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Award Number: W81XWH-09-2-0172

TITLE: Improving Deployment-Related Primary Care Provider Assessments of PTSD and Mental Health Conditions

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REPORT DATE: October 2011

TYPE OF REPORT: Annual

PREPARED FOR: U.S. Army Medical Research and Materiel Command
Fort Detrick, Maryland 21702-5012

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. REPORT DATE	2. REPORT TYPE	3. DATES COVERED
October 2011	Annual	30 September 2010 – 29 September 2011

4. TITLE AND SUBTITLE

Improving Deployment-Related Primary Care Provider Assessments of PTSD and Mental Health Conditions

5a. CONTRACT NUMBER

5b. GRANT NUMBER
W81XWH-09-2-0172

5c. PROGRAM ELEMENT NUMBER

6. AUTHOR(S)

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5d. PROJECT NUMBER

5e. TASK NUMBER

5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

Vanderbilt University
Nashville, TN 37203-2416

8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)
U.S. Army Medical Research and Materiel Command
Fort Detrick, Maryland 21702-5012

10. SPONSOR/MONITOR'S ACRONYM(S)

11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION / AVAILABILITY STATEMENT
Approved for Public Release; Distribution Unlimited

13. SUPPLEMENTARY NOTES

14. ABSTRACT

This project addresses the need for research on service delivery approaches for Service Members with combat-related physical or psychiatric symptoms, including Posttraumatic Stress Disorder (PTSD) and/or post-concussive symptoms. As a primary care encounter, the post-deployment health reassessment (PDHRA) process is critical to force health protection efforts. The project will develop and test the effectiveness of a sharply focused training and feedback intervention designed to increase Service member reports of behavioral health concerns and Service member acceptance of a referral for further assessment.

The project has two aims. (1) Determine key elements of and short term impact of training programs for deployment related assessments. (2) Evaluate the effectiveness of a targeted training and feedback program on primary care provider's interview and clinical communication patterns related to Service member behavioral health condition identification and referrals. To accomplish these aims, a training workshop that incorporates experiential learning strategies and evidence-supported characteristics of high quality communication training programs will be piloted at 3 sites with an estimated total of 20 providers.

15. SUBJECT TERMS
Training and feedback; provider behavior change; health risk appraisal; behavioral health

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			USAMRMC
U	U	U	UU	171	19b. TELEPHONE NUMBER *(include area code)*

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INTRODUCTION

This project addresses the need for research on service delivery approaches for Service members with combat-related physical or psychiatric symptoms, including Posttraumatic Stress Disorder (PTSD) and/or post-concussive symptoms. As a primary care encounter, the post-deployment health reassessment (PDHRA) process is critical to force health protection efforts.

The project will develop and test the effectiveness of a sharply focused training and feedback intervention designed to increase Service member reports of behavioral health concerns and Service member acceptance of a referral for further assessment. The project builds on a previous evaluation of the PDHRA process, a collaborative effort between Vanderbilt University (VU) and Force Health Protection and Readiness (FHP&R), and will be applicable to all Service Branches and Components. This evaluation was contracted to VU with the final report available on Defense Technical Information Center (DTIC) at http://handle.dtic.mil/100.2/ADA528063.

The project has two aims. (1) Determine key elements of and short term impact of training programs for deployment related assessments. (2) Evaluate the effectiveness of a targeted training and feedback program on primary care provider's interview and clinical communication patterns related to Service member behavioral health condition identification and referrals.

To accomplish these aims, a training workshop that incorporates experiential learning strategies and evidence-supported characteristics of high quality communication training programs will be piloted at 3 sites with an estimated total of 20 providers. All providers at the intervention sites who agree to participate in the study will take part in the training. As an interrupted time series design, each provider will serve as his/her own control through the secondary analysis of existing data sources (electronic records for PDHRA and health care encounters) for a time period prior to and following the training. The use of a time series approach will allow us to determine the influence of the communication training as a main effect as well as account for threats to validity, such as changes that occur over time independent of the intervention.

Pre- and post-outcome measurement will include brief post-PDHRA surveys completed by the Service member (anonymously) and provider immediately after each PDHRA interview. These surveys will be administered for a period of time before and after the workshop (typically 2-3 days before and 2-3 days after). Additional measures include a program manager interview and surveys completed by providers before and after the workshop. A secondary analysis of PDHRA data will also be conducted to identify risk factors in the development of PTSD.

The project is a cooperative effort among VU, FHP&R, and Purdue University (PU) (VUs subcontractor). The project period of performance is 30-SEP-09 to 31-OCT-12. This

report summarizes Year 2 (30-SEP-10 to 29-SEP-11) progress on scope of work (SOW) activities, key research accomplishments, and reportable outcomes. We conclude by summarizing results to date and projecting work to be accomplished through the remainder of the project.

BODY OF REPORT

Vanderbilt University SOW Tasks

Task 1. Timing of Approvals and Institutional Review Board (IRB) (Y1, M1-11)

Overview

Task 1 activities are oriented to ensuring that all proper approvals and IRB activities are completed in a timely manner, so that the provider intervention and other research activities proceeds according to schedule. All approvals were originally scheduled to occur in Year 1, but due to delays previously described in the first annual report (briefly summarized in the Task 1 "Problems and Circumstances that Necessitated Changes to Task" section below), Subtask 1d was accomplished in Year 2. Subtask 1d is described as follows under Task 1 in the original SOW:

- 1d. Training & feedback intervention study protocol (Y1, M3-10)
    - Submitted to VU IRB, estimated review time for expedited protocol (Y1, M3-4)
    - Submitted to appropriate Army IRBs, estimated review time (Y1, M5-11). Note that final training materials will be submitted for review in months 10-11.

During Year 2, VU also requested and received approval to modify the project's SOW and to exercise the option to add a one-year no-cost extension to the period of performance.

Status

We have obtained the necessary approvals from the Army Medical Research and Materiel Command (MRMC) IRB and VU's IRB.

The Vanderbilt research team submitted four protocols related to the intervention.

1. **Provider intervention and surveys**. This expedited protocol describes the data collection that providers in the training workshop will be asked to complete.
2. **Service member survey**. This exempt protocol describes the anonymous survey to be completed by Service members who see trained providers.
3. **Program manager interview**. This exempt protocol describes a semi-structured interview that will be conducted with the PDHRA program manager at participating sites.

4. **Secondary analysis**. This expedited protocol describes analysis of de-identified PDHRA data that will be requested for all Army Service members who complete a PDHRA during the study timeframe.

All four protocols were submitted to VU's IRB by 10-APR-11, with approval received for all protocols by 18-MAY-11. The four protocols were submitted to MRMC IRB on 19-MAY-11, and MRMC's initial review of all protocols was received on 20-JUL-11. Protocol 4 was approved without changes, and minor revisions were requested for protocols 1-3.

The changes requested by MRMC required resubmission to the Vanderbilt IRB. The protocols were revised and submitted to the Vanderbilt IRB on 27-JUL-11, with additional modifications by Vanderbilt to allow for electronic administration of the Service member survey and updated survey items. Approval was received from the Vanderbilt IRB on 28-JUL-11. Protocols 1-3 were resubmitted to MRMC IRB on 29-JUL-11 and approval was received on 25-AUG-11.

On 10-MAR-11, Vanderbilt requested MRMC's approval for modifications to the project's SOW and for a one-year no-cost extension to the period of performance defined in the original contract. Approval for both the extension and the SOW modification was received on 03-MAY-11. See Appendix A for the modified research design and the associated approval documentation from MRMC.

Problems and Circumstances that Necessitated Changes to Task

Task 1d was expected to be completed in Year 1, but was not due to two circumstances that substantially delayed training development. These are described in detail in the Year 1 Report, but a brief overview is included below.

- **Delayed Completion of DUA**. The primary activity during Year 1 was originally intended to be an extensive secondary analysis of the data collected during Vanderbilt's previous evaluation of the PDHRA process (see Task 3). This analysis was intended to inform training development; however, due to delays in signing of the DUA with AFHSC and in receiving data from the Services, no data were received during Year 1.
- **National Defense Authorization Act (NDAA) Section 708**. The evolving nature of the training required by NDAA Section 708 created a concern that any training Vanderbilt developed during Year 1 could be redundant or contradictory to the new policy. Thus, FHP&R and Vanderbilt jointly agreed in 2nd Quarter, Year 2 to proceed with a plan to focus the pilot training on patient-centered communication, which would complement the NDAA training, with the research design and training development to proceed accordingly.

Once these delays were resolved, IRB protocols could be prepared. After protocol submission, there were some delays in the approvals process. Based on communication with the respective IRBs, the Vanderbilt IRB approval was expected to take 8 weeks, but

took only 6 weeks (including initial review and amendment). However, MRMC approval was expected to take approximately six weeks, but actually took three months.

Outcomes and Next Steps

No additional IRB reviews are expected, other than annual reviews of expedited protocols.

Task 2 (Aim 1). PDHRA Focus Groups (Y1, M1-2, 5-9)

Overview

The original goal of Task 2 was to conduct focus groups of key stakeholders involved in the PDHRA process, and to analyze the resultant data with the intention of identifying key elements for training interventions relevant to content, format, and implementation. However, due to the impact of the National Defense Authorization Act (NDAA) legislation introduced between the time of the original proposal and the start of work, FHP&R and VU agreed not to conduct the focus groups pending Department of Defense (DoD) efforts related to the legislation. On 03-MAY-11, Vanderbilt received approval from MRMC to eliminate the focus groups from the SOW and to replace them with a literature review, informal conversations with key PDHRA personnel, and guidance by the Expert Panel (See Appendix A for the modified research design approved by MRMC).

Status

The literature review was included in the Year 1 report, and has informed development of the training throughout Year 2. Expert Panel guidance is described under Task 5 in this report.

Task 3 (Aim 1). PDHRA Secondary Analysis (Y1, M4-9)

Overview

The stated goal of Task 3 is to conduct an extensive, robust secondary analysis of the PDHRA data obtained during Vanderbilt's previous DoD-funded evaluation of the PDHRA process. The focus would be on identifying provider factors that contribute to candid Service member reporting of behavioral health concerns and to Service member acceptance of associated referrals. The resulting information was to be utilized in the development of the training and feedback intervention. While the following tasks were originally scheduled for Year 1, delays in receiving the data caused them to become Year 2 activities. The subtasks listed under Task 3 in the SOW are included below:

- 3a. Data requests to appropriate information technology officer at each Service for provider and Military Treatment Facility (MTF) identifiers for PDHRAs completed between 01-JAN-06 to 31-MAY-09 (Y1, M4)
- 3b. Linking file created by the Armed Forces Health Surveillance Center (AFHSC) to provide de-identified dataset to VU containing non-identifying Service member identifier and provider/MTF identifiers (Y1, M4-8)

- 3c. Data management and analysis (Y1, M5-7). Abbreviated analytic timeframe estimated because we will be adding this dataset to existing clean datasets with much of the analytic programming developed.
- 3d. Production of preliminary reports and briefings (Y1, M8-9).

Status

The main data sets for secondary analysis are owned by the AFHSC and include de-identified PDHA, PDHRA, and health care encounter records for Service members who completed the PDHRA between 1-JAN-06 and 31-MAY-09. In addition, a smaller data owned by the Services (Army, Navy, and Air Force) includes two variables not available in the AFHSC dataset, provider ID and location ID. The AFHSC and Service data were to be linked and de-identified by AFHSC prior to being received by Vanderbilt. In summary, the necessary steps for Vanderbilt to receive the entire secondary analysis data set is as follows: (1) to complete data use agreements (DUAs) with AFHSC and each of the Services, (2) to have the Services send their data to AFHSC, (3) to have AFHSC create a linking file to match the Services data with the AFHSC data, remove all personal identifiers from the data, and to send the de-identified data and linking files to Vanderbilt.

(1) DUAs
   a. The DUA for AFHSC was originally signed by Vanderbilt and AFHSC on 14-JAN-10, but due to complications described further under "Problems and Circumstances…," below, the DUA was not fully executed until 4-OCT-10.
   b. The DUA for the Army data was submitted 2-FEB-10, and was approved 7-APR-10. The DUA for the Navy data was submitted 9-FEB-10, and was approved 20-APR-10. The DUA for the Air Force data was submitted 12-FEB-10, and was approved 4-MAR-10.

(2) The data from all Services were received by FHP&R by 9-NOV-10, and sent by FHP&R to AFHSC on 10-NOV-10.

(3) The complete de-identified data set was received by VU 6-JAN-11.

Data management began once the data were received. The ultimate goal of the data management was to merge the provider and MTF ID data from the Services with the PDHRA data from AFHSC by using the linking file created by AFHSC. Our planned analyses require (1) a unique relationship between provider ID and provider (i.e., no divergence or convergence), and (2) that the MTF ID represent the location where the PDHRA interview took place. These requirements were not met in the raw data. Rather, the format of the variables provided was not standardized, the content was not consistent among Services, and proxy variables were received for Navy MTF ID and Air Force MTF and provider ID because the requested variables were not directly available.

Extensive communication with the Services was needed to understand how to interpret and clean the data since the variables were not created for the purposes of research. For example, the majority of provider IDs for the Army and Navy were names in the format firstname.lastname, but some were clearly not names (e.g., bababa, 1234). In addition,

some provider IDs seemed to correspond to the same provider, although they were not identical (e.g., tom.richards, t.richards, tom.richrds). To make sure we understood how to interpret the data, the Vanderbilt data manager confirmed with the Army point of contact (POC) that provider IDs should be names, and that it is possible providers entered their name slightly differently at different times, or that the names were misspelled (i.e., it was reasonable to consider tom.richards and t.richards as the same person). For the Air Force, providers IDs were simply numbers that had been assigned to provider names by the Air Force, regardless of spelling or alternate forms (e.g., tom.richards = 1234,t.richards= 2345). Thus, there was no way for Vanderbilt to verify that each provider ID represented a unique provider for the Air Force data. Therefore, the Air Force provider ID data could not be properly interpreted and were not used.

The location ID from each Service was much more problematic. The Army provided zip codes, but it was not clear what the zip codes represented (e.g., the Soldier's location when they completed the PDHRA, the Soldiers or provider's assigned location, or the physical location where the PDHRA interview took place). In the end, the Army POC clarified that zip code was a decent representation of where the PDHRA interview took place. The Navy and Air Force provided unit identification codes (UIC) for the location ID, but as with zip code for the Army, it was not clear if the UIC corresponded to the Soldier's or the provider's unit, or if it provided any representation of the location where the PDHRA interview took place. The POCs for these Services clarified that UIC was associated with the provider, but that it did not represent the location where the interview took place. For example, two providers at the same location might have different assigned UICs. However, the Air Force and Navy POCs matched UIC to base, and thus provided us with the base location where the PDHRA interviews most likely occurred.

The communication to understand the data from each of the Services took place via email and telephone over a 10-month period from 2-16-11 through 8-9-11. Communication took time, as several follow-up contacts often needed to occur, and at times, the Vanderbilt team would be referred to different contacts for further information. In addition, there was an 8-week delay in communication from the Vanderbilt team due to a staffing change. Vanderbilt's previous data manager left at the end of April and the new data manager started in mid-June. The final outcome is that all data from the Army and Navy can be used. However, only the MTF ID from the Air Force can be used. As described above, the provider IDs cannot be appropriately cleaned so that each ID represents a unique provider.

In summary, at the time of the submission of this report, all necessary information is available to clean the Services data and merge it with the AFHSC data, with the exception of provider ID for the Air Force. The Army data have been merged with the AFHSC data, and the Navy and Air Force data are in the process of being merged. The cleaning procedure for these data, including number of records and justifications for exclusions, is shown in Appendix B.

Vanderbilt will present preliminary findings from its secondary analysis of PDHRA data at the International Conference on Communications in Healthcare (18-OCT-11) and at the

American Public Health Association Annual Meeting (1-NOV-11). The abstracts for these two oral presentations are attached as Appendix C.

Problems and Circumstances that Necessitated Changes to Task

The receipt, data management, and preliminary analysis of secondary data were expected to be completed in Year 1. However, the first step in receiving the secondary data set, the execution of a DUA with AFHSC, was not completed until 4-OCT-10, almost one full year later than expected. The reasons for this delay are described in detail in the Year 1 Report.

Analysis was also delayed by staffing changes. In APR-11, the project statistician left Vanderbilt, and there was a two month gap between this departure and the hiring of a replacement. After hiring took place, a training period of approximately one month was needed before data analysis could recommence.

Outcomes and Next Steps

The Navy and Air Force data will be merged with the PDHRA data in the first quarter of Year 3. The analyses investigating the role of provider and location in PDHRA outcomes will continue and expand during the next year.

Task 4 (Aim 2). Training and Feedback Intervention Effectiveness Study (Y1, M1-9; Y2, M1-11)

Overview

The activities listed under Task 4 address the central goal of Vanderbilt's research, which is to develop and test the effectiveness of a targeted training and feedback intervention designed to help providers increase Service member reports of behavioral health concerns and Service member acceptance of referrals for further assessment. The subtasks for Years 1 and 2 originally listed under Task 4 in the SOW are as follows:

- 4a. Recruitment of four to six study sites (Y1, M1-2)
- 4b. Development of training materials (Y 1, M1-9)
- 4c. Randomization of 39 providers across four to six study sites (Y1, M12)
- 4d. Collection of pre-training audiotapes from 39 providers, consisting of one randomly selected hour of PDHRA interviews (Y1, M12)
- 4e. Training and feedback intervention (Y2, M1-4)
    - Initial eight-hour workshop for providers in the two intervention conditions (Y2, M1)
    - Feedback through ongoing peer learning in treatment team format conducted at relevant study sites for 30-45 minutes on a weekly or bi-weekly schedule (Y2, M2-4)
- 4f. Measurement of implementation fidelity and quality (Y2, M1-4)
    - Collection of initial training workshop attendance records, administration of pre- and post-workshop evaluations completed by attending providers, and

audiotaping of simulated interviews conducted by providers during initial workshop (Y2, M1)
    - Collection of attendance records at ongoing treatment team sessions (Y2, M2-4)
    - Administration of post-training evaluation survey to participating providers (Y2, M7)
- 4g. Measurement of intervention outcomes (Y2, M1-4, 7)
    - Collection of audiotapes from 39 providers, consisting of one randomly selected hour of PDHRA interviews, one each month of the study period (Y2, M 1-4)
    - Administration of Service member satisfaction survey for each Service member participating in a PDHRA interview with participating providers during the study period (Y2, M1-4)
    - Data requests to Army information technology officer at each installation for provider and MTF identifiers for PDHRAs completed by participating providers during study period (Y2, M7)
    - Data request to TMA for (1) de-identified PDHRAs completed during study period for participating providers during study period, and (2) de-identified health care utilization records for Service members interviewed by participating providers for eight weeks post-PDHRA. Linking file will be created by Tricare Management Activity (TMA) to provide de-identified dataset to VU containing non-identifying Service member identifier and provider/MTF identifiers (Y2, M7)
- 4h. Data management and analysis (Y2, M5-11)

Substantial changes to these original tasks were made and are described below. See Appendix A for the full revised study design.

