental Health Services for Active Duty and Reserve Service  
Members,  
and Dependents of Service Members

**Department of Defense  
Report to Congress  
On  
Mental Health Services for Active Duty and Reserve Service Members,  
and Dependents of Service Members**

There has been a great deal of concern that the current military operations in Iraq and Afghanistan will result in a large number of service members returning to the United States with psychological problems, and that care will not be available for these soldiers, sailors, airmen, and Marines. Additionally, there is concern that the stresses of deployment are having an adverse effect on the families of deployed service members and that mental health services will not be available to them. The Department of Defense (DoD) is very concerned with the health and wellbeing of all of its service members -- Active and Reserve Components -- and their families. The DoD has a broad continuum of programs and services to support the mental health of service members and their families. Most programs are executed by the Services to meet individual Service needs and requires. A description and evaluation of these programs is contained in the individual Service reports.

Across all programs, mental health support is available to individual service members before, during and after deployment. After returning home from deployment, help for any mental health issues which may arise, including depression and Post-Traumatic Stress Disorder (PTSD), is available through the Military Health System (MHS) for active duty and retired Service members, or through TRICARE and the Veterans Health Administration for non-retired veterans. The National Defense Authorization Act for Fiscal Year 2005 made permanent the 180-day TRICARE Transitional Assistance Management Program, which will help ease the transition for veterans separating from active duty, removing a potential barrier for returning veterans who need mental health care. The DoD also works actively with the Department of Veterans Affairs to assure a seamless transition of care from the MHS to the Veterans Health Administration (VHA). The DoD and the VHA have located case managers at selected military medical treatment facilities (MTFs) to manage the transition for service members processing for separation from military service. The DoD and the VHA have collaborated on Clinical Practice Guidelines for Post-Deployment Health Evaluation and Management along with supporting guidelines, including Acute Stress and PTSD, Major Depression, Substance Use Disorders, and Medically Unexplained Symptoms. These guidelines, along with detailed guidance for their use, are available via the Internet at <http://www.deploymenthealth.mil/guidelines/default.asp>.

We regard each suicide that occurs within the U.S. military as a tragic event; even one is too many. The military Services have vigorous Suicide Prevention Programs tailored to their organizational structure and operational plans and designed to protect our service members and their families. Suicide Prevention Programs are leadership

programs implemented using a community-based approach. Leadership at all levels takes an active interest in these programs; small unit leaders, chaplains, family support centers, counselors, primary healthcare providers and behavioral health professionals that make the programs work. The Suicide Prevention Subcommittee (of the DoD Prevention, Safety, and Health Promotion Committee) meets monthly to provide a forum for the Services to share ideas and work together to improve our ability to prevent suicides. The Subcommittee sponsors the annual Military Suicide Prevention Conference, a week-long training and education event most recently held in October 2004 in Washington, DC.

DoD is making use of the Internet to provide improved access to information and mental health care. This is especially important in reaching the families of Reserve Component Service members who may not live near the resources available on military installations. One of our media products designed to disseminate information about health care related issues is "The Doctor Is In" column from the OSD (Health Affairs) website. The issue at "[http://www.tricare.osd.mil/media/the\\_doctor18.cfm](http://www.tricare.osd.mil/media/the_doctor18.cfm)" highlights suicide prevention, programs sponsored by the Services to help returning Service members, as well as the Military One Source program. The One Source program is a 24-hour-a-day, seven-day-a-week counseling, information and referral resource available by telephone and the Internet to all active duty, Reserve and Guard personnel and their families. Since the publication of the referenced issue, the Service-specific One Source programs have been consolidated into a single Military One Source Program and the benefit of six confidential face-to-face counseling sessions outside of the health system, previously available only to Army personnel, is now available to all service members and their families. This counseling program includes procedures for referrals to qualified mental health providers as needed.