Status

Tasks 4c and 4d became irrelevant after changes to the SOW were approved. The revised research design specifies that no audiotapes will be collected and that a minimum of ten providers at two to three sites will participate in the study, which will now use an interrupted time series design with non-equivalent comparison sites. In this design, each provider will serve as his or her own control. A detailed description of the interrupted time series design and the selection of the non-equivalent comparison sites is included in Appendix A, under the section titled “Aim 2 Design and Methodology.”

The majority of Year 2 activities for Task 4 were related to subtasks 4a and 4b, as described in the next section. The tasks originally scheduled for Year 2 (4e-4h) will now be completed during the no-cost extension year, as approved by MRMC. However, some tasks related to subtask 4g have already been completed. A new DUA with AFHSC was executed on 18-APR-11 to allow for the request of PDHA, PDHRA, and health care encounter data completed during the study period. In addition, on 13-APR-11 we clarified the procedure for

requesting study-period provider and MTF IDs from the Army. The data from AFHSC and the Army will be requested in the first quarter of Year 3.

Site Selection

Military protocol requires that site recruitment be coordinated through the Army Office of the Surgeon General (OTSG). In MAY-11, representatives from OTSG began joining weekly planning meetings, and they subsequently reached out to representatives from the Western, Southern, and Northern Regional Medical Commands (RMC). Based on these conversations, possible sites were narrowed down to include Fort Campbell, Fort Carson, Fort Hood, and Fort Stewart, all of which are under either the Western or Southern RMC. Formal tasking could not occur until after the IRB approval process was completed. On 9-SEP-11, OTSG sent a Tasking to the Western and Southern RMCs after receipt of IRB approval from MRMC. Fort Campbell, Fort Stewart, and Fort Carson were selected based upon number of available providers and anticipated Service member PDHRA throughput during the data collection period.

Development of Training Materials

As of this reporting, the training and all associated research measures have been fully developed. Key communication strategies that contribute to patient-centered care were identified from the literature review and tailored to the structure of the PDHRA interview through analysis of recorded PDHRA interviews collected during Vanderbilt's previous study and consultation with PDHRA experts.

The one-time, four-hour training will be interactive rather than didactic in nature, and will include the following segments:

1. **Brief orientation.** A 15-minute orientation will set the stage for the remainder of the training.
2. **Facilitated discussion incorporating audio case examples derived from actual PDHRA interviews**. This portion of the training will last approximately one hour and 15 minutes. Details of this segment are provided below.
3. **Break (10 min)**
4. **Group observation and facilitated discussion of four simulated patient interviews.** This portion of the training will last approximately two hours. Details of this segment are provided below
5. **Debriefing and closing comments.** Approximately 20 minutes at the end of the training will be reserved for "debriefing," including asking each provider for a commitment to try two of the strategies covered in the workshop.

See Appendix D for a more detailed explanation of training content and structure.

Audio Case Examples

The intent of the audio case examples is to spark discussion about when and how to use the key communication strategies outlined above. Audio case examples were derived from actual PDHRA telephone interviews recorded in 2009, with minor modifications made when necessary (e.g. changing a provider's terminology so that it is reflective of 2011 standard

procedures). No identifying information is included in the call clips, and actors were employed to reenact the content to be used in the training; at no point will providers hear any actual PDHRA interviews. See Appendix E for transcripts of the audio case examples.

Simulated Patients

Intent and Process. The simulated patients will be the core instructional tools used during the training. The intent is to give providers an opportunity for applied practice with communication skills covered in the training. For each simulated patient, one volunteer will spend approximately ten minutes conducting a PDHRA interview in real time via a video link. The simulated patient will be located at Vanderbilt, and the provider will see the simulated patient on an iPad screen, while a larger projection of the screen image will be visible to other providers in the group. The volunteer and all observing providers will also be given copies of the simulated patient's completed DD Form 2900. After each interview is complete, approximately twenty minutes will be dedicated to group discussion and feedback. During this time, the iPad may be passed among observers, so that they can try out their own ideas for communicating with the SP. At the end of the discussion period, the simulated patients and/or the training facilitators will share additional information that was not elicited during the interview, along with guidance on what providers might have done to persuade them to share this information during the initial interaction.

Development. Simulated patient cases were developed collaboratively by the Vanderbilt research team and the Vanderbilt Center for Experiential Learning and Assessment (CELA), which specializes in simulated patient development and training. At the beginning of the development process, CELA described simulated patient training procedures and outlined the type of information that would be necessary to train realistic Soldier simulated patients. Vanderbilt subsequently participated in several meetings with PDHRA and Army mental health clinicians (See Appendix F). In these meetings, military providers shared rich detail on the presentation, history, and background of several patients who had experienced post-deployment mental health problems. (These cases were composites based on real people, with details altered to ensure protection of privacy). Based on this information, Vanderbilt developed four simulated patient cases, each of which includes a completed DD Form 2900, a summary sheet, and a longer description of the case, which outlines expected simulated patient responses to a variety of statements that providers conducting the interview might make. Vanderbilt also developed supplemental simulated patient training materials that include information on typical deployment experiences, military acronyms, and other military-specific information that actors portraying Soldiers may need to know. After receiving these materials, CELA finalized the cases and distributed the materials to the actors chosen to portray these Soldiers. CELA and the Vanderbilt research team trained the simulated patients during the week of 5-SEP-11, making minor case clarifications as needed. Additional training and feedback are planned for the simulated patients throughout the active training period.

The simulated patients portray Soldiers who are diverse in terms of age, gender, and rank, and they are varied in terms of demeanor, problems experienced, willingness to disclose problems, and willingness to accept referrals. Comprehensive case materials for each simulated patient, including completed PDHRAs, are attached as Appendix G."

Measures Development

As noted above, analysis of audiotapes will no longer be used to measure success of the training. However, the provider and Service member survey measures described in the original research design were all developed during Year 2, as was a PDHRA Program Manager Interview. Brief descriptions of each measure follow, and the full instruments are attached as Appendices H-M.

1. **A pre-workshop self-efficacy survey to be completed by providers before the training.** This instrument contains questions regarding provider demographics and background. It also assesses provider self-efficacy, knowledge, and attitudes relevant to patient-centered communication. Items from Parle's communication self-efficacy scale (Parle, Maguire, and Heaven, 1997; Ammentorp, Sabroe, Kofoed, and Mainz, 2006) and the previously validated Physician Belief Scale (Ashworth, Williamson, and Montano, 1984) are incorporated in this instrument along with items developed by Vanderbilt. (See Appendix H).
2. **A workshop evaluation to be completed by providers after the training.** This instrument includes questions about the perceived quality and utility of the training. (See Appendix I).
3. **A post-workshop self-efficacy survey to be completed 2-3 days after the training.** This instrument is similar to the pre-workshop provider survey. However, in the post-workshop instrument, the background questions are omitted and questions that assess the extent to which providers used the communication tools covered in the training have been added. (See Appendix J).
4. **A brief, 3-item form to be completed by providers after each PDHRA encounter.** Providers will use a Likert Scale to report the following: 1) whether the Service member reported mental health symptoms during the interview that were not reported on DD Form 2900, 2) the degree to which the provider believes the Service member accurately reported all mental health symptoms during the interview, 3) whether the provider believes the Service member could benefit from further evaluation for mental health symptoms. (See Appendix K).
5. **A semi-structured interview to be conducted with the PDHRA program manager at each installation before the training.** Program managers will be asked for information regarding general PDHRA background and implementation, typical Service member pre-briefing and education, command support, referral processes at the installation, provider training, and general barriers and facilitators of the PDHRA process. (See Appendix L).
6. **A brief, voluntary satisfaction survey to be completed by Service members after the PDHRA interview.** This anonymous survey will examine Service member satisfaction with the provider, Service member reported disclosure of mental health concerns, Service member intent to comply with referral, and Service member attitudes towards disclosure and health-seeking. Items are derived from the Service

member survey Vanderbilt administered and validated in its previous DoD study as well as from the previously validated Physicians' Humanistic Behaviors Questionnaire (PHBQ)(Weaver, Walker, and Degenhardt, 1993)and the Communication Assessment Tool (CAT) (Makoul, Krupat, and Chang, 2007). Several entirely new items were also added to elicit responses in areas specific to the PDHRA process. (See Appendix M).

Problems and Circumstances that Necessitated Changes to Task

Approvals and Recruitment Logistics

In the original SOW, site selection was scheduled to take place before IRB and MRMC approval of the intervention study protocol. However, during Year 2, Vanderbilt learned that OTSG could not send a Tasking to recruit sites until final approval was received. This process took approximately three months (as described in Task 1), during which only limited site coordination could take place.

Time Concerns

The original SOW stated that the provider communications training would be eight hours in length. However, our collaborators at FHP&R expressed concern that this would be too long for providers to be absent from other duties. Consequently, the proposed intervention was shortened to four hours. The ongoing feedback component described in the original SOW was also determined to be too time-intensive; therefore feedback on communication with simulated patients will be given during the training.

Year 1 Delays

See Task 1 for a description of Year 1 delays that affected the timeline for training development.

Outcomes and Next Steps

The training and research design are both now fully developed, and trainings will be conducted according to the schedule shown in Table 4.1. After all workshops are complete, Vanderbilt will receive electronic records related to PDHRA and health care encounter data and will begin analysis of the training's effectiveness.

Table 4.1—Training and Data Collection Schedule with Estimated Soldier Throughput

	W 19-Oct	TH 20-Oct	F 21-Oct	M 24-Oct	T 25-Oct	W 26-Oct	TH 27-Oct	F 28-Oct	. . .	M 7-Nov	T 8-Nov	W 9-Nov	TH 10-Nov
Fort Campbell (6-7 providers)	175	175	175	**AM: Training** PM: 70	175	175	175						
Fort Stewart (9 providers)				310	310	AM: 130 **PM: Training**	310	310					
Fort Carson (4 providers)										134	134	**AM: Training** PM: 100	300

= Training = Data Collection (number indicates estimated Soldier throughput).

Task 5. Expert Panel Meetings (Y2, M2, 11)

Overview

The purpose of the Expert Panel meetings is to ensure that intervention development is fully informed by the needs and resources of all Service Branches and Components. The subtasks for Year 2 listed under Task 6 in the original SOW are as follows:

- 5a. Four-hour in-person meeting in Washington DC (Y2, M11)
- 5b. Two-hour teleconference call (Y2, M2).

Status

A ninety minute teleconference call among FHP&R, the Expert Panel, and Vanderbilt was initially scheduled for 08-OCT-10, but was cancelled due to a joint FHP&R and Vanderbilt decision to conduct further work on the intervention design before asking the Expert Panel to devote time to the development process. Following extensive development, Vanderbilt invited the Expert Panel to review and electronically comment on a description of the proposed intervention's design and content. The review period lasted from 14-JAN-11 to 24-JAN-11, after which Expert Panel feedback was used to inform further development of the training. On 15-SEP-11, the final training plan was presented to the Expert Panel during a ninety-minute teleconference call. (See Appendix D to view slides used in this presentation).

During the later stages of training development, Dr. Ivan Covas –Maldonado and COL Heidi Terrio joined the Expert Panel. Both were added during AUG-2011, following extensive contributions to the development of the simulated patients and other training materials. The updated membership roster is included as Appendix N, and Expert Panel teleconferences are listed in Appendix F.

Problems and Circumstances that Necessitated Changes to Task

As described previously, the development of the training and feedback intervention design was delayed due to the need to better understand the implications of the NDAA Section 708 legislation. This has made it necessary to change the timing of originally planned Expert Panel meetings. In addition, due to the busy schedules of the Expert Panel members, it was determined that shorter meetings (ninety minutes instead of two to four hours) and email correspondence scheduled as needed would improve participation.

Outcomes and Next Steps

Throughout Year 2, contributions from the Expert Panel have helped shape training development, and Vanderbilt has made further revisions to the training based on feedback received at the 15-SEP-11 meeting.

The study's two new Expert Panel members both bring extensive knowledge and experience related to post-deployment health screening. Over the course of several teleconferences, Dr. Covas helped Vanderbilt develop realistic simulated patient cases for use during the training (See Task 4). COL Terrio also contributed to this development, and additionally provided guidance on PDHRA policies and procedures.

After the training has been conducted, it is anticipated that the Expert Panel will continue to provide input as Vanderbilt interprets the data.

Task 6. Project Planning Meetings (Y2, All months)

Overview

The planning meetings outlined in Task 6 are intended to ensure that both the development of the intervention and the resolution of any problems that might arise can be dealt with in a collaborative fashion by VU, FHP&R, and PU . The subtasks for Year 2 listed under Task 6 in the original SOW are as follows:

- 6a. Weekly one-hour teleconference calls (Y2, all months).
- 6b. Three one-day intensive project meetings to be held at FHP&R in Washington, DC (Y2, M2, 6, 11).

Status

Weekly one-hour teleconference calls with FHP&R were held as planned during Year 2. Calls were productive, and as planning for the intervention progressed, representatives from the Army OTSG and the RMCs began participating regularly. Additional teleconferences were scheduled as needed, supplemented by frequent email communication. A table of all external meetings (project planning meetings, Expert Panel meetings, and other assorted meetings) is included as Appendix F. In addition to these meetings, the Vanderbilt research team meets internally at least once each week.

By mutual decision between Vanderbilt and FHP&R, one-day, in-person planning meetings at FHP&R were not held during Year 2. Instead, additional teleconferences with FHP&R were scheduled as needed, and in-person planning meetings were held between the Vanderbilt research team and the other facilitators who will deliver the training.

Problems and Circumstances that Necessitated Changes to Task

Scheduling difficulties led Vanderbilt and FHP&R to conclude that teleconferences provided a better venue for planning than did all-day meetings. The rapidly evolving nature of NDAA, Section 708 also contributed to this decision, as work undertaken during the first part of Year 2 was frequently overcome by events. Replacing the three proposed in-person meetings with multiple shorter meetings allowed training development to move forward while reducing the risk that large portions of work would subsequently become irrelevant.

Outcomes and Next Steps

The weekly meetings have allowed Vanderbilt to receive frequent updates regarding military and government factors influencing the design of the intervention, and have also provided a venue for ongoing collaboration. It is anticipated that project planning meetings will continue weekly and as needed during the period of training administration and data analysis in Year 3.

Task 7. Preparation of Final Reports (Y2, M11-12)

Overview

Final reports and briefings are to be prepared according to guidelines and requirements set forth by the granting agency.

Status

Final reports will be submitted at the end of Year 3, the no-cost extension year approved by MRMC on 03-May-11. Vanderbilt did present project work completed to date at Military Operational Medicine's Posttraumatic Stress Disorder Research In Progress Review Meeting on 2-FEB-11 (See presentation slides in Appendix O).

Outcomes and Next Steps

After the training has been conducted, data management and analysis will begin. The culmination of this process will be the Final Report submitted to MRMC. MRMC has approved Vanderbilt's request to create a Final Report that is predominantly comprised of articles submitted for publication to academic and professional journals.

Purdue University Scope of Work (SOW) Tasks

Task 1. Analysis of merged VHA and DoD data (Y2, M1-4)

Overview

Purdue personnel will analyze the merged dataset in accordance with the specific aims of the Purdue secondary analysis.

Status

We established procedures for data transfer between AFHSC and the VA in order for the VA to receive the list of eligible subjects and for the AFHSC study ID to be attached to the VA data. Aimee Mayeda at the VA has received the list of eligible subjects and a data manager has written the necessary Statistical Analysis Software (SAS) programs to download the VA data from the VHA national data repository. Sarah Mustillo at Purdue has received the AFHSC data from Vanderbilt and is, with a research assistant, cleaning, coding, and analyzing the PTSD and health care encounter data. For example, we have models that examine the predictors of positive PTSD screen in PDHA and PDHRA based on the explanatory variables specified in the proposal. We are cleaning and recoding the health care encounter data in order to examine subsequent PTSD diagnoses during inpatient and outpatient encounters.

Problems and Circumstances that Necessitated Changes to Task

Although we completed all known steps to obtain Department of Veterans Affairs (VA) approvals in Year 1, an additional approval came to our attention when we attempted the actual data download. That is, the system would not let us complete the download until we had one more approval. Hence, we submitted the necessary paperwork and are now

waiting for the approval. Once we receive it, we can complete the download and merge the data.

Outcomes and Next Steps

Once we receive the final VHA approval, we can complete the download, send the encrypted file to FHP&R for study ID attachment, and merge the VHA data with the AFHSC data. For now, we have been building models addressing our specific aims in the AFHSC data by itself that we can rerun once the VHA data are merged.

Task 2. Purdue personnel will write a report for DoD, summarizing key findings and submit manuscripts to professional journals (Y2, M5-12)

Overview

Sarah Mustillo and her research assistant will write a report of their findings for the DoD as well as manuscripts for publication in professional journals. Sarah Mustillo will travel to Washington DC to consult with DoD personnel, present key findings, and receive input on analyses as necessary. Sarah Mustillo also will present at least one manuscript at a research conference.

Status

Sarah Mustillo and her research assistant have updated their literature review on PTSD in the military by reviewing studies that have come out since 2007 (See Appendix P). Relevant sections of the literature review can be easily incorporated into the final report to DoD and into manuscripts.

Problems and Circumstances that Necessitated Changes to Task

Because PU received the data in Y2, M8, and has yet to receive the VHA data, we have not written reports or manuscripts.

Outcomes and Next Steps

We will continue to analyze the data we have and will complete analyses when we receive the VHA data. Once analyses are complete, we will write a report summarizing the findings for DoD and draft manuscripts for journal publication and a conference presentation to disseminate findings with DoD approval.

KEY RESEARCH ACCOMPLISHMENTS

- **Data Management.** Vanderbilt received all data for secondary analysis on 6-JAN-11, and has so far been able to accomplish the following tasks:
    - For the Army data, provider ID and MTF ID data have been cleaned and merged with the PDHRA data.

  - Preliminary analysis focusing on the investigation of the role of provider and location in PDHRA outcomes has begun for these data.
- **Training Development.** In spite of delays, Vanderbilt completed development of a four-hour communications training for PDHRA providers. Specific accomplishments related to training development include the following:
  - Key communication strategies tailored to the PDHRA interview that were identified based on analysis of Vanderbilt's previous PDHRA research, on literature review, and on conversations with experienced PDHRA providers.
  - In lieu of focus groups, Vanderbilt participated in informal conversations with PDHRA providers at two Army installations in order to better understand PDHRA interview logistics and content.
  - Four detailed simulated patient cases were constructed, and the actors who will portray the simulated patients were trained. (See Appendix G)
  - Five audio case examples were developed from recordings of actual PDHRA telephone interviews, with resulting transcripts recorded by actors for use in the workshop. (See Appendix E)
- **Research Design**. During Year 2, Vanderbilt finalized development of the research design that will be used to assess the impact of the communications training. (See Appendix A).
- **Measure Development.** Five survey instruments and one semi-structured interview were developed and approved by Vanderbilt's IRB and MRMC during Year 2. (See Appendices X-Y)
  - A pre-workshop self-efficacy survey to be completed by providers before the training.
  - A workshop evaluation to be completed by providers after the training.
  - A post-workshop self-efficacy survey to be completed 2-3 days after the training.
  - A brief, 3-item form to be completed by providers after each PDHRA encounter.
  - A semi-structured interview to be conducted with the PDHRA program manager at each installation before the training.
  - A brief, voluntary satisfaction survey to be completed by Service members after the PDHRA interview.
- **Literature Review.** Relevant literature review has been conducted by both Vanderbilt and Purdue, which will improve our ability to meet the stated project aims.
- **Approvals.** Almost all approvals and IRB processes were completed for both Vanderbilt and Purdue. The exception is an unexpected approvals process that must be completed before Purdue has full access to the Veteran's Administration (VA) data.

- **Expert Panel.** Two new members have been added to the Expert Panel. One meeting was held, and additional email correspondence and break-out meetings occurred with individual members.
- **Planning Meetings.** Project planning meetings were held as scheduled.
- **Purdue Items.** In spite of delays in receiving the data, Purdue has accomplished the following tasks:
    - Established procedures for data transfer between FHP&R and the VA.
    - Began cleaning, coding, and analyzing the PTSD and health care encounter data.

REPORTABLE OUTCOMES

To date, two abstracts have been accepted for presentation at upcoming conferences, with additional manuscripts for presentation and publication being planned. The scheduled presentations focus on findings from secondary analysis (Task 3) and highlight the need for and potential benefits of communications training for PDHRA providers. The abstracts are included as Appendix C. Planned manuscripts will build on this work and focus on outcomes of the training.

Kelley, S.D., Boyd, S.D., Perkins C.E., Hargraves, R.P., Leslie, M.W., Bickman, L., (October, 2011). *Communication Patterns During Health Screening Interviews with a High Risk Population.* Oral presentation at the International Conference on Communications in Healthcare, Chicago, Illinois.

Leslie, M.W., Kelley, S.D., Hargraves, R.P., Boyd, S.D., Davis, L., and Bickman, L. (November, 2011). *Evidence of Under-reporting of Behavioral Health Problems by High-risk Individuals during a Standardized Screening*. Oral presentation at the American Public Health Association Annual Meeting, Washington, DC.

CONCLUSIONS

Progress in completing planned Year 2 SOW activities has been delayed due to two main circumstances: (1) delays in completing an agreed upon data use agreement for data required to complete analysis relevant to intervention design (a Year 1 delay that affected activities in Year 2) and (2) the rapidly evolving nature of the 2010 NDAA Section 708 legislation implementation, which directly impacted the study design (largely a Year 1 circumstance, but a continued source of delay during the first part of Year 2). In order to ensure that our intervention and study design did not either duplicate or contradict the new PDHRA processes required by NDAA Section 708, it was necessary for us to alter our SOW, and to request a one-year no-cost extension to the period of performance. Both of these were approved in MAY-11.

In spite of the delays, substantial work has been accomplished during Year 2. We have received and begun cleaning the secondary data from AFHSC, and have finalized development of the research design and communications training. We have also scheduled dates for the training and associated data collection to be conducted at three Army installations. Year 3 is expected to be highly productive. We will complete training delivery and active data collection at all three study sites by 10-NOV-11, and will immediately begin cleaning that data while initiating our requests for PDHRA, PDHA, and health care encounter data with the appropriate entities. During Year 3 we will conduct extensive analysis and will prepare manuscripts based on our findings. We will also continue our secondary analysis of previously received PDHRA data, and will be presenting preliminary findings from that analysis at two conferences during the first quarter of Year 3.

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Appendix A: Revised Research Design

IMPROVING DEPLOYMENT-RELATED PRIMARY CARE PROVIDER ASSESSMENTS OF PTSD AND OTHER MENTAL HEALTH CONDITIONS

Award #: W81XWH-09-2-0172

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REVISED RESEARCH PLAN FOR REVIEW AND APPROVAL

March 10, 2011

BACKGROUND AND SIGNIFICANCE

Military personnel returning from overseas deployment are at increased risk for a wide range of physical and mental health problems. To screen for such difficulties and to refer Service Members (SMs) in need of focused clinical evaluation and care, the military departments conduct two post-deployment health risk assessments. The *Post-Deployment Health Risk Assessment (PDHA)* (DD Form 2796, see Appendix A) is administered as close to the redeployment date as possible—within 30 days before SMs depart an overseas assignment or within 30 days after they return to home station. For Reserve Component members, the PDHA must be conducted before they are released from active duty. The *Post-Deployment Health Reassessment* (*PDHRA*) (DD Form 2900, see Appendix B) is conducted within 90 to 180 days of redeployment. Item contents and clinical procedures for the PDHA and PDHRA are closely parallel. Each entails multi-stage processes requiring that the SM complete a self-report assessment of physical and emotional symptoms, experiences with several aspects of combat, and exposures to a variety of environmental and chemical agents while in the combat zone. Following this, the SM is individually evaluated by a trained health care provider and is given education and informational materials relevant to his or her concerns. Health care providers also make referrals for further evaluation and follow-up treatment on the basis of clinical judgment.

There are concerns about SM under-reporting of mental health issues on the Post-Deployment Health Reassessment (PDHRA)

In our previous study (Bickman et al., 2009), anonymous surveys were collected from SMs completing the PDHRA process. A substantial minority (10-14%) of SMs admitted to underreporting physical, emotional, and alcohol use problems on the PDHRA. More than a third (39%) of SMs agreed that they had experienced an emotional, alcohol, stress, or family problem since returning from deployment or that family or friends had suggested they seek help for such a problem. However, almost half (43%) of these SMs did not report any such problem on the PDHRA form. Further, these unreported problems were usually not uncovered (i.e., documented) by the health care provider during the interview. That is, providers documented five times fewer major concerns and three times fewer medical referrals for those who did not disclose problems on the assessment form versus those who did disclose.

Reasons for under-reporting could include concerns about stigma or barriers to care (e.g., perceived lack of effective treatments). Hoge et al. (2004) reported that only half of those who screened positive for a mental disorder sought mental health care. Furthermore, SMs who screened positive for a mental health problem were twice as likely as those who did not to endorse concerns about stigma and barriers to care.

We found that measures of perceived stigma and barriers to care were higher for SMs who reported on an anonymous survey that family or friends had suggested they seek

help or confidentially reported an emotional, alcohol, stress, or family problem since returning from deployment. These SMs also reported lower satisfaction with the PDHRA provider, less post-deployment support and help seeking, and less general willingness to self-disclose (Bickman et al., 2009).

The provider interview is an important opportunity to identify previously unreported behavioral health issues

During the PDHRA process, the provider interview offers the opportunity for providers to reduce concerns about stigma or barriers to care. However, audio recordings of telephone PDHRA interviews that were coded for content and socio-emotional exchange suggest there is substantial room for improvement, especially regarding mental health issues. We found that providers were less likely to explore behavioral health issues than physical health issues (Bickman et al., 2009). Physical health was almost always mentioned, regardless of SM endorsement on the self-report (87% v 84%), but behavioral health topics were mentioned more when SMs endorsed concerns (64%) than when no concerns were endorsed (35%). Furthermore, we found that education related to behavioral health issues was provided in only 14% of all calls, although this increased to 24% in calls where a medical referral was given. Finally, we found that communication strategies to elicit more self-disclosure were lacking. For example, providers asked five times more closed-ended than open-ended questions, and rapport building statements (e.g., empathy, legitimation) occurred in less than 6% of calls.

For appraisal processes that include a self-report questionnaire and clinical assessment, like the PDHRA, the sensitivity and specificity for the individual components have not been established (Rona, Hyams, & Wessely, 2005). The success of the PDHRA process in helping SMs receive further evaluation where warranted depends on both the SM and the provider. For example, whether the SM self-identifies on the self-report depends on awareness, willingness to disclose, environment specific factors (e.g., leadership support), and understanding of the questions on the form. The provider interview adds the opportunity to identify SMs in need of assistance based not only on the self-report, but also the provider's evaluation of the SM's presentation during the interview. This is especially useful for items where SMs are reluctant to report because of perceived stigma, such as with mental health issues. Yet, evidence suggests that the provider interview does little to increase sensitivity of the process. After accounting for the number of problems areas endorsed by SMs, provider documented concerns made only a small contribution to predicting who received a medical referral. The number of problem areas endorsed by the SM explained 20% of the variance in medical referrals; adding provider major concerns as documented on the PDHRA explained an additional 7% of variance. While this leaves a large percentage of variance unaccounted for, the main point here is that the SM-reported problems are the main predictor of a referral, with the clinical interview as documented on the PDHRA adding a relatively small contribution (Bickman et al, 2009).

Improved provider communication skills could enhance the quality of the PDHRA interview

Research in a broad range of areas indicates that patient-provider interactions can be enhanced by attention to training in interpersonal communication patterns (e.g., active listening). Providers who have received training on interpersonal communication skills provide more medical counseling (Brown et al., 2000), elicit more information and concerns from the patient (Joos et al., 1995; Rao et al., 2007; Langewitz et al., 1998), exhibit greater facilitative communication and information giving (Kim et al., 2002; Rao et al., 2007), ask more open ended questions, ask patients for opinions more frequently, give more biomedical information, have less negative affect (Levinson & Roter, 1993), show improved overall communication skills (Back et al., 2007; Roter et al., 2004; Helitzer et al., 2010; Rao et al., 2007; Roter et al., 1995; Fallowfield et al., 2003), and receive higher patient satisfaction ratings (Rao et al, 2007; Frosthom et al., 2005).

Patients visiting providers who have received training in interpersonal skills communicate more during the interaction (Brown et al., 2000), disclose more medical and psychosocial information (Brown et al., 2000; Levinson & Roter, 1993), are more satisfied with the provider (Brown et al., 2000), perceive receiving more information from the provider (Joos et al., 1995; Rao, 2007), and report reductions in symptoms and impairment (Wissow et al. 2008) and in emotional distress (Roter et al., 1995).

It should be noted, however, that most of the research in this area has been conducted with general practitioners; the applicability to a brief assessment interview warrants further consideration.

Characteristics of a good communications training intervention

There are at least 6 indicators of a quality communication skills training (Maquire and Pitceathly, 2002):

1. Provide evidence of current deficiencies in communication, reasons for them, and the consequences for patients and doctors
2. Offer an evidence base for the skills needed to overcome these deficiencies
3. Demonstrate the skills to be learned and elicit reactions to these
4. Provide an opportunity to practice the skills under controlled and safe conditions
5. Give constructive feedback on performance and reflect on the reasons for any blocking behavior
6. Provide ongoing support and encouragement

Intervention intensity is also important. Many effective training programs are moderate to high intensity, involving at least one day of initial training (Fallowfield et al., 2003; Levinson & Roter, 1993; Rao et al., 2007). Shorter trainings are often not effective or less effective (Cheraghi-Sohi & Bower, 2008; Levinson & Roter, 1993; Joos et al., 1995).

Intensity of the training is not just associated with length, but also with the level of experiential learning and interactivity of training strategies. Indeed, focusing on length may be confounded by the typical didactic nature of shorter trainings. A recent review indicates that didactic training (e.g., typical CME workshops) is less effective than mixed didactive and interactive workshops for improving health care provider practice and health care outcomes (Forsetlund et al., 2009). Some specific components of successful training include providing the evidence base for the suggested skills, the use of role play and/or simulated patients, modeling (i.e., positive and negative examples), and allowing participants to explore their own feelings regarding the desired skills (Merckaert et al., 2005; Aspegren, 1999).

PROPOSED STUDY CHANGES FOR APPROVAL BY MRMC

The current study is consistent with the original aims as proposed in the approved award. However, there are modifications to the timeline and design due to delays caused by intervening events as described in the first year report. Below is a summary of the two primary challenges faced by the team:

1. 2009 NDAA legislation (Sec. 708) mandated substantial revisions to the health risk appraisal process and instituted new requirements for provider training. As of this writing, the NDAA training slides are available online, but the video is still being developed (and thus unavailable for review). Further, the Army is currently piloting the secondary stage screening forms. Our study can proceed regardless of whether the new NDAA requirements are implemented at study sites or not. Our pilot is anticipated to occur in June-July 2011.
2. Substantial delays have been experienced in receiving data from the Armed Forces Health Surveillance Center (AFHSC) required by Vanderbilt and Purdue to complete secondary analyses relevant to Aim 1. A data use agreement (DUA) was signed by all parties on 14-JAN-10; however, as described in detail in the first year report, Vanderbilt did not receive the data from AFHSC until 06-JAN-11. An issue has arisen concerning linking data from VA and AFHSC, but a solution has been found and efforts are underway to begin the linking process.

Following is a summary of the proposed modifications to the previously approved Scope of Work (SOW) timeline and/or tasks for review and approval by MRMC. **There are no cost changes associated with these modifications.**

Proposed Modifications to Aim One to Be Approved

The intent of the tasks for Aim 1 remains the same, to determine key elements of a training program for providers conducting deployment-related assessments. The three proposed changes are:

1. Eliminate the focus groups with key stakeholders involved in the PDHRA process. The justification for this change is to allow the project to complete data

collection by SEP-11. As described in the first year report, focus groups were not conducted during the first year of the project due to the impact of the evolving nature of the NDAA Sec. 708 training. We believe that the thorough literature review, informal conversations with key PDHRA personnel, and guidance by the Expert Panel are sufficient substitutes.

2. Incorporate the potential effects of the NDAA Sec. 708 training into the intervention design by making pilot training content consistent with (and expanding upon) the portion of the NDAA online training slides available on 3-FEB-11 that addresses the therapeutic rapport between SM and provider (particularly slides 41-43 available at http://fhpr.osd.mil/pdfs/NDAA%20FHP_DHCC.pdf).

3. Extend the timeline for the secondary analysis of data conducted by Vanderbilt and Purdue Universities through the no-cost extension year (to SEP-12). The justification for this change is to allow adequate time for analysis and interpretation of these highly complex datasets. To the degree possible, any results will be used to inform the intervention (Aim 2) as it is developed. Results will be incorporated into the final report to inform interpretation of the results of new data analyses conducted for this study.

Proposed Modifications to Aim Two to Be Approved

The intent of the tasks for Aim 2 remains the same, to evaluate the feasibility and effectiveness of a pilot training program. The three proposed changes are:

1. Simplify the research design to the interrupted time series with non-equivalent comparisons as described in the remainder of this document. The simplified design also uses survey methods to assess outcomes rather than intensive coding of audiotaped PDHRA interviews. This change allows for a shorter time period for data collection and fewer providers needed for minimum power to detect medium effect sizes. The justification for this change is to allow the project to complete data collection by SEP-11.

2. Incorporate the potential effects of the NDAA Sec. 708 training into the study design by: (a) collecting data from FHP&R on provider completion of the online NDAA training for providers involved in the study (if feasible); and (b) incorporating questions about NDAA-related implementation in study measures (e.g., the PDHRA program manager interview, the provider background form). Even though providers may not be required to complete NDAA training until after Vanderbilt's study is complete, we still need to track whether providers had been exposed to the training if we are to control for its effects during the study. Exposure to the training may moderate effects due to our intervention.

3. Extend the timeline for analysis of data, interpretation of results, and report-writing through the no-cost extension year (to SEP-12).

RESEARCH AIMS

Aim 1: Determine key elements of and short term impact of training programs for deployment related assessments. The focus will be on guidance related to eliciting more candid reporting of behavioral health concerns, identification of behavioral health concerns that warrant referral and motivating the SM to accept a referral for further evaluation and/or treatment for behavioral health conditions and concerns. This aim will be accomplished through (a) Expert Panel review of results from 2007-2009 VU-FHP&R collaboration to determine criteria for clinical competencies; (b), review of the NDAA Sec. 708 training to assist in identifying key elements for training interventions relevant to content, format, and implementation and,(c) secondary analysis of PDHRA data from a specifically developed database that includes provider and military treatment facility (MTF) identifiers that will allow identification of variability in concerns and referrals attributed to the provider, over and above SM self-reported problems. In addition, Purdue will conduct a secondary analysis of DoD and VA data to identify PDHRA variables associated with the development of and recovery from PTSD.

Note that the remainder of this document focuses on Aim 2 as the primary study.

Aim 2: Evaluate the effectiveness of a targeted training and feedback program on primary care provider's interview and clinical communication patterns related to SM behavioral health condition identification and referrals. A training workshop that incorporates experiential learning strategies and evidence-supported characteristics of high quality communication training programs will be piloted with a group of approximately 10 providers who conduct PDHRAs at two to three sites. All providers at the intervention sites who agree to participate in the study will participate in the training. As an interrupted time series design, each provider will serve as his/her own control through the administration of measures and collection of existing data sources (e.g., PDHRA) for a time period prior to and following the training. The use of a time series approach will allow us to determine the influence of the communication training as a main effect as well as account for threats to validity, such as changes that occur over time independent of the intervention.

Implementation will be measured through training attendance records, evaluations completed by the providers, and study team observations and recorded notes of the training. Potential moderating variables will be measured through a provider background form (e.g., professional background, demographics, self-efficacy in patient-centered communication), a PDHRA program manager interview (e.g., typical PDHRA processes, existing training programs, etc.), and analysis of secondary data of electronic records (PDHA, provider completion of the NDAA online training and related test scores). Outcome measurement will include brief post-PDHRA surveys completed by the

SM (anonymously) and provider immediately after the PDHRA interview and an analysis of secondary data (including electronic records for PDHRA and health care encounters).