PTSD was added to the manual of mental health diagnoses primarily as a result of the long-term experience of veterans of the Vietnam War. Treatment for PTSD involves a combination of medication, psychotherapy, and group therapy, depending on the particular circumstances of each patient. Military personnel returning from Operation Enduring Freedom and Operation Iraqi Freedom are given education on depression and PTSD prior to redeployment and are screened during redeployment (using the Post-Deployment Health Assessment process) for symptoms of mental health concerns and exposure to events that may increase their risk for PTSD. If mental health issues are identified during redeployment, referral to appropriate care and follow-up is made. The assessment results becomes part of the Service member's medical record in case problems arise in the future, and a copy is stored in a centralized database. A second assessment for physical and mental health concerns will be performed at 90 to 180 days after redeployment, and appropriate referrals will be made for further evaluation, treatment, and follow-up. If a service member develops problems after returning home, care is available through the Military Health System and TRICARE, as well as through the VHA for those veterans who have separated from the military.

The MHS also supports research in the area of mental health concerns including PTSD. Psychiatric epidemiologists at the Walter Reed Army Institute of Research published a ground-breaking article in the New England Journal of Medicine in July 2004. This study showed about 15 percent of soldiers returning from Iraq had symptoms of PTSD, but a substantial number had chosen not to seek medical care for their symptoms. The reasons stated for not seeking care included fear of harm to their military careers and potential negative attributions by other personnel or commanders. The perceived stigma associated with mental illness is well-known both within the military and in the American public in general. Nevertheless, there have been vast improvements in our understanding of the causes of mental illness, and there are now effective treatments for many conditions that allow people to fully recover from mental health concerns and to have a high quality of work and family life. Our mental health professionals take every opportunity to educate soldiers and commanders that service members with mental health issues are not “problem soldiers,” but are soldiers with problems and that those problems have solutions. Of course, just as with physical illnesses, not every person with a mental illness will continue to meet health and fitness requirements for military duty, but the vast majority will be able to go back to work and will be effective, productive service members. For them, and even for those who leave the military, life is significantly improved when they receive care. The Military Health System and the VHA stand ready to provide returning soldiers the care they need, and we actively encourage them to use the many resources for care available to them.

### **Department of Defense Plans for Ensuring Quality Mental Health Care for Service Members and Their Families**

The Secretary of Defense supports all of the efforts made by the Services, as described in their reports below, to provide and improve mental health care for all soldiers, sailors, airmen, and Marines. In addition, there are a number of efforts planned for the upcoming year at the Office of the Secretary of Defense level.

#### **Suicide Prevention**

The Suicide Prevention and Risk Reduction (sub)Committee (SPRRC) of the Department of Defense Prevention, Safety, and Health Promotion Committee is active in improving the Department of Defense efforts in suicide prevention. The SPRRC sponsors and organizes the annual week-long Military Suicide Prevention Conference. This conference provides a forum for training and education in suicide prevention to all of the community, leadership, and health care organizations of all of the Services involved in suicide prevention efforts.

The SPRRC also plans to sponsor a working group to develop a standardized methodology for defining and evaluating suicides, suicide attempts and suicide gestures;

calculating suicide rates in a timely and scientifically valid manner; and monitoring changes in the rates of suicide to guide timely interventions as needed.

### **Transition of Care**

The Department of Defense will continue its ongoing efforts with the VHA to make the transition of care for Service members separating from active duty as seamless as possible. The Department has also joined with the VHA to establish a DoD/VHA Council on Post-Deployment Mental Health which will identify pressing needs and opportunities for collaboration, and design a comprehensive interdepartmental clinical and educational plan.

### **Post-Traumatic Stress Disorder (PTSD)**

The Department of Defense will continue its support of research into the causes and treatment of PTSD. We have asked the Armed Forces Epidemiological Board to make recommendations on needed research into risk factors and vulnerabilities for PTSD, interventions before or after exposure to combat that might reduce the risk of developing PTSD along with actions that could reduce the perceived stigma associated with seeking mental health care.