In order to further control for threats to external validity, we will also passively collect data from non-equivalent comparison sites. In spite of the short timeframe for data collection (two months), maturation (the passage of time not specific to the event) and history (events that occur between the first and second measurements) are still threats whose potency can be reduced by the inclusion of the comparison sites. Given the additional time and logistics needed and questionable feasibility, and to reduce cost and burden to AFHSC and potential comparison sites, we will not perform active data collection at specific sites, but will instead request data for the study time period (PDHA, PDHRA, HCE, and NDAA training completion and test score data) for *all* Army installations and then choose appropriate comparison sites based on similarity to the intervention sites (see Site Selection, below). This procedure will eliminate the need to create a separate memorandum to the Surgeon General of the Army for recruitment of comparison sites. All data collection at comparison sites will be passive, and will take place over approximately the same time period as data collection for the pilot.

Research questions and hypotheses related to Aim 2 include:

1. Can a brief intervention to enhance communication skills be implemented in the field?
    a. Any increase in the length of the PDHRA interview is within an acceptable range.
    b. Key personnel (i.e., participating providers and program managers) find the intervention to be relevant to their work and acceptable.

2. Will this intervention help providers use the interview as an opportunity to identify SMs in need of assistance for behavioral health problems?
    a. Increased provider concerns and referrals for behavioral health issues documented on the PDHRA.
    b. Higher ratings of SM self-reported disclosure; intent to comply with referral; and ratings of provider patient-centered communication.
    c. Higher ratings of provider-reported elicitation of behavioral health concerns.
    d.

INTERVENTION DESIGN: COMMUNICATION TRAINING WORKSHOP

Format

VU will arrive at the site 2-3 days prior to the intervention to collect data pre-training. The trainer will arrive on site on the 3rd day to deliver the training workshop. VU would remain on site 2-3 days post intervention to collect post-training data.

The workshop content will be tailored to the PDHRA encounter and will be informed by the communications skills presented in the NDAA training, as well as published literature on best practices in patient centered communication techniques (see Table 1, below).

The workshop will last approximately 4 hours and will include established quality techniques, such as establishing need for training, eliciting provider experiences/ frustrations, introducing and demonstrating skills, group discussion, and providing the opportunity to practice and receive feedback. The practice will occur in the form of either role play or interaction with a standardized patient (SP).

TBD - Possibility of individualized feedback

Providing individualized feedback and consultation is an established method for enhancing training effects. This could be in the form of a follow-up consultation by telephone to review actual cases with providers and their experience in implementing communication skills. A second option is to have providers interact with a standardized patient as part of the training, and to receive feedback on the interaction from both the SP and the trainer. Because it is time consuming, this interaction would take place separately for each provider and would add one hour to the training per provider (5 hours total).

Topics Covered

While the specifics of training content are still being developed, we have identified the communication behaviors that the training will aim to improve. These are divided into "Context-Free" and "Context-Specific" behaviors. By context-free, we mean provider communication behaviors that do not apply to any specific area of the PDHRA, but rather are viewed as consistent with a patient-centered approach. By context-specific, we mean provider communication behaviors that are specific to the PDHRA process. The purpose of the PDHRA is to increase SM access to care *where warranted* and provide documentation of deployment-related concerns. Published material available on pdhealth.mil and elsewhere states four primary objectives for the PDHRA: (1) Clarify and confirm SM responses on DD Form 2900; (2) Educate SMs about concerns, healthcare, and treatment options; (3) Conduct a risk assessment; and (4) Make referrals for further evaluation where warranted. We intend to target several provider communication behaviors that are consistent with the patient-centered approach and that expand upon these four PDHRA objectives. Table 1 summarizes both context-free and context-specific target behaviors.

Table 1: Training Content Summary

Context-Free Communication Behaviors	
Behavior Targeted	**Example**
Increasing use of open-ended questions*	"What symptoms are you having right now?"**
Listening	Decrease in ratio of provider talk to SM talk
Expressing empathy	"That would be depressing."
Showing concern	"I'm glad it worked out . . .
Providing reassurance	"There are effective treatments for that."
Legitimizing statements	"It doesn't get any easier."
Asking SM opinion	"Do you want to be seen for that?"
Active listening	Back channeling to indicate interest, e.g. "mmm" or "Tell me more."
Making partnership statements	"I can get that information for you."
Check SM understanding of PDHRA purpose and address concerns about disclosure.	What's your understanding about what you're doing here today?
Partnering in PDHRA process	Explaining the process, what the provider is doing with the form on the computer, what they mark down.
Specifically ask open-ended questions about general well-being at the beginning of the interview including psychosocial issues related to reintegration, PTSD/depression, relationships, and alcohol use regardless of what SM marked on DD Form 2900	• What concerns do you have that I can help you with today? • How are things going since you returned? • Everyone goes through an adjustment coming home. How is it going for you? • Now we've talked about your physical health problems. What about other concerns related to adjusting to being back home, like feelings of being worried or sad or having trouble in relationships?"
Ask specific questions of all SMs who report a problem	• Ask if SM has received treatment or is in treatment • Ask if satisfied with treatment or feels need for further treatment
For all SMs regardless of whether referral is warranted, provide brief statements to legitimize common reintegration concerns	Many soldiers have ups and downs adjusting to being back.
For all SMs, give brief counseling on self-care and self-referral that can be accessed any time	You can always talk to a chaplain or make an appointment on your own with your primary care provider. (Note: could also refer to websites and other resources)
For all SMs who warrant a referral, elicit SM reactions to problem identification/referral recommendation and address concerns/barriers	I'd like to recommend a referral for that; how does that sound to you?
For all SMs who warrant a referral, provide brief education on treatment effectiveness for mental health problems.	There are effective treatments for that. (Note: could also refer to resources in NDAA Sec. 708 training slides if providers are already familiar with it).
For all SMs who warrant a referral, check SM understanding of how to achieve referral	Do you know how to make the appointment for that? or any statement explaining the next step in SRP.
Building therapeutic alliance and bridging of social distance	• Statements that acknowledge cultural differences like civilian provider, deployment experience, leadership support. • Thanking SM for service

**Close-ended questions (e.g., "Have you been screened for PTSD?") and checks for understanding (e.g., "I see that you were in an explosion") will not necessarily decrease, because these are indicative of the PDHRA.*
***Examples in quotation marks are actual provider utterances from de-identified audio-recordings collected during Vanderbilt's previous research (Bickman et al., 2009).*

AIM 2 DESIGN AND METHODOLOGY

The design is an interrupted time series with non-equivalent comparison sites. The intervention will take place during site visits to 2-3 installations. The comparison sites are labeled non-equivalent because we are not randomly assigning comparison and intervention sites to the intervention. The inclusion of comparison sites will allow for measurement of common threats to validity (e.g., Army-wide changes in PDHRA processes that co-occur with the intervention). The interrupted time series data will be collected before and after the intervention so each provider serves as his/her own control.

At all sites, we will be collecting previously existing data (e.g., passive data collection) related to PDHA, PDHRA, health care encounter information, and NDAA training. At the intervention sites, we will be actively collecting data through survey methods and qualitative methods (interviews and observation) as described further below.

Site Selection
This study targets Army installations. The intervention sites will be selected based on number of providers and PDHRA flow through. Also, sites that previously expressed interest in participating (Campbell, Riley, Benning, Carson) will be considered. This introduces the possibility of a "volunteer effect" creating systemic bias. However, because we are only including 2-3 intervention sites, generalizability will be limited in any case. In addition, for a pilot, demonstrating generalizability is less important than maximizing the chances of finding an effect. Using sites that have previously expressed interest is likely to result in higher levels of leadership and provider cooperation, which will increase chances of detecting positive results. After a pilot demonstrates feasibility and effectiveness, questions of whether the intervention is generalizable could be addressed by conducting an evaluation of implementation and effectiveness of the intervention at a broader range of installations.

The non-equivalent comparison sites will be selected from the Army-wide dataset. The data will be evaluated at the installation level for PDHRA flow through, number of providers, and types of units. Then comparison sites will be selected according to comparability with the intervention sites based on these criteria.

Study Sample

Table 2 shows the number of expected/required sites and participants. Previously identified potential study sites and the approximate number of available providers at each are shown in Table 3.

Table 2. Number of expected/required participants.

Participant	Number required/expected to participate	
	Intervention Sites	Comparison Sites*
Site	2-3	At least 2-3
Program Manager	2-3 (One per site)	n/a
Providers	12 total	At least 30
SMs	80 minimum per provider, but ideally as many as possible**	20 minimum***

*Note that data collection at comparison sites will not require active participation since only passive data collection will occur.

** More SMs would be lead to smaller standard errors and narrower confidence intervals (i.e., more precision).

*** 20 SMs would detect a small intraclass correlation (ICC). A significant ICC would indicate that providers differ from each other rather than offering a uniform standard of care.

Table 3. Previously identified installations and number of available providers.

Potential Intervention Sites	Number of Providers
A	4-6
B	3-4
C	16
D	unknown

Recruitment

Sites

Intervention sites will be recruited via a memorandum to the Surgeon General of the Army describing study events in detail and requesting the nomination of sites for participation. The memorandum will be prepared in cooperation with FHP&R. Because only passive data collection will take place at comparison sites, no memorandum to the Surgeon General of the Army will be required for their nomination.

Program Managers and Providers

The responsibilities of Program Managers and providers during the study will be described in the memorandum sent to the Army Surgeon General, and appropriate site personnel will inform these individuals of the tasks involved in participation.

All study procedures will be submitted to the Vanderbilt and MRMC IRBs for approval prior to implementation. Separate IRB protocols will be prepared for the Program Manager interview, and the provider training and survey completion. The Program Manager protocol is expected to be approved as exempt (i.e., not requiring annual

review by IRB) under 45 CFR 46.101(b)(2) (non-identifiable data and minimal risk to subjects). The provider training protocol will be submitted as expedited and informed consent will be obtained from all participants.

SMs

It is expected that SM survey procedures will be submitted as exempt under 45 CFR 46.101(b)(2). All SMs completing the PDHRA process during VU's site visit will be eligible to complete the survey. We expect recruitment will occur during the pre-briefing that SMs are typically given prior to starting the PDHRA process. The recruitment script will be delivered by a VU researcher with a short introductory statement by the site personnel giving the pre-briefing. SMs agreeing to complete the survey would be instructed to do so after completing the PDHRA interview.

Measures

Research measures used in this study fall into three categories: 1) Existing data sources, 2) Vanderbilt-developed quantitative measures, and 3) Vanderbilt-developed qualitative measures. The sections below briefly describe the content and administration details of each measure. For a description of data management issues associated with these datasets, including a summary of how different datasets will be linked to each other, see the Analysis Plan below.

Existing Data Sources

These measures come from pre-existing sources and do not require any additional time commitment from providers or SMs (see Table 4).

Table 4: Existing Data Sources

Data Source	Construct	Respondent	Collected from		Frequency and Collection Period
			Intervention Sites	Comparison Sites	
PDHRA	• SM self-reported symptoms • Provider documented concerns • Provider documented referrals • Demographic variables	SM and Provider (includes provider ID)	**X**	**X**	All PDHRAs completed during the study time period: 4 weeks before and 4 weeks after intervention (8 weeks total) All pre-existing PDHRAs associated with the PDHRAs collected in the timeframe. These data will include a unique StudyID for each SM.
PDHA	• SM self-reported symptoms • Provider documented concerns • Provider documented referrals • Combat exposure	SM and Provider	**X**	**X**	All pre-existing PDHAs associated with the PDHRAs collected in the timeframe described above. These data will include a unique StudyID for each SM.
Health Care Encounter (HCE)	• Dates of encounters, admissions, discharges • Setting of encounters ICD-9 Code (Diagnosis) • CPT Code (Service provided)	n/a	**X**	**X**	All pre-existing HCE associated with the PDHRAs collected in the timeframe described above PLUS an additional six weeks after the PDHRA. These data will include a unique StudyID for each SM.
NDAA training completion and final score*	• Date completed • Post-test score	Provider	**X**	**X**	One time 4 weeks after intervention. These data will include fields for provider service, rank, name, type, and duty station.

Table 4: Existing Data Sources (continued)

Data Source	Construct	Respondent	Collected from		Frequency and Collection Period
			Intervention Sites	Comparison Sites	
DEERS	• Education level • Component at form completion • Race and ethnicity • Unit identification code (UIC).	SM	**X**	**X**	All data associated with the PDHRAs collected in the timeframe described above. These data will include a unique StudyID
Army (MEDPROS)	• Provider ID • Location ID	n/a	**X**	**X**	One time for all intervention and comparison sites
Intervention installations	• Provider ID • Location ID • Form completion date • Form version	n/a	**X**		One time 4 weeks after intervention. These data will include a unique study ID for each SM

* We plan to receive these data from FHP&R. However, if this is not possible due to security restrictions, we will ask individual providers for these data.

Quantitative Measures

There quantitative measures include written surveys to be completed by providers or SMs. All are brief instruments which will require a minimal amount of time for respondents to complete. These measures are summarized briefly in the table below.

Table 5: Quantitative Measures

Data Source	Respondent	Time to Complete	Constructs	Collected from		Frequency and Collection Period
				Intervention Sites	Comparison Sites	
SM Post – PDHRA satisfaction survey	SM	5-10 minutes	• Reported disclosure of mental health (MH) symptoms • Intent to comply with referral (if given) • Attitudes to disclosure and help-seeking • Concerns about barriers and stigma • Previous help-seeking • Self-reported MH concerns • Satisfaction with provider • Rating of provider patient-centered communication	**X**		All SMs completing PDHRAs within 2-3 days pre- and post-intervention (4-6 days total)
Provider post-PDHRA satisfaction survey	Provider	30 seconds	Providers will use a Likert Scale to report on 3 items: • Whether SM reported MH symptoms during interview that were not reported on DD Form 2900 • Degree to which provider believes SM accurately reported all MH symptoms during interview • Whether provider believes SM could benefit from further evaluation for MH symptoms	**X**		Completed after each PDHRA interview conducted within 2-3 days pre- and post-intervention (4-6 days total)

Table 5: Quantitative Measures (continued)

Data Source	Respondent	Time to Complete	Constructs	Collected from		Frequency and Collection Period
				Intervention Sites	Comparison Sites	
Provider background survey	Provider	5 minutes	• Demographic background • Professional experience • PDHRA experience • Self-efficacy, knowledge, and attitudes relevant to patient-centered communication	X		One time prior to intervention
Provider post intervention evaluation	Provider	10 minutes	• Self-efficacy and knowledge relevant to patient-centered communication • Satisfaction with training	X		One time after intervention

Qualitative Measures

Three qualitative measures will also be used during the study and will be administered at intervention sites by members of the Vanderbilt research team.

Program Manager Interview

Before the communication training takes place, a member of the Vanderbilt research team will conduct a twenty minute face-to-face or telephone interview with the Program Manager(s) at each intervention site. This interview will be semi-structured in nature; set questions will be asked of each respondent, and following initial responses, interviewers will use pre-developed prompts to probe for more detailed information. Interviewers will take notes during the interview but will also use digital audio-recorders to ensure greater accuracy and capture of detail. Topically, the program manager interview will focus on several key areas of interest related to the PDHRA process: general PDHRA background, PDHRA implementation, SM pre-briefing and education, command support, referral processes at the installation, background and training of providers conducting PDHRA assessment, utilization management and reporting, and general barriers and facilitators. Program managers at intervention sites will also be asked to provide feedback on the intervention's feasibility and effectiveness in a second semi-structured interview to take place after the intervention.

Observation of Training Sessions

Members of the Vanderbilt research team will observe and take notes on trainings at each intervention site. In order to improve the accuracy of recording and to help standardize the observations of multiple observers, a written observation guide will be developed and used during all trainings. Training sessions will also be video recorded to ensure accuracy of observations.

Observation of Time for Completion of PDHRA Interviews
Members of the Vanderbilt research team will use time-sampling techniques to gather data on duration of the PDHRA interviews at each intervention site. A written observation sheet will be developed and used to collect data.

Analysis Plan

Data Management

The PDHA, PDHRA, DEERS variables, and health care encounter (HCE) data will be received from AFHSC in an electronic format. The NDAA completion data will be received in an electronic format from FHP&R (if feasible). The SM and provider surveys and written measures associated with the training workshop will be collected with paper and pencil during site visits. CEPI has a formal data management workflow used for many R01-scale projects (Smith, Breda, Simmons, Lambert & Bickman, 2009). Raw data are captured in the most convenient source, e.g., double-entry Microsoft (MS) Access databases and files from various sources. Data are then arranged in orderly hierarchy on VU's Windows server, which has daily tape backups and daily security checks by the VU network manager and senior technicians. Quantitative data are then exported into SAS data sets, either by directly reading by SAS or export by software. Then an array of SAS programs are written to clean, label, and transform the raw data, mark missing values, and enforce consistent statistical coding (e.g., no-yes 0-1). Finally, the SAS data sets are merged into analytic files that are either wide (one line per participant) or tall (multiple lines per participant for repeated measures analysis).

Linking Procedures

Note that all linking procedures are consistent with existing procedures used in the previous Vanderbilt evaluation and in retrieval of secondary analysis datasets related to Aim 1 of this study to facilitate ease of use for AFHSC.

The linking procedures described below are shown graphically in Figure 1 on the next page.

Pre-existing data sources
All pre-existing data sources except NDAA scores (PDHA, PDHRA, HCE, and DEERS variables; see Table 4) will be linked because AFHSC assigns each case (i.e., SM) a unique study ID in place of the SSN. Vanderbilt will receive these data de-identified with only the study ID. If feasible, the NDAA data will be obtained from FHP&R and will include provider name, which can be used by VU to link these data to the other pre-existing data (provider ID from the Army is in the format firstname.lastname). If FHP&R cannot provide these data we will ask individual providers from study sites for the completion date and score.

SM survey and PDHRA
All SMs who agree to take a survey will be asked to provide their birth date, initials, branch of service, and pay grade on a card stapled to the survey. Each card will be printed with a unique serial number, which will also be printed on the survey. The cards will be separated from the surveys and sent to FHP&R by a designated individual on site who is not associated with Vanderbilt. The cards will then be retrieved by an outside data entry company which will enter the data into a spread sheet and return the file to FHP&R via email. This spreadsheet will be sent to the epidemiologist at AFHSC who has

access to PDHRA files and who will pull the existing data for this study (see Table 4). The card data will be used by the epidemiologist to identify the subset of PDHRAs that correspond to the surveys. AFHSC will assign each record (i.e., SM) in the data set a unique study ID which will be used to link the SM survey data and the existing data. After all identifying information has been removed Vanderbilt will be sent the file containing the unique study ID and corresponding survey ID. Vanderbilt will maintain the hard copies of the SM surveys from site visits, which will be labeled with the survey ID, but contain no identifying information. Thus, Vanderbilt will know which SM Surveys and PDHRAs come from the same SM but will not at any time have access to any information that can identify SMs.

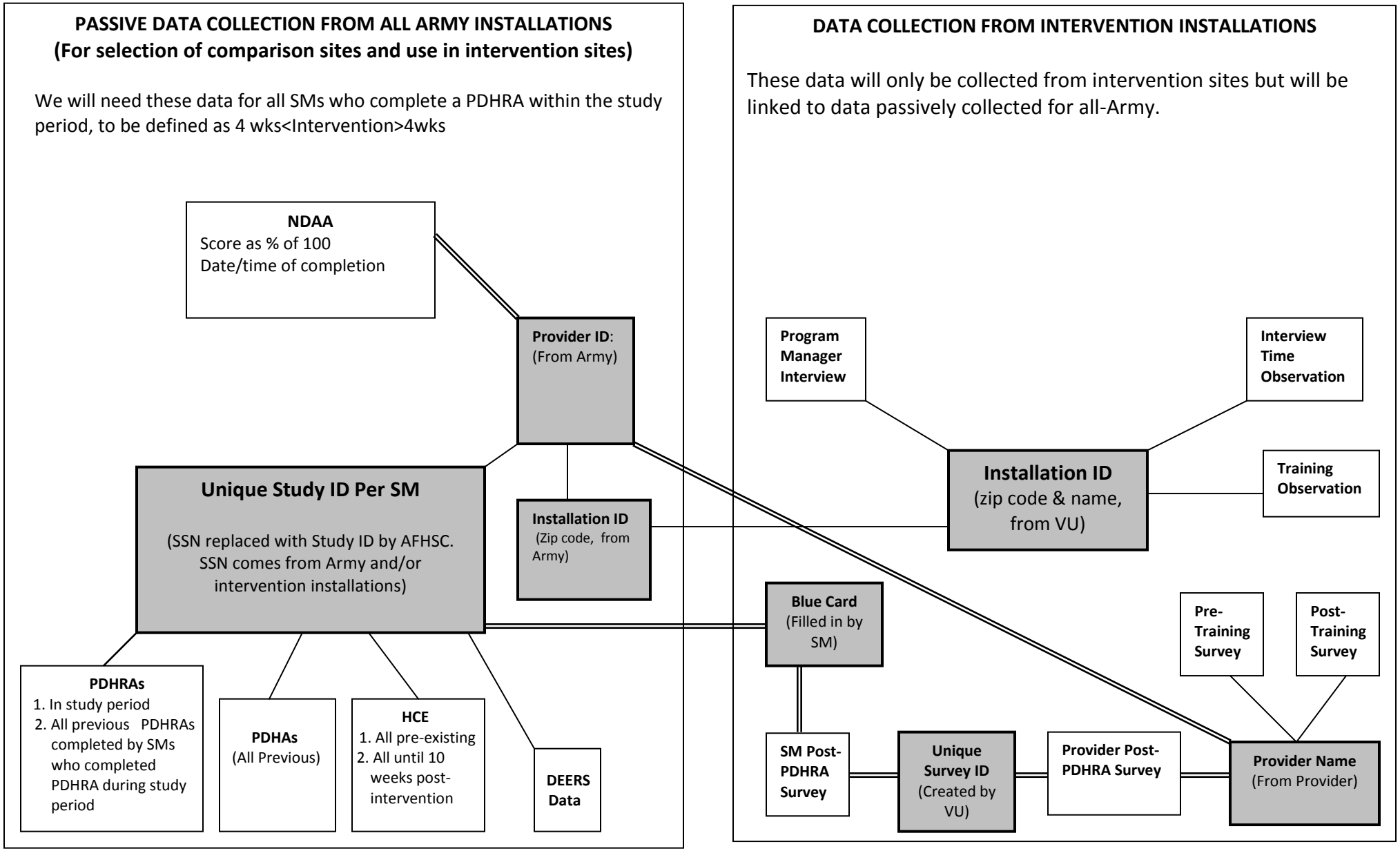
Provider and SM post-PDHRA satisfaction surveys

The SM and provider satisfaction surveys will be linked directly to each other with a unique serial number printed on each pair of surveys. The corresponding SM and provider surveys will be stapled together and detached by the provider just before completion. The surveys will be collected by VU during the site visit. Thus, it will be possible to assess the impact of the intervention for each provider by examining the corresponding PDHRA, SM survey, and provider survey for each PDHRA interview.

Provider surveys

Providers will be asked to indicate their provider ID/name with a check box on each survey they compete. In our previous study (Bickman et al., 2009) only 75% of SM surveys were able to be linked to PDHRAs following the card separation procedures described above. In the event of a broken link, having provider ID and name on the provider survey will allow us to identify each provider's surveys.

Figure 1. Diagram of linking procedures for all data elements. Grey boxes indicate linking variables. Double lines indicate critical links.



Expected Data Requests

Data requests will be submitted for the pre-existing data sources described in Table 4. The timeline for these data requests is described below for each organization providing data.

Army

The data request to the Army will be an amendment to the existing data request to include data for the intervention (i.e., for SMs who completed PDHRAs within 4 weeks before and after the intervention). This amendment will be submitted as soon as possible, but no later than four weeks after the intervention.

AFHSC

The data request to AFHSC will require a new data use agreement (DUA) that is currently being drafted. The data request will be submitted as soon as possible, but no later than 10 weeks after the intervention (this will allow for six weeks of post-PDHRA HCE for PDHRAs completed four weeks after the intervention)

FHP&R

If feasible, FHP&R will provide NDAA test scores and completion dates, and because FHP&R is the co-sponsor in this award, they will submit this request. This request will be submitted as soon as possible, but no later than 4 weeks after the intervention.

Intervention Sites

The specific sites for the intervention have not been selected yet, so the data request procedures are unknown. However, the data request will be submitted as soon as possible, but no later than four weeks after the intervention.

Testing Hypotheses

The analyses are organized around the study's specific questions, as shown in Table 6.

Table 6. Specific Questions and Analytic Plan

Specific Question	Design	IVs	DVs
Can a brief intervention to enhance communication skills be implemented in the field?			
Any increase in the length of the PDHRA interview, is within an acceptable range.	Mean comparison of pre- and post-intervention interview length and opinion of provider	• Whether the interview or response was pre- or post-intervention	• Mean length of interview before and after training • Duration of interview that is acceptable
Participating providers find the intervention to be relevant to their work and acceptable.	Mean comparison of pre- and post-intervention responses	• Whether the response was pre- or post-intervention	• Change in self-efficacy in eliciting mental health concerns and interpersonal communication • Satisfaction with training (post only)

Table 6. Specific Questions and Analytic Plan (continued)

Specific Question	Design	IVs	DVs
Will this intervention help providers use the interview as an opportunity to identify SMs in need of assistance for behavioral health problems?			
Increased provider concerns and referrals for mental health issues documented on PDHRA	Interrupted time series within the intervention providers	• Time from the start of the observational period • Whether the observation is pre- or post-intervention • Time since the intervention	• Number and type of provider documented concerns • Presence of provider documented medical referral • Presence of provider documented mental health referral
	Mean comparison of intervention group and non-equivalent comparison group	• Whether the observation is from the intervention or comparison group	• Number and type of provider documented concerns • Presence of provider documented medical referral • Presence of provider documented mental health referral
Higher ratings of SM self-reported disclosure; intent to comply with referral; SM ratings of provider patient-centered communication	Interrupted time series within the intervention providers	• Time from the start of the observational period • Whether the observation is pre- or post-intervention • Time since the intervention	• SM-reported disclosure • Intent to comply with referral (if given) • SM satisfaction with provider • Ratings of provider patient-centered communication
Higher ratings of provider-reported elicitation of mental health concerns	Interrupted time series within the treatment providers	• time from the start of the observational period • whether the observation is pre- or post-intervention • time since the intervention	• Whether SM reported MH symptoms during interview that were not reported on DD Form 2900. • Whether provider believes SM accurately reported all MH symptoms during interview. • Whether provider believes SM could benefit from further evaluation for MH symptoms (e.g., providers may believe a referral would be beneficial but not have a technically

			positive screen to justify).
Increased number of health care encounters after the PDHRA	Mean comparison of health care encounters before and after PDHRA for SMs with trained provider vs. SMs with untrained providers	• Whether the observation is from the intervention or comparison group	• Number of health care encounters after the PDHRA

Analytic models

Segmented (or piecewise) linear regression analyses will be conducted with separate slopes of outcome for the pre- and post-intervention period. This type of regression controls for the baseline trend by testing the change in level and slope. The dependent variables will be the outcomes of interest (provider concerns, referrals, self-efficacy and SM disclosure and attitudes) and the independent variables will be time from the start of the observational period, whether the observation is pre- or post- intervention, and time since the intervention. The three levels of the regression will be 1) slope, 2) time within provider, and 3) providers within site. The analyses will account for clustering of SMs within providers within installations.

In addition, potential moderating variables from the PDHA (e.g., pre-existing mental health problems, combat exposure), provider background form (e.g., professional background, demographics, self-efficacy in patient-centered communication), PDHRA program manager interview (e.g., typical PDHRA processes, existing training programs, etc.), and analysis of secondary data (e.g., provider completion of the NDAA online training and related test scores) will be incorporated into the analytic models. These moderating variables may affect the strength of the relationship between the independent and dependent variables; therefore adding them to the model will allow us to better account for the variance attributable to the intervention itself.

Power analysis

A power analysis (Hintze, 2005) was conducted and it was determined that 10 providers across all intervention sites are needed to detect medium effects (power = 80%, alpha < 5% two-tailed). An average cross wave (per day) correlation of 0.9 was used, assuming that providers tend to behave similarly from day to day. According to Cohen (1988, 1992), effect sizes of about 0.2 are considered small; 0.5 are considered moderate; and 0.8 are considered large.

As stated previously, non-equivalent comparison installations will also be selected based on criteria they have in common with the intervention sites. PDHRA data will be gathered passively in order to 1) develop estimates for installation- and provider-level influences on SM self-reported problems and referral patterns, and 2), to inform the generalizability of installations through a description of the PDHRA process. A significant intraclass correlation (ICC) would

indicate that providers differ from each other rather than offering a uniform standard of care. To see how many providers are needed to detect an ICC, we estimate power to detect a small ICC, which according to Raudenbush (Raudenbush & Liu, 2000) is ICC = 0.05. According to Pass software (Hintze, 2005), if each provider had 20 SMs and there were 30 providers, we would be well powered (p = 0.85) to detect a small effect. Samples with fewer than 30 providers or fewer than 20 SMs would have less power to detect a small ICC.

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AMENDMENT OF SOLICITATION/MODIFICATION OF CONTRACT

1. CONTRACT ID CODE	PAGE OF PAGES
S	1 | 2

2. AMENDMENT/MODIFICATION NO.	3. EFFECTIVE DATE	4. REQUISITION/PURCHASE REQ. NO.	5. PROJECT NO.(If applicable)
P00002	03-May-2011	SEE SCHEDULE	

6. ISSUED BY CODE W81XWH

USA MED RESEARCH ACQ ACTIVITY
820 CHANDLER ST
FORT DETRICK MD 21702-5014

7. ADMINISTERED BY (If other than item 6) CODE W81XWH

USA MED RESEARCH ACQ ACTIVITY
ATTN: CRAIG ANDERSON
301-619-2702
CRAIG.E.ANDERSON@AMEDD.ARMY.MIL
FORT DETRICK MD 21702

8. NAME AND ADDRESS OF CONTRACTOR (No., Street, County, State and Zip Code)

VANDERBILT UNIVERSITY, THE
110 21ST AVENUE S STE 937
NASHVILLE TN 37203-2416

CODE 5E694 FACILITY CODE

	9A. AMENDMENT OF SOLICITATION NO.
	9B. DATED (SEE ITEM 11)
X	10A. MOD. OF CONTRACT/ORDER NO. W81XWH-09-2-0172
X	10B. DATED (SEE ITEM 13) 23-Sep-2009

11. THIS ITEM ONLY APPLIES TO AMENDMENTS OF SOLICITATIONS

☐ The above numbered solicitation is amended as set forth in Item 14. The hour and date specified for receipt of Offer ☐ is extended, ☐ is not extended.

Offer must acknowledge receipt of this amendment prior to the hour and date specified in the solicitation or as amended by one of the following methods: (a) By completing Items 8 and 15, and returning _____ copies of the amendment; (b) By acknowledging receipt of this amendment on each copy of the offer submitted; or (c) By separate letter or telegram which includes a reference to the solicitation and amendment numbers. FAILURE OF YOUR ACKNOWLEDGMENT TO BE RECEIVED AT THE PLACE DESIGNATED FOR THE RECEIPT OF OFFERS PRIOR TO THE HOUR AND DATE SPECIFIED MAY RESULT IN REJECTION OF YOUR OFFER. If by virtue of this amendment you desire to change an offer already submitted, such change may be made by telegram or letter, provided each telegram or letter makes reference to the solicitation and this amendment, and is received prior to the opening hour and date specified.

12. ACCOUNTING AND APPROPRIATION DATA (If required)

13. THIS ITEM APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS. IT MODIFIES THE CONTRACT/ORDER NO. AS DESCRIBED IN ITEM 14.

☐ A. THIS CHANGE ORDER IS ISSUED PURSUANT TO: (Specify authority) THE CHANGES SET FORTH IN ITEM 14 ARE MADE IN THE CONTRACT ORDER NO. IN ITEM 10A.

☐ B. THE ABOVE NUMBERED CONTRACT/ORDER IS MODIFIED TO REFLECT THE ADMINISTRATIVE CHANGES (such as changes in paying office, appropriation date, etc.) SET FORTH IN ITEM 14, PURSUANT TO THE AUTHORITY OF FAR 43.103(B).

☐ C. THIS SUPPLEMENTAL AGREEMENT IS ENTERED INTO PURSUANT TO AUTHORITY OF:

X D. OTHER (Specify type of modification and authority)
Unilateral Modification - USAMRAA General Terms & Conditions

E. IMPORTANT: Contractor ☒ is not, ☐ is required to sign this document and return _____ copies to the issuing office.

14. DESCRIPTION OF AMENDMENT/MODIFICATION (Organized by UCF section headings, including solicitation/contract subject matter where feasible.)
Modification Control Number: canderso114112

A. The purpose of this modification is to:

(1) Incorporate a revised research plan, dated 10 March 2011. This revision is necessary due to the delay in starting this research effort; and
(2) Extend this contract at no additional cost to the Government for a period of one-year.

B. The contractor requested both the revised research plan and the no-cost extension in an e-mail dated 10 March 2011, and the GOR approved of both requests in an e-mail dated 04 April 2011.

C. This is a no-cost modification. All other terms and conditions remain unchanged.

Except as provided herein, all terms and conditions of the document referenced in Item 9A or 10A, as heretofore changed, remains unchanged and in full force and effect.

15A. NAME AND TITLE OF SIGNER (Type or print)	16A. NAME AND TITLE OF CONTRACTING OFFICER (Type or print)
	BURZIE C. BAKER / ACCOUNT MANAGER TEL: 301-619-3463 EMAIL: burzie.baker@amedd.army.mil

15B. CONTRACTOR/OFFEROR	15C. DATE SIGNED	16B. UNITED STATES OF AMERICA	16C. DATE SIGNED
_____ (Signature of person authorized to sign)		BY _____ (Signature of Contracting Officer)	03-May-2011

EXCEPTION TO SF 30
APPROVED BY OIRM 11-84

30-105-04

STANDARD FORM 30 (Rev. 10-83)
Prescribed by GSA
FAR (48 CFR) 53.243

SECTION SF 30 BLOCK 14 CONTINUATION PAGE

SUMMARY OF CHANGES

SECTION 00010 - SOLICITATION CONTRACT FORM

CLIN 0001

The CLIN extended description has changed from Vanderbilt University - Cooperative Agreement # 09090006.PI: Dr. Susan D. KelleyFunding for Cooperative Agreement Proposal # 09090006; MOMRP/RAD III FY08 Congressional Special Interest, Military Operational Medicine Research Program (MOMRP).Period of Performance: 30 September 2009 - 31 October 2011 (Research ends 29 September 2011).90-Day Pre-Contract Costs are authorized for payment **TO** Vanderbilt University - Cooperative Agreement # 09090006.PI: Dr. Susan D. KelleyFunding for Cooperative Agreement Proposal # 09090006; MOMRP/RAD III FY08 Congressional Special Interest, Military Operational Medicine Research Program (MOMRP).Period of Performance: 30 September 2009 - 31 October 2012 (Research ends 29 September 2012).90-Day Pre-Contract Costs are authorized for payment.

DELIVERIES AND PERFORMANCE

The following Delivery Schedule item for CLIN 0001 has been changed from:

DELIVERY DATE	QUANTITY	SHIP TO ADDRESS	UIC
POP 30-SEP-2009 TO 31-OCT-2011	N/A	USA MED RESEARCH MAT CMD JUANITA LIVINGSTON 504 SCOTT STREET FORT DETRICK MD 21702-5012 FOB: Destination	W23RYX

To:

DELIVERY DATE	QUANTITY	SHIP TO ADDRESS	UIC
POP 30-SEP-2009 TO 31-OCT-2012	N/A	PR W03J USA MED RESEARCH MAT CMD JUANITA LIVINGSTON 504 SCOTT STREET FORT DETRICK MD 21702-5012 FOB: Destination	W23RYX

The following have been modified:

PI NAME/PROPOSAL TITLE

Vanderbilt University - Cooperative Agreement # 09090006.
PI: Dr. Susan D. Kelley; 615-343-1654; susan.d.kelley@vanderbilt.edu
Proposal Title: “Improving Deployment-Related Primary Care Provider Assessments of PTSD and Mental Health Conditions.”
Period of Performance: 30 September 2009 - 31 October 2012 (Research ends 29 September 2012).
(End of Summary of Changes)

Appendix B: Cleaning Procedure for Army Data

Table B.1. Number of records removed and reasons for Army Active dataset.