### **Reducing Stigma**

DoD will continue its support for the Military One Source Program to ease the entry of service members and their families into needed mental health care. We will also continue to take every opportunity, through annual military-sponsored healthcare conferences, media exposure, invited appearances at military leadership training conferences, and daily interaction of military health professionals with Service members, families, and leadership to stress the message that mental health issues have solutions and when service members take advantage of the solutions available, they can recover and go back to their duties and their families.

## **Service Programs**

### **U.S. Army**

#### **Report on Mental Health Services**

The Army is committed to ensuring all returning veterans receive the behavioral health care they need. An extensive array of mental health services is available. Still, we anticipate a continued high demand, and more will need to be done, as described below.

Surveys of soldiers deployed during Operations Enduring Freedom and Iraqi Freedom indicate approximately 17 percent of returning soldiers involved in combat operations report symptoms consistent with anxiety, depression or PTSD at the time of their return. All soldiers redeploying from overseas are required to complete the Post Deployment Health Assessment (DD 2796) before leaving theater. Once a soldier begins reintegration and/or demobilization, if adequate documentation does not exist to verify the DD 2796 screening, soldiers are required to again complete the form and be screened for behavioral health issues. We must ensure each soldier has been screened and processed appropriately and that this screening is properly documented. If a soldier answers affirmatively to any question on the screen, they are further evaluated by a healthcare provider and appropriate referral is made as needed for definitive diagnosis, treatment, and follow-up.

The DD 2796 screens for PTSD, major depression, anger and aggression, family concerns, and substance abuse concerns. A primary care provider reviews the form, interviews the soldier, and refers the soldier to a behavioral health care provider as appropriate. However, we recognize that many soldiers may be reluctant to check positive responses and that all health concerns will not be immediately apparent. Additional screening and outreach methods will be needed across the deployment cycle.

As part of the reintegration process, soldiers are briefed on what stressors to expect on homecoming, the common symptoms of post-deployment hyper-arousal as well as family tension, ways to ameliorate these symptoms, when to recognize further professional help is needed, and how to access treatment services. Each demobilization site has a care manager who manages the behavioral health aspect of care and ensures behavioral health referrals are made.

Walter Reed Army Institute of Research (WRAIR) validated DD 2796 in random, controlled trials as being as effective for identifying PTSD as a longer, standard questionnaire. WRAIR has also identified 90 to 120 days post-redeployment as the important interval for re-screening all service members. Generally, 90 to 120 days after redeployment many stress symptoms will have resolved. However, sometimes mental health symptoms persist, worsen, and even present for the first time at this later interval.

As a result, procedures for conducting a reassessment of Active Component and Reserve Component soldiers are being developed.

To address the days lost due to mental health reasons, a review of the medical evacuations out of Central Command (CENTCOM) for the past 6 months (June-November 2004) revealed 115 service members were medically air transported from theater for psychiatric diagnoses. During the same time period, a total of 736 service members were medically air transported; hence, 16 percent of the medical air transports were for psychiatric diagnoses. Service days could be lost due to other efforts to ameliorate behavioral health concerns, but Service members rarely are placed on quarters for mental health concerns, reducing the ability to centrally track time lost for mental health reasons.

Early data suggests up to 60 percent of soldiers fail to access behavioral health care, partly as a result of the perceived stigma associated with mental illness. In efforts to reduce the stigma often associated with mental health counseling, the Mental Health Advisory Team I (MHAT I) recommended training Combat and Operational Stress Control (COSC) personnel and other behavioral health personnel to adopt a more proactive consultation posture. Mobile Training Teams are deployed to train COSC personnel in the CENTCOM area of responsibility. The intent of the training is to reduce the stigma at the leadership level by increasing their familiarity and confidence in behavioral health personnel. Still more can be done; key Department of the Army personnel have met with both the VA and Army staff to develop a strategic communication plan that will address the service members' concerns about the stigma associated with requesting behavioral health care and re-educate the senior leadership.