	# records	# providers	# zip codes
Active Army PDHRAs from AFHSC	113646	n/a	n/a
Matched to original provider ID file from Army. Note # of records went UP because of duplicate & semi-duplicate rows in the ID file (>1 row per study_id-d_event combo).	114065	1301	135
Same as above, but looking at the cleaned zip code (zip) rather than the original zip code (orig_zip)	114065	1301	107
After removing rows missing provider_id in original ID dataset (that is, orig_provider_ID) – no rows in this case	114065	1301	107
After removing rows with unusable/invalid provider_id	113825	1301	107
After removing duplicate (i.e. complete duplicate) rows	113123	1301	107
After removing extra rows for the same study_id-d_event-provider_id combo, where “extra” means that they had missing location info—no rows in this case	113123	1301	107
After randomly keeping only 1 row in cases where we have >1 row for the same study_id-d_event-provider_id combo, all with different nonmissing location_id info	113121	1301	107
After randomly keeping only 1 row in cases where we have >1 row for the same study_id-d_event- combo, all with different provider_id info	113097	1300	107
After keeping only the first record (date) per SM (no change here—each SM had exactly one record at this point)	113097	1300	107
After deleting records corresponding to “rejected” zip codes for a provider	63922	1300	92
Final dataset	**63922**	**1300**	**92**

Table B.2. Number of records removed and reasons for Army Reserve dataset.

	# records	# providers
Army Reserve PDHRA data (the clean data)	41,217	n/a
Merge Army Reserve PDHRA data with MTF/ID data (The MTF_ID data have clean provider ids and MTFs. In this step we are merging the two datasets only based on Study_ID not provider id or mtf)	22,505*	318
Merge Army Reserve PDHRA data & MTF/ID data with LHI data	15,934	57
Remove rows with NO original provider ID (orig_provider_id) (We expect that the provider_ids were clean before the merge but we included this step as a precautionary check to make sure we have not overlooked a problem)	15,934	57
Remove rows with NO provider ID (provider_id) (this step is to drop any cases with a valid Study_ID, but with missing provider_ID)	14,413	57
Remove complete duplicate rows	14,204	57
Remove rows that are semi-duplicate rows (i.e. they have the same study_id,d_event, and provider_id combination)	14,204	57
Randomly keep only 1 row in cases where there were >1 row for the same study_id,d_event, and provider_id combo (all with different nonmissing location_id)	14,204	57
Randomly keep only 1 row in cases where there were >1 row for the same study_id and d_event (all with different provider_id)	14,195	57
Keep only the first record (sorted by date) per SM (we expect that the dataset is clean at this point and that no observations will be dropped so this is one more precautionary step to make sure that we have not missed something in previous cleaning steps)	14,195	57
Final Dataset	**14,195**	**57**

*The drop in the number of observations is due to the limited amount of Study_ID matches between the two datasets. 18,712 of the Study_ID's were dropped from the MTF/ID data before the merge because of unclean provider IDs or MTFs.

Appendix C: Abstracts for Upcoming Conference Presentations

Conference: *International Conference* on *Communications* in Healthcare (Chicago)
Presentation Date: October 18, 2011
Presentation Format: Oral Presentation

Title: Communication patterns during health screening interviews with a high risk population

Authors: Susan Douglas Kelley, Ph.D., Stephanie Boyd, M.A., Corinne E. Perkins, B.A., Ryan Hargraves, M.A., Melanie Leslie, Ph.D., Leonard Bickman, Ph.D

Abstract: The military conducts deployment-related health assessments for Service Members (SMs) returning from deployment. SMs complete a self-report assessment about common post-deployment health problems, including mental health symptoms, and then are interviewed by a health care provider. The intent of the interview is to review self-report responses, to provide education, and to make referrals for further evaluation where warranted. Audio-recordings of 272 interviews were coded with the Roter Interaction Analysis System (RIAS), which codes for socio-emotional content. In addition, 146 of these calls were linked to the corresponding SM self-report forms and custom coded to capture screening-specific topics. Our sample is unique in studying communication during a screening encounter, and because these interviews occurred telephonically instead of in-person. Provider communication patterns did not reflect strategies that have been found useful in more traditional sick-patient encounters for overcoming stigma or concerns that might discourage reporting of behavioral health symptoms. For example, providers asked five times more closed-ended than open-ended questions. Rapport building statements (i.e., RIAS codes for empathy and legitimation) occurred in less than 6% of calls. We also found that behavioral health concerns were treated differently than physical health concerns. Physical health was almost always mentioned by the provider, regardless of whether or not the SM endorsed problems in this area on the self-report (87% when endorsed vs. 84% when not endorsed), but behavioral topics were mentioned more when SMs indicated concerns (64%) than when no concerns were indicated (35%). Education related to mental health concerns was provided in only 14% of all calls, although this increased to 24% in calls where a medical referral was given. We discuss these and other findings in the context of establishing appropriate communication patterns during an assessment interview and consider implications for training providers to enhance communication techniques for health risk assessments.

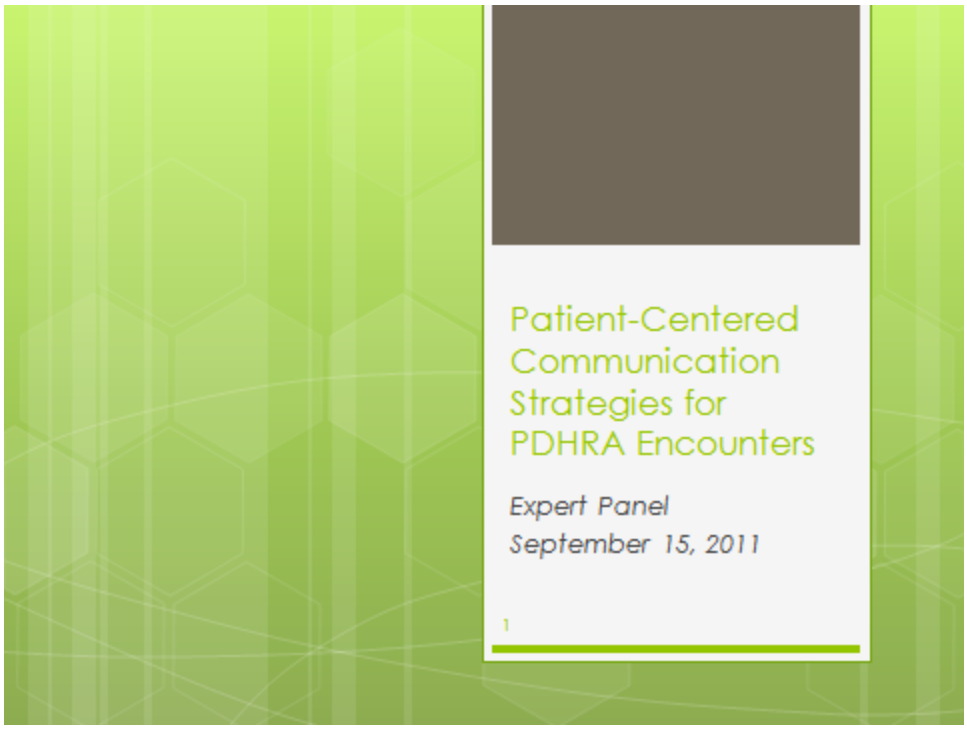
Conference: *American Public Health Association Annual Meeting (Washington DC)*
Presentation Date: November 1, 2011
Presentation Format: Oral Presentation

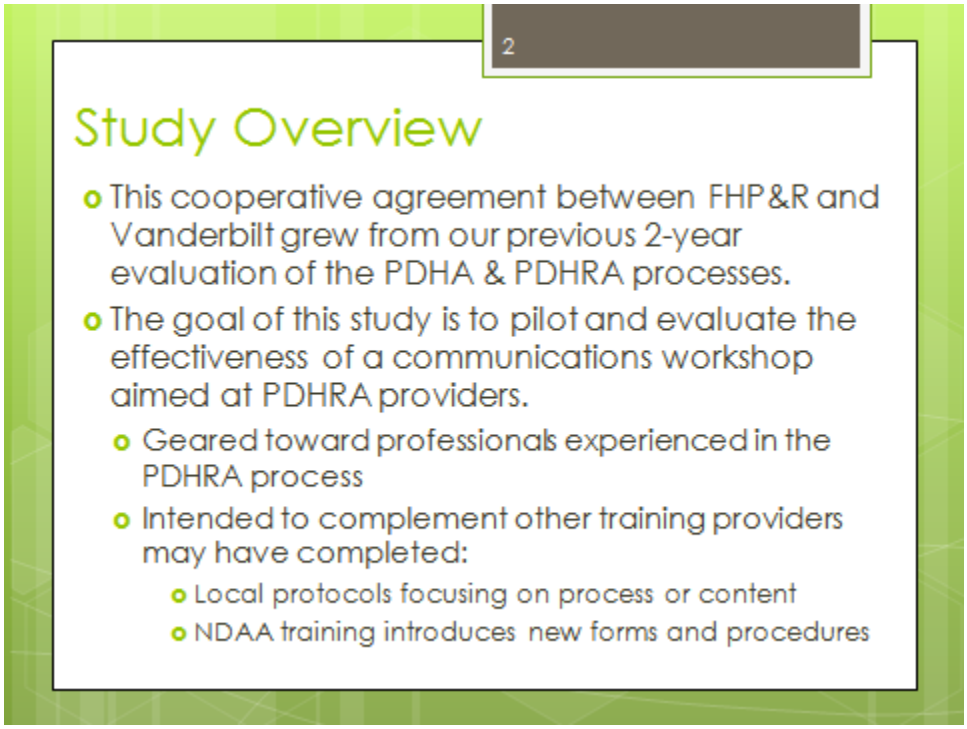
Title: Evidence of under-reporting of behavioral health problems by high-risk individuals during a standardized screening

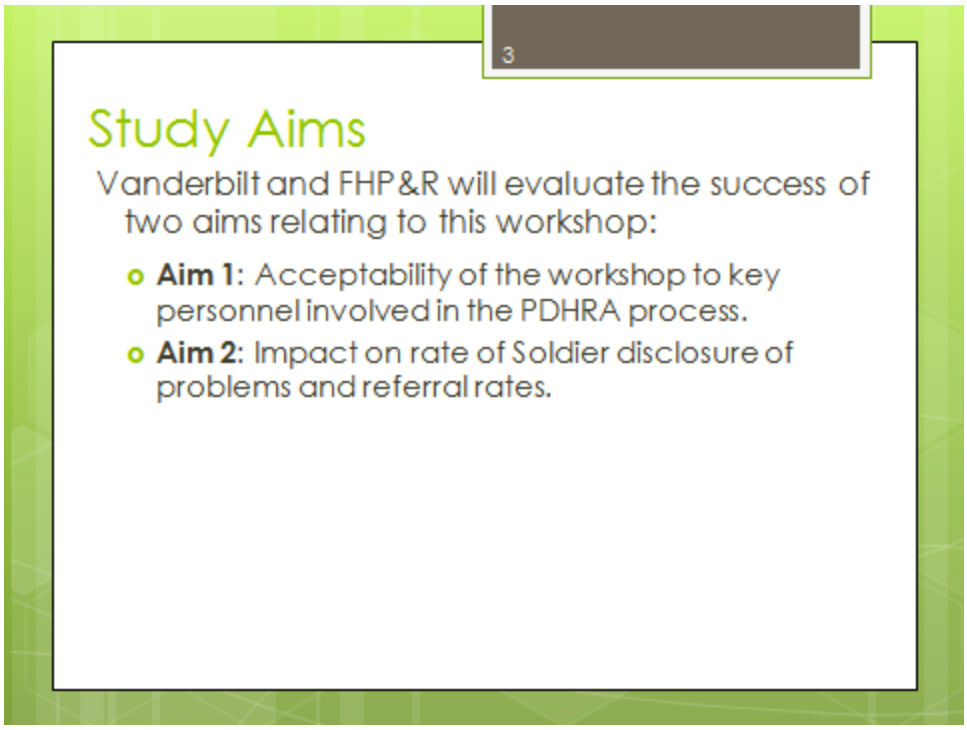
Authors: Leslie, Melanie W.; Kelley, Susan D.; Hargraves, Ryan P; Boyd, Stephanie D; Davis, Lauren E; Bickman Leonard

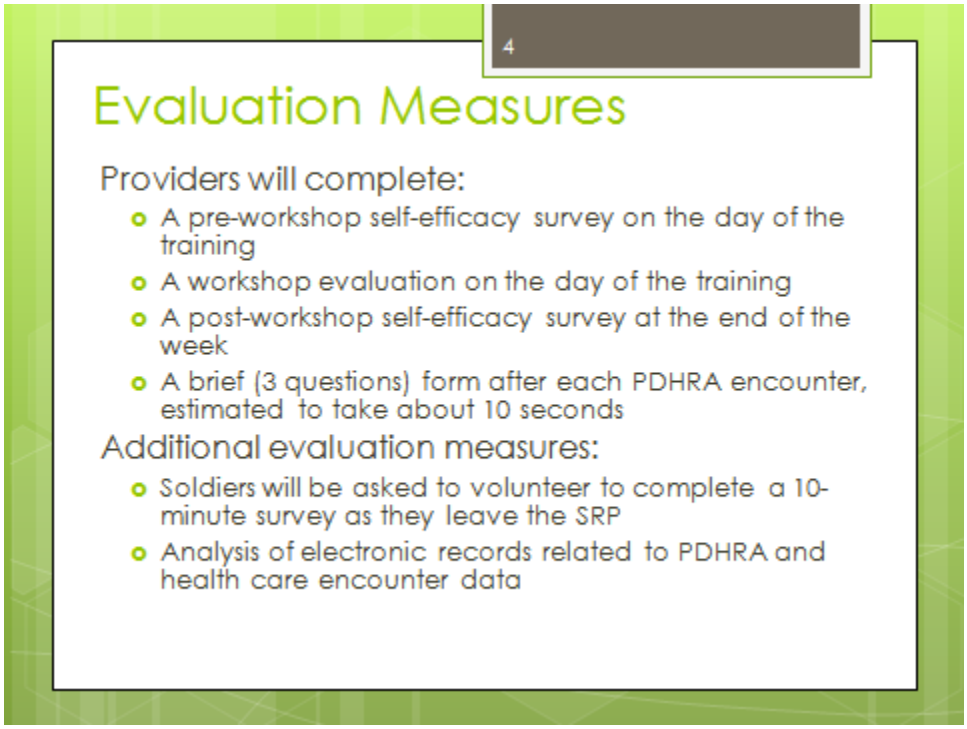
Abstract: The military conducts health risk screening for Service Members (SMs) returning from combat. SMs complete a self-report assessment about common post-deployment health problems, including behavioral health, and then are interviewed by a health care provider. The intent of the interview is to review SM self-report responses, provide needed information, and make referrals for further evaluation where warranted. We conducted a survey of SM characteristics relevant to this process, including perceptions of stigma, attitudes toward help-seeking and self-disclosure, and social support. Anonymous surveys were collected from 6,714 SMs, with 2, 217 linked to SMs' de-identified screening results. A substantial minority (10-14%) of SMs admitted to underreporting physical, emotional, and alcohol use problems on the screening. More than a third (39%) of SMs agreed that they had experienced an emotional, alcohol, stress, or family problem since returning from deployment, or that family or friends had suggested they seek help for such a problem. However, almost half (43%) of these SMs did not report any such problem on the military's screening form. Further, these unreported problems were usually not uncovered (i.e., documented) by the health care provider during the interview. That is, providers documented five times fewer major concerns and three times fewer medical referrals for those who did not disclose problems on the screening form vs. those who did disclose. We discuss these and other findings in the context of SM characteristics associated with under-reporting and consider the implications for the health care provider's role in the screening process.

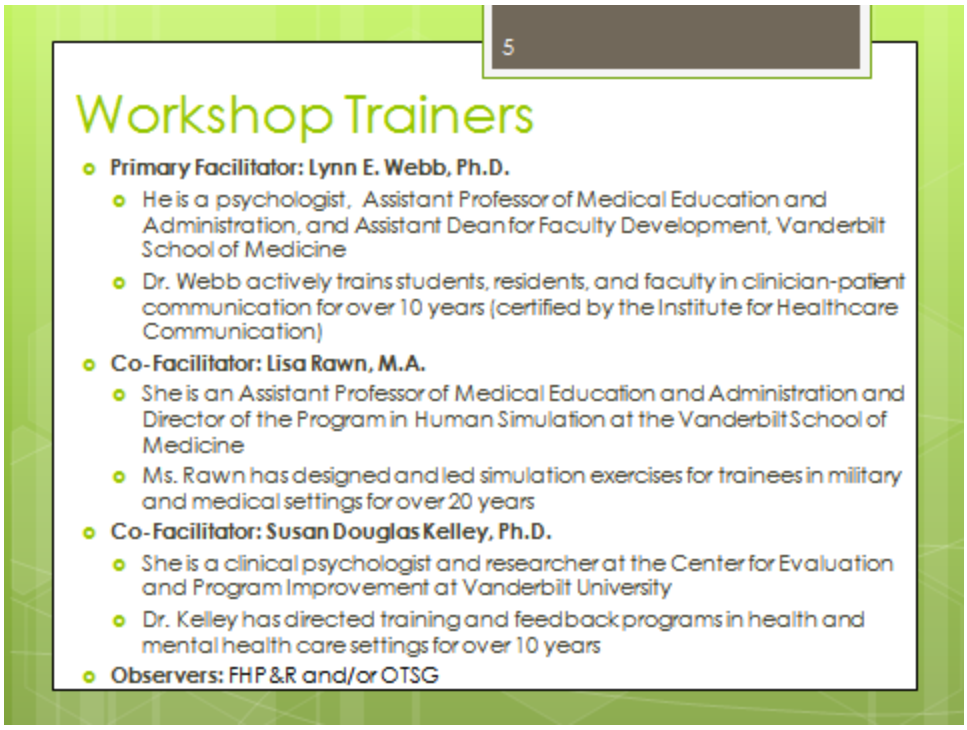
Appendix D: Presentation of Training to Expert Panel (9/15/11)

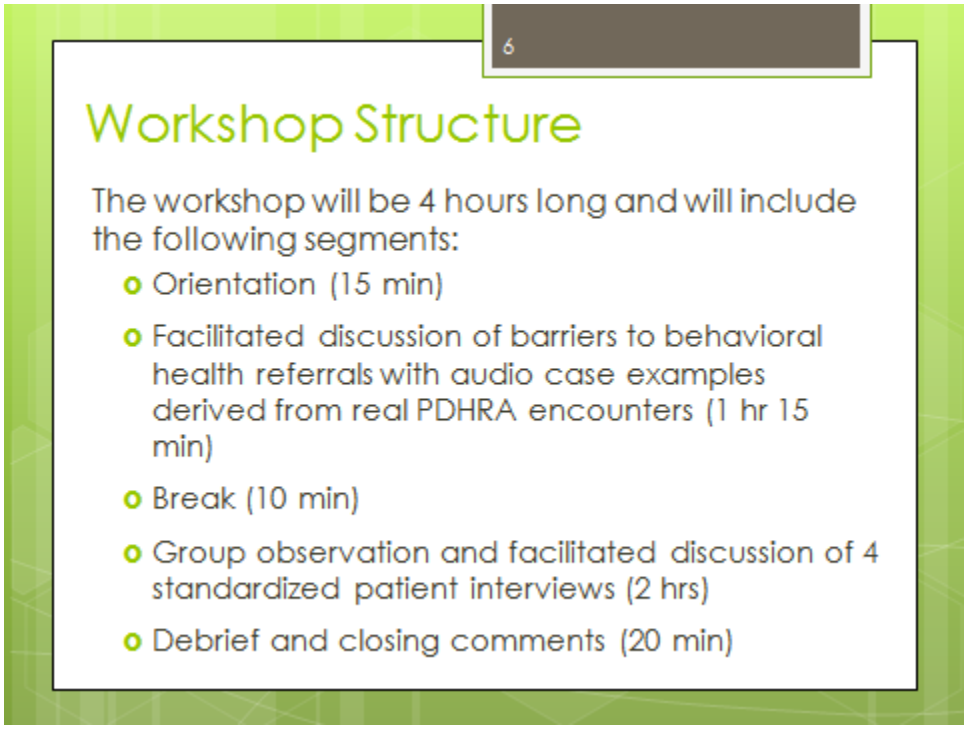

Patient-Centered Communication Strategies for PDHRA Encounters
Expert Panel
September 15, 2011
1

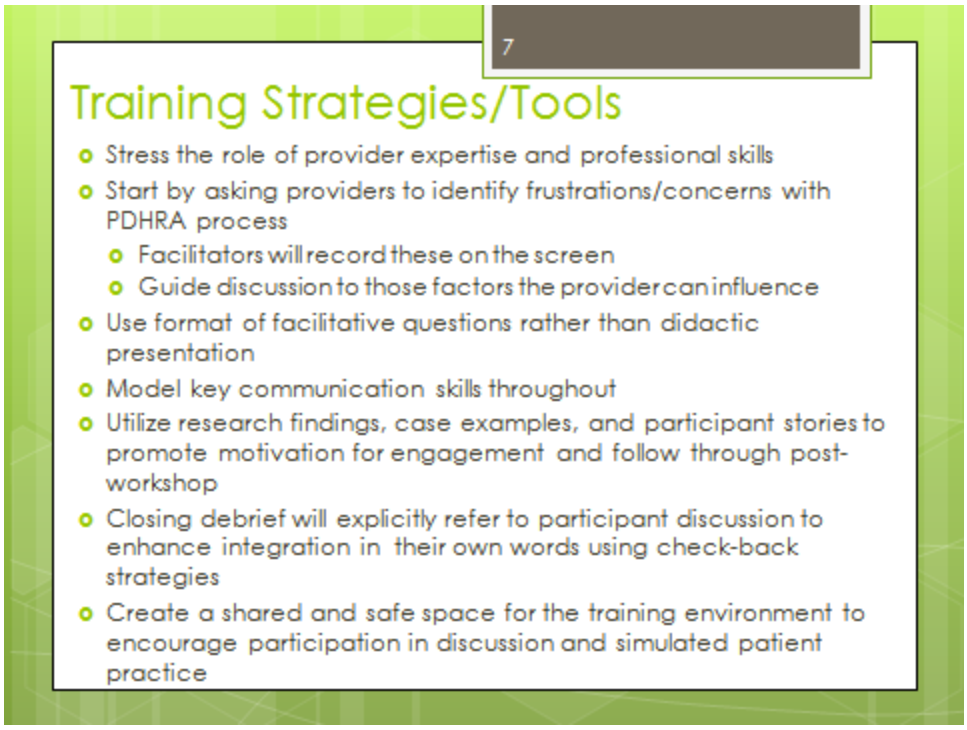

2
Study Overview
This cooperative agreement between FHP&R and Vanderbilt grew from our previous 2-year evaluation of the PDHA & PDHRA processes.
The goal of this study is to pilot and evaluate the effectiveness of a communications workshop aimed at PDHRA providers.
Geared toward professionals experienced in the PDHRA process
Intended to complement other training providers may have completed:
Local protocols focusing on process or content
NDAA training introduces new forms and procedures

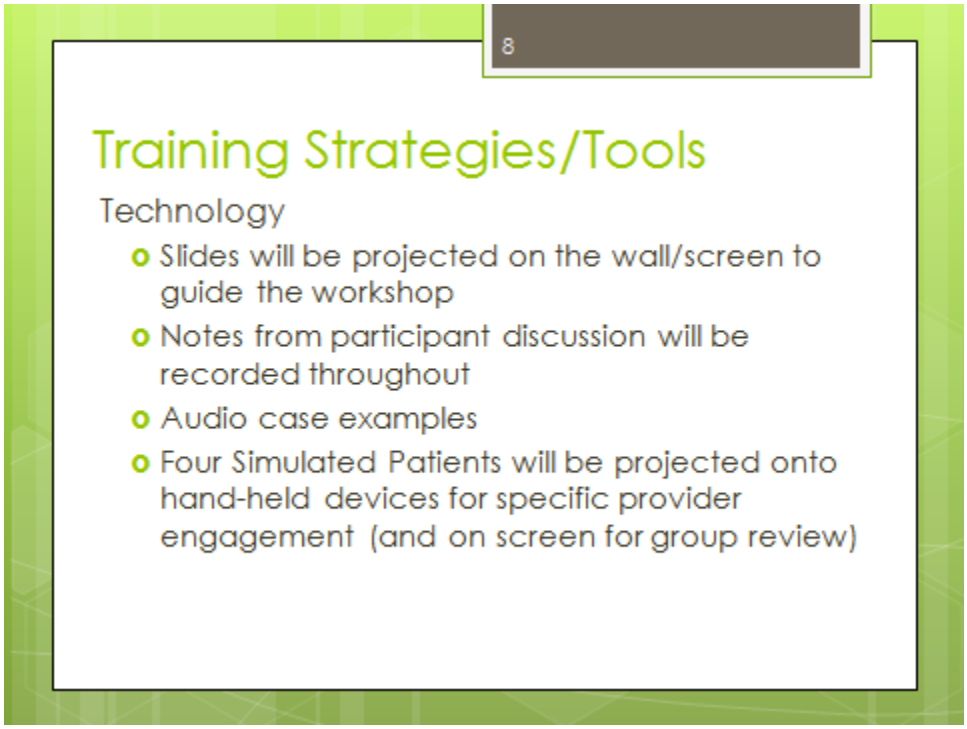

3
Study Aims
Vanderbilt and FHP&R will evaluate the success of two aims relating to this workshop:
Aim 1: Acceptability of the workshop to key personnel involved in the PDHRA process.
Aim 2: Impact on rate of Soldier disclosure of problems and referral rates.


4
Evaluation Measures
Providers will complete:
A pre-workshop self-efficacy survey on the day of the training
A workshop evaluation on the day of the training
A post-workshop self-efficacy survey at the end of the week
A brief (3 questions) form after each PDHRA encounter, estimated to take about 10 seconds
Additional evaluation measures:
Soldiers will be asked to volunteer to complete a 10-minute survey as they leave the SRP
Analysis of electronic records related to PDHRA and health care encounter data


5
Workshop Trainers
Primary Facilitator: Lynn E. Webb, Ph.D.
He is a psychologist, Assistant Professor of Medical Education and Administration, and Assistant Dean for Faculty Development, Vanderbilt School of Medicine
Dr. Webb actively trains students, residents, and faculty in clinician-patient communication for over 10 years (certified by the Institute for Healthcare Communication)
Co-Facilitator: Lisa Rawn, M.A.
She is an Assistant Professor of Medical Education and Administration and Director of the Program in Human Simulation at the Vanderbilt School of Medicine
Ms. Rawn has designed and led simulation exercises for trainees in military and medical settings for over 20 years
Co-Facilitator: Susan Douglas Kelley, Ph.D.
She is a clinical psychologist and researcher at the Center for Evaluation and Program Improvement at Vanderbilt University
Dr. Kelley has directed training and feedback programs in health and mental health care settings for over 10 years
Observers: FHP &R and/or OTSG


6
Workshop Structure
The workshop will be 4 hours long and will include the following segments:
Orientation (15 min)
Facilitated discussion of barriers to behavioral health referrals with audio case examples derived from real PDHRA encounters (1 hr 15 min)
Break (10 min)
Group observation and facilitated discussion of 4 standardized patient interviews (2 hrs)
Debrief and closing comments (20 min)


7
Training Strategies/Tools
Stress the role of provider expertise and professional skills
Start by asking providers to identify frustrations/concerns with PDHRA process
Facilitators will record these on the screen
Guide discussion to those factors the provider can influence
Use format of facilitative questions rather than didactic presentation
Model key communication skills throughout
Utilize research findings, case examples, and participant stories to promote motivation for engagement and follow through post-workshop
Closing debrief will explicitly refer to participant discussion to enhance integration in their own words using check-back strategies
Create a shared and safe space for the training environment to encourage participation in discussion and simulated patient practice


8
Training Strategies/Tools
Technology
Slides will be projected on the wall/screen to guide the workshop
Notes from participant discussion will be recorded throughout
Audio case examples
Four Simulated Patients will be projected onto hand-held devices for specific provider engagement (and on screen for group review)

9

Training Content—Key Communication Strategies

1. Orienting and setting Soldier expectations for the PDHRA interview
2. Key words at key times: Using open-ended prompts and questions to increase opportunities for Soldier disclosure
3. Using legitimizing statements to normalize deployment and reintegration experiences as well as common barriers to disclosure
4. Using empathic statements to build the relationship
5. Using transition statements to introduce risk assessment
6. Partnering with the Soldier in your summary of current concerns and referral recommendations
7. Providing brief psychoeducation to encourage future utilization of healthcare and support resources

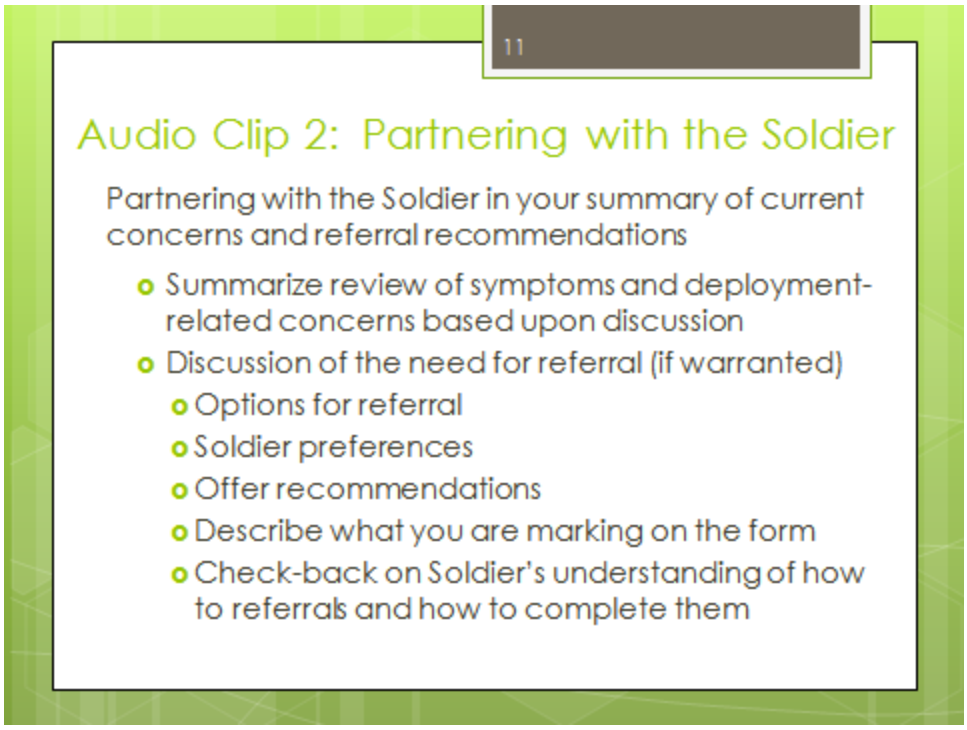
10

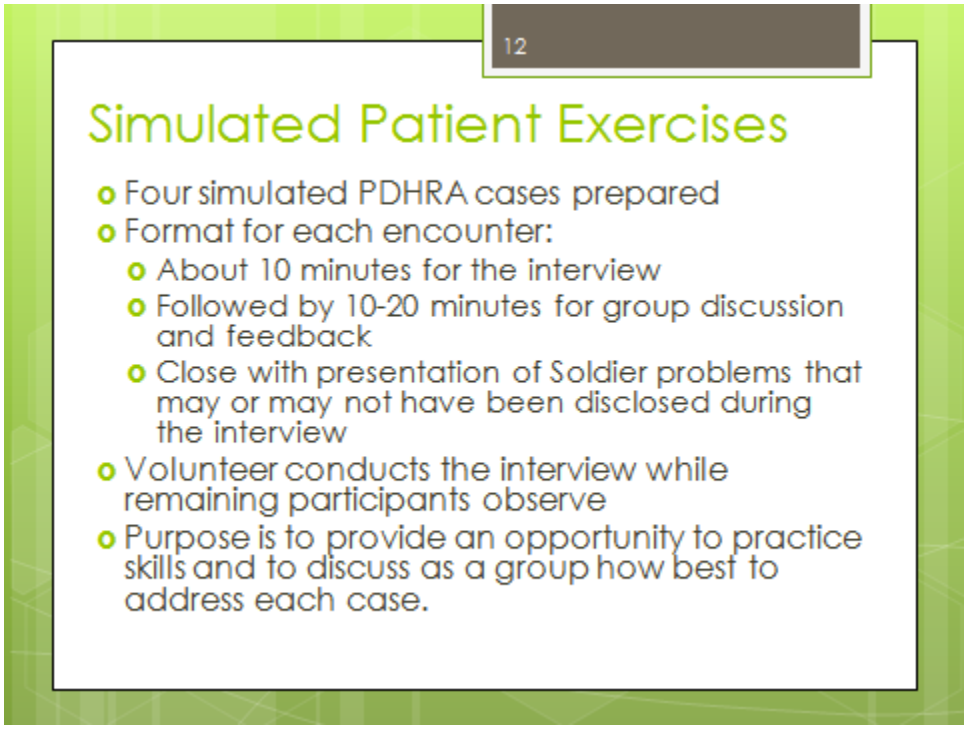
Audio Clip 1: Key Words at Key Times

Using open-ended prompts and questions to increase opportunities for Soldier disclosure

- "Tell me more about that..."
- "Say more about why you responded to this question by marking..."
- "For some Soldiers, your response to question ___ may be an indication of ___. While this may not be the case for you, can you tell me more about what led you to respond in that way?"

- Summarize responses to confirm information/feelings followed by 'anything else?'
- Ask directly about mental health concerns mid-way through (consistent with DD Form 2900)
  - "We've talked so far about your physical health. Before I look at the form again what problems or concerns might you have about mental health or relationship issues?"
- Ask directly about any concerns the Soldier may have about disclosing mental health problems


11
Audio Clip 2: Partnering with the Soldier
Partnering with the Soldier in your summary of current concerns and referral recommendations
Summarize review of symptoms and deployment-related concerns based upon discussion
Discussion of the need for referral (if warranted)
Options for referral
Soldier preferences
Offer recommendations
Describe what you are marking on the form
Check-back on Soldier's understanding of how to referrals and how to complete them


12
Simulated Patient Exercises
Four simulated PDHRA cases prepared
Format for each encounter:
About 10 minutes for the interview
Followed by 10-20 minutes for group discussion and feedback
Close with presentation of Soldier problems that may or may not have been disclosed during the interview
Volunteer conducts the interview while remaining participants observe
Purpose is to provide an opportunity to practice skills and to discuss as a group how best to address each case.

13

Standardized Patient Cases

Case 1: Barriers to Care (20 year old male E3)

- Case Description: Friendly demeanor. Will admit he feels a bit confused about his emotions, but assumes problems are from frustration with an injured ankle or "normal post-deployment stuff."
- Provider Goal: Help the SM recognize his mental health symptoms and convince him to accept a referral despite stigma and confidentiality concerns.

Case 2: Avoidance and Denial (27 year old male E5)

- Case Description: Demeanor is taciturn but not rude. He has unexplained pain but doesn't believe he has a MH issue beyond mild anxiety. If probed, he will admit to several symptoms, including nightmares (which he calls dreams).
- Provider Goal: Help soldier recognize physical symptoms could be related to MH issue. Convince him to accept referral by educating about treatment effectiveness.

Case 3: Career Concerns (42 year old Latina female O6)

- Case Description: Pleasant demeanor, lost many people in Iraq, believes (probably accurately), that Iraqi civilians were killed because they associated with her. Has depression and PTSD symptoms but is very concerned about the effect disclosing could have on her career. As a woman officer, feels she must be doubly strong.
- Provider Goal: Use probing and open-ended questions to elicit disclosure in the face of extreme reluctance. Soldier must be convinced of confidentiality.

Case 4: Time Management (40 year old male E7)

- Case Description: Soldier has back pain and emotional problems, including extreme anger at his wife (anger is apparent in interview but not directed at provider). He is aware of problems and wants help, but won't stay on topic.
- Provider Goal: Acknowledge soldier's concerns adequately while still keeping the interview on track and finishing in the allotted amount of time.

14

Status and Timeline

- Potential sites
  - Ft Campbell
  - Ft Hood
  - Ft Stewart
  - Ft Carson
- Taskord sent to potential sites last week. Expect site selection by early October
- Workshop and data collection to be completed one month after site selection


15
Your Questions & Comments Please!
Measures
SP cases
Training format/content
Data collection
Expected outcomes

Appendix E: Scripts for Audio Clips Used in Training

Audio Clip 1

Summary: Provider changes from using the term "PTSD" to "stress issues" during this 1:21 long call.