Aside from stigma as a barrier, access to behavioral health care is also a barrier. There is a wide range of behavioral health services available to soldiers and families including military medical treatment facilities (MTFs), TRICARE civilian providers, and Department of Veterans Affairs (VA) hospitals and clinics. However, MTF staffing resources are historically programmed around a 30-day TRICARE access standard for mental health and designed primarily to accommodate active duty with limited access families of active duty. Family members are routinely accommodated by TRICARE community-based resources. Reserve Component soldiers who are transferred to the Community Based Healthcare Organizations continue to receive behavioral health services in their local communities with the resources available (MTFs, VA hospital or clinic, or TRICARE providers). Access barriers for Reserve Component are largely a result of the size of their home community, with more scarcity in rural areas as is experienced in the civilian population at large.

The MHAT II team conducted the second survey of mental health concerns in theater, returning from CENTCOM the week of 22 October 2004. The MHAT has written its report, and that report is being staffed with CENTCOM and the Army

leadership. The MHAT II report will address the status of the implementation of the MHAT I recommendations.

We continue to modify the Deployment Cycle Support Program based on lessons learned to ensure early identification and treatment of soldiers with behavioral health problems. At the Deployment Cycle Support Conference in November 2004, behavioral health personnel met to address the care of soldiers with PTSD and other stress related disorders. Recommendations included increased emphasis on training and education of soldiers, families, and leaders; increased pre-clinical consultation services; augmentation of primary care clinics for increased screening, consultation and intervention; and the appointment of Continuity Management Teams to ensure continuity for Active Component and Reserve Component behavioral health services. The Behavioral Health Working Group met in December, under the leadership of the Office of the Assistant Secretary of Defense (Health Affairs). There have been numerous follow-up meetings at both OSD level and in Army senior staff.

## **U.S. Navy and U.S. Marine Corps**

### **Provision of Mental Health Services to Navy and Marine Corps Active Duty and Reserve Personnel and Their Dependents**

DoD Appropriations Conference Report (HR 4613, 108-622) requests a review of mental health services within the Armed Services to address data on the average number of Service days lost to mental health reasons; types of measures taken to reduce stigma associated with mental health counseling; analysis of mental health services available and barriers to access to services; and a plan for action that SECDEF determined appropriate for improving the delivery of mental health services to members of the Armed Forces and their dependents.

The average number of service days lost to mental health concerns is difficult to estimate. Comparable figures for civilian populations between the ages of 16 and 44 suggest a prevalence of depression of 37.3/1000 in men and 59.4/1000 in women. It is assumed that prevalence will be lower in a matched sample of military personnel, a select healthy population. Nevertheless, even considering a higher index of health in active duty military, prevalence of depression alone might be estimated to be in the range of 20-40/1,000 or approximately 10,000-20,000 active duty USN and USMC service members. These figures are inexact and refer only to the diagnosis of depression, not PTSD or other related disorders.

Time in hospital is another index of lost productivity. Examination of all inpatient stays with a mental health diagnosis involving active duty Naval personnel (Marines, Sailors, and activated USMC and USN reservists) indicates a total of 10,721 bed days in FY03 for Navy personnel and 6,294 bed days for Marine personnel in FY03. In FY04, comparable figures are 9,181 for Navy and 7,355 for USMC personnel.

Looking at outpatient visits for mental health reasons, lost productivity is more difficult to estimate. In the following scenario, we projected a total loss of 3 hours away from work for a mental health visit. Although this allows one hour for an appointment and two hours travel time, this may be an underestimate depending on the proximity of the service member to the MTF or treatment site. Using these estimates, in FY 2003, there were 62,456 mental health visits reported for Marine personnel and 208,567 reported for Navy personnel. In FY 2004, there were 67,528 reported for USMC and 201,155 for USN personnel respectively. This results in an estimated loss of 33.94 work years for USMC in 2003, and 36.7 work years in 2004. For Navy personnel, comparable losses would be 113 work years in 2003 and 109 work years in 2004. However, this estimates only losses due to attendance at medical appointments and represents time invested in maintaining the health of the service member. It does not reflect any improvement in productivity due to better health, which would be the return on the investment. If one assumes that problems will occur at some rate, regardless of

circumstances, then this time invested in getting help may, in fact, reduce lost work hours and improve productivity.<sup>1</sup>

Other estimates that include an estimate of “presentee-ism”, or presence in the workplace but functioning in reduced capacity, suggest untreated or incompletely treated depression alone accounts for 69,000 sick days (or 300 person-years) annually in enrollees to the Navy health care system (Rockswold, Paul, unpublished communication, Oct 28, 2004). Depression is a leading cause of reduced productivity in civilian studies (Druss, et al., 2001; Lerner, et al, 2004), in some studies accounting for up to 5.6 hours/week of lost productive time (Stewart, et al., 2003). Effective treatment of depression is a consistent target of efforts to reduce the effects of “presenteeism”(Hemp, 2004). Enhancing the detection and treatment for depression in the primary care setting may significantly improve productivity and reduce absenteeism. A recent civilian study found enhanced primary care treatment reduced absenteeism by an average of 12.3 days over 2 years and improved productivity by 8.2% (Rost, Smith, & Dickinson, 2004). Although depression is the most commonly studied diagnosis when investigating productivity, other mental health diagnoses are also clearly associated with decrements in productivity.

Stigma is a prominent concern when attempting to reduce barriers to care. As illustrated in the Hoge, et al. (2004) study of mental health services in land combat personnel deployed to Iraq, fear of negative reaction from leaders was the principle impediment in seeking care among active duty personnel. Therefore, strategies to reduce stigma must involve conveying a consistent message that seeking mental health services is not a sign of weakness or lack of suitability to carry out the military mission. The Navy’s Bureau of Medicine and Surgery and the Deputy Commander for Manpower and Reserve Affairs are producing a *Leader’s Guide for Personnel in Distress* to assist commanders in addressing needs, including mental health needs, of personnel experiencing difficulty.

Providing mental health services outside of the MTF specialty mental health clinic is another mechanism of reducing stigma. In active duty forces, mental health services provided through division medical assets or through services provided by psychologists attached to ships’ company may reduce this barrier to care. Psychologists are deployed on all Navy aircraft carriers and certain Expeditionary Strike Groups (ESGs). Psychologists, psychiatrists, and social workers are deployed on operational platforms directly supporting the military mission in Operation Iraqi Freedom. USMC division mental health assets have been augmented with Navy psychologists and psychiatrists by

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<sup>1</sup> Key assumptions and limitations: Source of data is the M2 database. Data collection assumes a visit for any mental health diagnosis. It is assumed that depression and anxiety disorders (of which PTSD can be considered a subset) represent the majority of such diagnoses. Inpatient data for FY 2004 are incomplete. Work years are calculated on the basis of 230 days per calendar year. These models capture only service provided in fixed MTFs, not deployed or other operational units. The extent of mental health services provided in such arenas is not systematically captured.

way of the Operational Stress Control and Readiness Project, which employs a community mental health model in making services available to operational units throughout the deployment cycle.

Mental health services are reasonably accessible to active duty members in non-deployed environments, though stigma and related concerns may reduce the utilization of such services. Services are variably available to dependents of active duty members directly through military treatment facilities; this availability a particular problem in MTFs where active duty providers may be deployed in support of the operational mission or large numbers of active duty cases limit services to other beneficiaries. In some cases, TRICARE providers serve as the primary providers of mental health care. The current TRICARE benefit allows for eight unmanaged network mental health visits for TRICARE Prime enrollees. The same access problems exist for dependents of activated reservists who may not live near an MTF or for those who live in more rural areas where mental health services are not widely available. Service members and their families may also seek counseling services for a range of issues, including marriage and family problems, through Military One Source counselors.

## **U.S. Air Force**

### **Air Force Mental Health: Before, During and After Deployments**

Within the Air Force, awareness of mental health related problems, its antecedents and its consequences continues to evolve and to grow. This growing base of knowledge is especially true in the area of deployment-related stress and its effect on Airmen, their families and the Air Force mission. The Air Force's current approach to management of mental health related issues is based upon this evolution of understanding, and includes the following precepts:

- The "Wingman" concept, in which Airmen take personal responsibility in looking out for one another, is a critical component for ensuring mental health readiness throughout the Air Force team
- Stress and all of its consequences are not the purview of one agency, but rather involve a collective community response with inter-agency collaboration and strong, involved leadership
- Reducing barriers to help-seeking behaviors leads directly to enhanced mission readiness
- A population health based model which emphasizes prevention through early identification of problems is critical in mitigating mental health related problems

#### **Readiness at the Unit Level: The Wingman Concept**

The Air Force Chief of Staff has stressed the wingman concept as critical to the Air Force culture. In this culture, each Airman is responsible for looking out after his or her fellow wingman, and taking whatever action is needed to ensure each other's health and well being. The wingman ethos is grounded in the Air Force's core values: integrity, service before self, and excellence in all we do. In November 2004 each Air Force installation held a Wingman's Day that required every member of the Air Force team to spend dedicated time to focus on these concepts and their application. Wingman Day activities were also conducted in theater to carry that culture of taking care of each other into the field of combat.

#### **Readiness as a Community Issue**

Air Force Instruction 90-501 establishes a Community Action Information Board (CAIB) at the installation, Major Command and Headquarters levels. The focus of CAIBs at all levels is to "identify and resolve issues that impact the readiness of Air Force members and their families." At each level the CAIB utilizes an interagency working group, referred to as the Integrated Delivery System (IDS). The IDS includes agencies that provide member and family services: Family Matters, Chaplains, Family Member Programs, Family Advocacy, Life Skills and the Health and Wellness Center.

Representatives from the Reserve Component and from the Air National Guard are also included in the IDS.

The CAIB and IDS perform biennial community needs assessments, which examine the unique needs of each Air Force community. These assessments help shape the Community Capacity Action Plan, which identifies community issues and proposes solutions. If solutions cannot be derived at the installation level, an issue may be forwarded to the Major Command level. Unresolved issues at the Major Command level may then be passed on to the Headquarters CAIB and IDS.

### **AF Suicide Prevention Program**

After witnessing a disturbing trend in suicide rates in the early 1990s, the Air Force established a team to study the issue and come up with an action plan. The result was the Air Force Suicide Prevention Program (AFSPP), based on the premise that suicide was not a mental health or medical problem, but rather a broad issue that involved the entire Air Force community. The AFSPP is a broad based program with 11 key initiatives, which include aggressive leadership involvement, suicide prevention in all levels of professional military education, annual suicide prevention briefings, limited psychotherapist-patient privileges, an epidemiological database and the establishment of the IDS.

The results of the AFSPP, analyzed and published by university researchers, have been impressive. Since 1997, suicide rates in the Air Force have dropped significantly. Efforts are currently underway to reinvigorate the program, with a renewed emphasis on the 11 original initiatives.

### **AF Leader's Guide for Managing Personnel in Distress**

The AFSPP and IDS collaborated with first sergeants and commanders to create a guide to address leaders' questions about how to manage highly stressed personnel. The guide, distributed throughout the Air Force in CD format, features 35 common situations that personnel face, such as deployment, alcohol related incidents, depression; and it guides leaders on what to look for and how best to intervene to prevent and mitigate more critical mental health problems.

### **Medical Mental Health Services**

As part of an effort to reduce the stigma of seeking help for personal and emotional problems, the Air Force changed the name of their Mental Health clinics to Life Skills Support Centers (LSSC). LSSCs are staffed by a combination of psychologists, clinical social workers, psychiatrists, psychiatric nurse specialists and mental health technicians. LSSC staffs typically include a mix of active duty, civilian and contract workers. Within a clinic or hospital the Life Skills flight encompasses outpatient mental health services,

the Alcohol and Drug Abuse Prevention and Treatment (ADAPT) program, the Drug Demand Reduction program, and the Family Advocacy program. The Air Force is the only service in which Family Advocacy prevention and intervention services are both provided within the medical treatment facility.

### **Using a Population Health Model to Target Prevention and Intervention**

To maintain a fit and healthy force, the Air Force has adopted proactive healthcare policies that continuously assess, monitor and address all health related issues, to include mental health concerns. This is accomplished with a population health approach to healthcare management in which all beneficiaries are assigned to a specific Primary Care Manager (PCM) upon enrollment at a new military treatment facility. The PCM team reviews the medical records of new enrollees to identify healthcare issues that need targeting. This medical review occurs during both in-processing and out-processing. The goal of this approach is to optimize primary and secondary prevention efforts and to minimize the clinical conditions that require more intensive treatment.

Potential or emerging mental health issues are also identified through the annual Preventive Health Assessments (PHAs), which are required of all active duty personnel. PHAs allow PCMs to review a variety of health care issues, including mental health concerns on an annual basis. PCMs may refer patients to the LSSC for a more thorough mental health evaluation and treatment if indicated.

### **Integrating Behavioral Health into Primary Care**

In 1997 the Air Force initiated a pilot program that placed behavioral health providers in primary care clinics. This initiative, based on innovative civilian healthcare practices and designed with the help of a civilian subject matter expert consultant, was driven by an enhanced appreciation of how mental health concerns typically present within a healthcare system. Roughly 70 percent of visits to primary care involve a behavioral health component. While primary care providers often recognize underlying mental health issues and make referrals for specialty care, only one in four referred patients actually keep their appointment with the specialty care provider.

The Air Force now incorporates psychologists and social workers into PCM teams, with the following aims:

- Improved access to behavioral healthcare for all beneficiaries
- Improved collaborative care and management of patients with psychosocial issues in primary care
- Delivery of behavioral healthcare in a setting that is more acceptable to patients
- Provision of easy access to behavioral healthcare consultation for primary care providers
- Prevention of more serious mental disorders through early recognition and intervention

- Triage of more serious cases with coordination and referral to LSSC

### **Mental Health: Pre-Deployment**

To ensure mental health readiness, the Air Force Medical System incorporates a number of mechanisms to identify and address emerging or existing mental health issues. As described above, these mechanisms include recurrent medical record screening by PCM teams, annual PHAs, and behavioral health integration in primary care. Active duty personnel diagnosed with a psychological disorder that impacts duty performance are given a physical profile, which classifies the duty impact, alerts the member's commander, and precludes deployment if warranted.

Prior to deployment, AF personnel complete DD Form 2795, the Pre-Deployment Health Assessment, and they are seen by their PCM team. This allows for yet another opportunity to identify and address any mental health conditions which may either impact deployment duties, or which may be exacerbated by the demands of deployment. Life Skills providers are available for more extensive mental health evaluation as needed, and the member's commander is informed of any conditions which may affect duty performance.

### **Mental Health in Deployed Locations**

Within the Air Force, deployed healthcare is provided according to the AF Aerospace Expeditionary Force (AEF) model, which provides tailored force packages to meet the requirements of the theater Commander in Chief. The AF Medical Service uses the Expeditionary Medical Support/Air Force Theater Hospital system to achieve these requirements. The Air Force has identified two types of mental health team packages that can be deployed in combinations to meet theater requirements.

The Mental Health Rapid Response Team is comprised of one social worker, one psychologist and one mental health technician. This team provides rapidly deployable mental health personnel and equipment to (1) Perform in-theater prevention and outreach services, to include command consultation and traumatic stress response services; (2) Operate a Combat Stress Facility (CSF) if required; and (3) Operate an Outpatient Mental Health Clinic. The other team package, the Mental Health Augmentation Team, consists of one psychiatrist, three mental health nurses and two mental health technicians. This second team augments the first, and provides the same capabilities, as well as the ability to manage combat stress casualties in a 20-bed facility.

Both mental health teams are trained to implement Combat Stress Control programs IAW DODD 6490.5.

## **VA/DoD Clinical Practice Guideline (CPG) on the Management of Post-Traumatic Stress**

The Air Force is in the process of replacing its *Critical Incident Stress Management* instruction with an instruction on *Traumatic Stress Response*. The changes are based on the recent publication of the VA/DoD CPG on the Management of Post-Traumatic Stress. The CPG provides step-by-step algorithms to assist providers in assessing and intervening with individuals who have been exposed to traumatic stress. The CPG includes an algorithm for Combat and Operational Stress Reactions, which identifies symptoms and offers various interventions, with the goal of returning the affected member to duty as quickly as possible, unless acute interventions fail to sufficiently remedy the member's symptoms.

### **Post-Deployment Mental Health Care**

Those returning from deployments face a number of challenges and risks that have a direct bearing on short-term and long-term mental health functioning. Possible exposure to traumatic stress can result in mental health issues that are not always apparent in the immediate aftermath of exposure to traumatic stress. Also, reintegration to family and duty responsibilities can be difficult, and carry the risk of significant disruption and dysfunction if not managed properly.

Two primary processes within the Air Force address post-deployment mental health. The first process involves careful screening and assessment of mental health concerns using the Post-Deployment Health Assessment (DD Form 2796). This process is completed by all personnel who return from deployment. Endorsement of mental health concerns is assessed in person, and referrals to the LSSC are made when more thorough evaluations are indicated. Annual PHAs present future opportunities to identify mental health problems not apparent upon initial return from deployment.

The second process involves reintegration programs. Members of the IDS have collaborated to facilitate the development of reintegration programs throughout the Major Commands within the Air Force. These programs integrate services offered by the chaplains, family member programs, and Life Skills to provide returning members and their families with the tools needed to facilitate smooth reintegration following a deployment. Programs typically include spouse communication classes, reintegration dynamics awareness, education on the unique needs of children, and in some instances free childcare. The AF IDS is now in the process of reviewing all of the existing reintegration programs to provide a standardized template for reintegration that can be used by all installations, while allowing for installations and Major Commands to add features tailored to their populations. This standardization will address the often-unique needs of the Reserve Component, the Air National Guard, and its family members.

## **Air Force One Source**

Air Force One Source (AFOS), part of the DoD Military One Source initiative, provides extensive support services to Active duty, Reserve and Guard personnel and their families wherever they are located. AFOS provides expanded Family Support Center services through an interactive, web-based and telephonic program. AFOS provides personalized support, referrals to military and community resources, online articles, educational materials, workshops, booklets, audio recordings and telephonic consultation at no cost. The service is available 24-hours a day, 365 days a year. AFOS is ideally suited to assist family members of those deployed by providing education and consultation with the myriad of issues they might face before, during and after deployments.

## **Reducing Barriers to Mental Health Care**

The widely cited New England Journal of Medicine article from July 2004 (*Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*) stated military personnel and civilians share many of the same reasons for not seeking mental health treatment for psychological problems. The study noted however the unique barriers to mental health care in the military, such as concerns about how seeking help will be perceived by peers and leadership, and possible adverse career ramifications. Interestingly, the study found those screened with more significant mental health problems were more likely to be concerned about possible stigmas associated with seeking care than those with less significant problems. It is likely that one of the explanations for this increased concern is related to the nature of the illness. Nevertheless, the study highlights the need to actively reach out to this group.

The study recommended efforts to address this stigma, through “outreach, education, and changes in the models of health care delivery, such as increases in the allocation of mental health services in primary care clinics and in the provision of confidential counseling by means of employee-assistance programs.” These are sound recommendations that warrant serious consideration in light of the integral relationship between mental health readiness and mission readiness. While the Air Force has had great success with behavioral health integration in primary care, the resourcing of this initiative comes at the expense of the staffing resources of Life Skills. Funding for additional behavioral health resources in primary care would allow an expansion of this innovative program while not adversely impacting the mental health requirements within the LSSC. Efforts should also be made to study whether enhanced confidentiality and privacy for mental health care would in fact lead to an increase in delivery of mental health care along with an associated decrease in adverse outcomes.