Background: In this call, a male SM with one OIF deployment spoke with a male provider. On the DD 2900, the SM had scored a 3 on the PTSD screen and reported being injured physically on deployment. He scored a 2 on each of the depression questions and reported some relationship conflict. On the section of the DD 2900 where the SM is asked whether he wants to see someone for symptoms, SM answered no to all. He DID accept a referral for "stress issues" after his conversation with this provider, though.

Clip's Relationship to 7 Key Communication Strategies:

- Open-ended questions.
- Normalizing statements (mostly indirect)
- Partnership, acknowledges SM may be right about not having PTSD, but then comes back from another angle.

Transcript:

Red text represents notes for scripting.

This provider sounds particularly confident and fluent. His tone sounds both professional and friendly. The SM's tone is fairly natural and friendly. He usually answers questions readily without long pauses.

PROVIDER: At this point sir, any difficulty adjusting to home or work life? You had a few yeses under the stress battery of questions.

SM: Yeah just all, I mean just what's there.

PROVIDER: Sure, okay and, concentration, appetite, energy, how's that going for ya?

SM: You know, it kinda varies in and out. Obviously appetite's increased, but at the same time like I figured it's just a lot of emotional stress re-adjusting and stuff like that.

PROVIDER: Yes it is.

SM: My wife was deployed as well and so we're both dealing with re-adjustment.

PROVIDER: Sure, sure. That's got to make readjusting even harder. Do you have children sir?

SM: I'm sorry?

PROVIDER: You two have children or. . .?

SM: No, no. (Tone implies "oh heck no, can't even imagine that!")

PROVIDER: Okay. You know I wonder about the possibility of, even though it hasn't been that long you know sometimes these symptoms get better and sometimes as you know they, they progress to a point where you really do need some help, so given the way you answered them, I could make a referral if you'd like for a traumatic stress evaluation

SM: You mean for PTSD? I don't think I have PTSD. [PAUSE] For what that's worth. (Says this immediately and firmly, but doesn't sound disgusted or appalled by the suggestion, tone conveys some openness to further discussion).

PROVIDER: Certainly, certainly. It's very possible you don't.

SM: Yeah.

PROVIDER: The only reason I mention it is, because, you know, you checked off, there's only four questions,

SM: Hmm hmm.

PROVIDER: and the questions are pretty good at picking up problems, nonetheless, it doesn't necessarily, like you say, mean that you have PTSD.

SM: Right.

PROVIDER: Let me throw this out there. What I could put down are stress issues. Instead of saying PTSD, I could just make a referral for stress issues or stress, that kind of thing.
SM: Okay, yeah. That sounds all right. (SM sounds comfortable with this arrangement).

Audio Clip 2

Summary: A good "base" call, in which provider does many things well, but for which training participants will still be able to pick out opportunities to do even better. This clip is 5:12 in length, though it is likely that instead of playing the entire clip, particular segments will be used to generate discussion.

Background: In this call, a male SM speaks with a male provider. The SM had indicated some PTSD symptoms on the DD 2900, but reported no physical symptoms or history of injuries or exposures. This SM never does accept a referral, though the provider does make several opportunities for the SM to accept one. The provider does provide him with education on several options that the SM can access for care later, and several times encourages him not to wait too long before seeking help. We do not have a PDHRA form available for this SM.

Clip's Relationship to 7 Key Strategies:

- Key words at key times: Using open-ended prompts and questions to increase opportunities for disclosure
- The longer clip includes all of the following:
  - Legitimizing statement
  - Partnering with soldier in summary of concerns and recommendations
  - Empathic statements (a little. And the provider's tone does convey concern).
  - Education—Provider talks about Military OneSource and does say it is confidential.

Transcript:
Red text represents notes for scripting.
SM generally sounds a little sad, maybe a little "lost" sounding. He generally speaks fairly slowly and with some hesitation, but doesn't sound as overwhelmed and confused as the SM in 98863.
Provider speaks quietly and not quickly. He sounds calm. In the transcript, it may appear that this provider stumbles over words a lot, but in the actual audio clip, he usually sounds fluent and clear.

PROVIDER: I'm just gonna review your answers here to the post-deployment health-reassessment, uh, and let's see, you returned from theater September last year, is that correct?
SM: Correct.
PROVIDER: Okay. All right. Now looking at your form here, it looks like you had listed, currently still having a couple stress symptoms. Have you spoken to anyone about that?
SM: No, not really.
PROVIDER: Okay.
SM: Um,
PROVIDER: Is that something you feel that you'd like to talk to someone about at this point?
SM: Um, I think I'm managing it, [small pause] alright.
PROVIDER: Do ya?

SM: Yeah.
PROVIDER: Okay.
SM: Yeah, I mean I think [insert 1 second pause] it's gonna take time.
PROVIDER: How are you doing in crowds and stuff?
SM: Um, crowds don't seem too bad any more.
PROVIDER: Okay, okay. Still having some nightmares and things though?
SM: Uh, not, not really, not too bad, um,
PROVIDER: Okay.
SM: A few, but not terrible.
PROVIDER: Okay. Anything, anything at all that you feel like you'd like to get in and have checked out?
SM: As far as medically no.
PROVIDER: Okay.
SM: I think, uh, you know it's just, you know just one of those things that's gonna take some time and . . . [trails off]
PROVIDER: Well I, you know, you're back since September, and I would just suggest to you that you know time doesn't always take care of it and there's, there's a lot of good people out there that wanna help. You can see someone and talk about some of these concerns, so you know I'm happy to do a referral for ya and, and you know have an appointment arranged so you can get in and talk to somebody if you'd like to do that.
SM: uh, I don't know, I, at this point I think, you know one of my guys that I was actually deployed with is a mental health tech and
PROVIDER: Okay.
SM: you know he was with me and
PROVIDER: Hmm hmm.
SM: you know we deal, we talk and he's actually a counselor at the V.A., so.
PROVIDER: Okay. Are you, are you familiar with Military One Source?
SM: Yeah, yeah I am.
PROVIDER: Okay, cause I'll just remind you that they've got behavioral health folks that are available you know around the clock, and it's confidential, so you don't have to worry about it getting back to somebody.
SM: Right.
PROVIDER: But any time you want to you can give them a call, you know that, that's kind of an easy way to get started at least and sometimes they can you know help you figure out if it's something that needs further evaluation or, or what have you, so that, that's certainly an option for you also.
SM: Right, right. I just think it, you know it's just something that with, with time I think it'll be all right [voice trails off]
PROVIDER: Well if, if at some point you, you feel like maybe things aren't progressing the way you had hoped you know, give 'em a call
SM: Right, right.
PROVIDER: I'm obligated to ask you a couple of quick questions here and these are just routine. In the course of the past month, any thoughts that you might be better off dead, hurting yourself, anything like that? [Tone of voice is calm.]
SM: No.
PROVIDER: Good, good. Do you ever have any thoughts or concerns that you could hurt someone or maybe lose control with someone?
SM: Um, no.

PROVIDER: Okay. All right. Well what I'll go ahead and do is just indicate that I, you know I talked to you about Military One Source, but at this point we didn't do any formal referral, does that sound okay?
SM: Yeah, that, that sounds good right now.
PROVIDER: All right.
SM: Uh, like I say, it's just, you know my, my main concern was that you know I thought the medical people were being kinda looked over and the trauma that the medical people are seeing especially in the trauma centers where I was at [brief pause]
PROVIDER: Hm hmm.
SM: is, far more than you know some of the, what the combat guys are seeing,
PROVIDER: Sure, yeah. . . So you were, were you, you were involved in some, some medical facility over there?
SM: Yeah I was at Balad at the trauma center,
PROVIDER: Okay.
SM: prior to the surge,
PROVIDER: Okay.
PROVIDER: Well you know again, you're, you know you're seeing things that a lot of people you know never have to see and that's a good thing, but I, I just would say you know don't, don't wait too long for, for tincture of time to take care of it if you don't feel like things are improving, you know just make, make the call and, and get some, get some assistance.
SM: Yeah I will.
PROVIDER: [brief pause] Well I'll, I'll certify the form for ya and like I say, uh, take advantage of your resources if you need anything, otherwise I wanna thank you for your service to the country, we sure appreciate that and hope things, hope things work out well for ya.

Audio Clip 3

Summary: Provider tells SM she can't help him assess stigma. 0:42 in length.

Background:
In this call, a male SM speaks with a female provider. On DD 2900, SM had endorsed head trauma and persisting symptoms, and scored a 4 on the PTSD screen. He also reported being injured and that he had back and muscle pain. He scored a one for each depression question and he reported that he was unsure whether he'd had serious conflicts with family or friends. He also endorsed interest in talking with a provider, with someone about stress, with a family counselor, and with a chaplain, though in the interview, he expressed concerns about stigma.

Clip's Relationship to 7 Key Strategies:

- Normalizing statement—lack of.
- Key words at key times (open-ended follow-up questions)—lack of.

Transcript:
Red text represents notes for scripting.

Provider's tone of voice is fairly rough and a little flat. She sounds very practical and if not exactly rushed, she certainly has a "moving along" inflection to her speech.

SM annunciates clearly and communicates fairly directly. Even when he's deliberating about whether to accept the referral or saying he doesn't know the answer to a question, his tone is not hesitant. For the most part, he answers questions immediately after he's asked.

PROVIDER: Okay. And you were exposed to a blast or an explosion, has anyone evaluated you for concussion?
SM: No, I never got one of those.
PROVIDER: Do you have signs or symptoms of it?
SM: I don't even know if I do or not. (SM sounds a little frustrated).
PROVIDER: All right, okay, that could be sleeplessness, restlessness, headaches, memory issues.
SM: I, uh, I'm still having some memory issues.
PROVIDER: You wanna a referral for those symptoms?
SM: (Long Sigh—about 4 seconds) I'm, I'm trying to assess in my mind right now the stigma of all that. (Spoken slowly)
PROVIDER: (2 second pause) OK.

Audio Clip 4

Summary: SM brings up emotional symptoms, and provider does not engage at that time (she is following the form). 0:42 in length, with a second potential ending also recorded. The second ending is based off of a second call in which the provider responded differently to a similarly confused SM.

Background:
This SM is male and the provider is female. SM has some physical and emotional problems, and his fiancée has commented on his drinking. The SM does not think he has a drinking problem but says he would like to talk to a professional about it and see what they say—if it is confidential and convenient. We do not have a PDHRA form available for this SM. The SM eventually accepts a referral for some of his symptoms, but it is not clear that he understands the process even at the end of the call.

Clip's Relationship to 7 Key Strategies:

- Lack of partnering, legitimizing, & empathetic statements.
- Lack of open-ended prompts and questions to increase disclosure.

Transcript:
Red text represents notes for scripting.

PROVIDER: And right now you'd rate your health as very good, but somewhat worse than before you deployed. (Very rote sounding. Interviewer sounds pleasant (i.e. not rude or abrupt) but like she's reading from a script).
SM: Right.
PROVIDER: And you haven't had any physical problems that have made daily activities difficult, but you have had some emotional problems that have made things somewhat difficult. (Again, interviewer sounds very much like she's reading a script)

SM:	**SM**: Well emotional, I was not really . . . before, I was. . . kinda like I was telling, uh, the other person I was talking to is that most, most recently, you know I don't even know why, it kinda gets to me sometimes I guess, I don't know why.. . I don't know Like I just go into these, I just go into these little, these little, I don't, I don't even know what you would call 'em, but it's.. . SM trails off. [SM is hesitant, slow, disorganized when he speaks here. He just ends hanging, & it conveys an impression that he would have talked more if asked an appropriate question. Tone does not convey desire to close the conversation]
PROVIDER:	Okay, okay. But you have no other physical concerns related to your deployment? (There is space between the "okays"—as far as tone goes, this is said as confirmation, not in a "okay, okay, STOP" kind of way. However, instead of following the confirmation with more exploration, she goes back to the rote sounding "script reading" tone).
SM:	No, not right now. (Tone sounds deflated).
PROVIDER:	Okay. And you were in a vehicle accident, but you had no problems with that?

*****Alternative Ending Below*****

SM:	Like I just go into these, I just go into these little, these little, I don't, I don't even know what you would call 'em, but it's. . .[SM trails off, and there is a small pause before the provider asks her follow-up questions.]
PROVIDER:	Okay, let me ask you some questions about that. Do you, do you just stay in bed? [Provider's tone conveys empathy]
SM:	Ma'am?
PROVIDER:	Do you just stay in bed?
SM:	Uh, some days.
PROVIDER:	Okay.
SM:	Some days I just, I just, well any, any, anywhere where I can just be alone.
PROVIDER:	Okay. Are you eating?
SM:	Sometimes I don't.
PROVIDER:	Have you lost weight?
SM:	Yes ma'am.
PROVIDER:	Are you sleeping?
SM:	I haven't slept a full night since I've been back.
PROVIDER:	Okay. Well no wonder things are hard right now.
SM:	Yes ma'am.
PROVIDER:	Well let's see about getting you some help . . . all right?
SM:	Yes ma'am. (sounds relieved)

Audio Clip 5

Summary: SM answers only yes or no to all questions, and provider takes no extra steps to follow up. 0:57 in length.

Background: Male SM, female provider. SM reported on the form that he had some emotional issues including irritability, serious family conflicts, and insomnia. He reported that he was in a blast and a vehicle incident but had no symptoms. Also reported drinking more alcohol than he meant to and feeling down or depressed. SM refuses all referrals, and provider does not follow up at all. She does give him Military OneSource information though.

Clip's Relationship to 7 Key Strategies:

- Open-ended questions—lack of.
  - Especially on the "deployment related health concern" topic, the SM sounded like he might have had more to say if she asked some more questions.
  - Another good place for this would be the serious conflicts with family question. Some providers ask what is causing the serious conflicts, who they are with, whether there are kids involved, etc.
- Normalizing statements—lack of.

Transcript:

Red text represents notes for scripting.

In general, the provider sounds pleasant and friendly, but her tone isn't very dynamic, especially in the first two questions she asks. She usually sounds a little hesitant when she asks questions and accepts his responses.

SM always answers briefly. He doesn't sound belligerent or rude, but his tone of voice definitely conveys that he doesn't wish to say more.

PROVIDER: We'll get your DD 2900 form completed here, get it submitted and get you up to date.

PROVIDER: Overall you rate your health as good, about the same as before you deployed, but in the past four weeks you've had some emotional issues. Is that related to your deployment sir? Provider's tone sounds like she's reading a script—not unfriendly, but very rote.

SM: I don't know.

PROVIDER: Okay.

SM: I, I really don't know ma'am. This is the one place where the SM doesn't answer very briefly with a yes or no, and the one place where his tone doesn't sound quite as "closed" as in his other answers. His tone implies that he might answer more questions or explore the issue if given an opportunity, but the provider does not create one.

PROVIDER: Is it something you wanna be seen about sir?

SM: No ma'am.

PROVIDER: All right. You did not list any physical problems, however you did experience a blast and an explosion and a vehicle accident. Are you having any problems in that regard sir? Provider's tone sounds like she's reading a script—not unfriendly, but rote.

SM: No ma'am.

PROVIDER: Okay. It says here that you're irritable, having problems sleeping?

SM: Hmm hmm.

PROVIDER: As well as some serious conflicts with your family. Can we refer you to get some help?

SM: No ma'am.

PROVIDER: All right. Are you talking to someone about feeling down or depressed?
SM: No.
PROVIDER: All right.

Audio Clip 6

Summary: A very talkative SM is experiencing stress symptoms. He readily discloses to the provider, but is very concerned about stigma and the possibility that accepting a referral could result in him being asked to leave the military.

Background:
This SM is male and the provider is female. He endorsed many symptoms on his DD Form 2900. At the end of the call, he does accept a referral for emotional concerns.

Clip's Relationship to 7 Key Strategies:

- Partnering, legitimizing, and empathetic statements
- Education
- Other: Time management

Transcript:
Red text represents notes for scripting.
This provider generally sounds patient, even though the interview might have been frustrating due to the SM's talkativeness.
The SM is polite, generally fluent without too many pauses as he talks, though he's not a very fast speaker. He is very talkative. He seems to be thinking as he goes, and in fact seems aware that this could be excessive—he says he has some communication problems since returning, and when the provider asks him to clarify, he says "you know, like I'm doing right now, thinking while I talk." He sounds more in control than the transcript may make it appear, though. SM is always polite. Throughout the call, he describes situations about which he is disgruntled or disappointed, but his tone of voice never gets very animated; it's relatively flat.

PROVIDER: Okay. Are you still having those symptoms?
SM: Eh, I thin-, it comes and goes.
PROVIDER: Would you like to be seen again?
SM: Yea-, uh, there's a concern about that, as being booted from, being booted from the military.
PROVIDER: Oh, absolutely not, absolutely not. On other forms and surveys that you were fill, that you will fill out, they have even eliminated any questions to mental health or behavioral issues. They want service members to feel free to go and get the help without worrying about it affecting your career or stigma or any of that, so,
SM: Right.
PROVIDER: only where it's related to your health do they ask those questions. Anything else they don't even ask.
SM: Yeah, I mean I know, I mean definitely yeah if that's the case, you know definitely yeah.
PROVIDER: Okay.
SM: [he interrupts her as she's saying ok] there's just, there's, I mean just probably some residual concerns and I guess there's a lot of pressure, it's a lot of pressure in my mind,

you know a lot, it's not, I don't know if it's guilt or not, I'm not, I mean it could be part of that, I've, you know I've lifted, I've handled deceased U.S. soldiers.

PROVIDER: Oh boy. [SM doesn't really pause—SM says this quietly/empathetically when SM ends the sentence above, but SM starts his next sentence as she is speaking].

SM: And it's just, some of those things are just really starting to come back and then you know I have, then I have you know certain individuals that haven't been there done that and they try to tell you what to do, just it, it's a combination of things, . . . So I don't know if it's just something just to talk about or. . .

PROVIDER: Hmm hmm.

SM: maybe other things. I just wanna, the only thing is I just want, uh, you know a careful maintenance, you know on myself to make sure, hey I'm good, because I do like the military and I want to stay in a little longer.

PROVIDER: Okay. Yeah, yeah, I can hear that you're really anxious, but you know these, these are problems you wanna get taken care of while they're small,

SM: Right. [provider hasn't really paused in her sentence, SM just inserts quietly]

PROVIDER: so they don't just take over your life.

SM: Right, well you gotta understand too from a, from another individual's point of view too, ma'am, that yeah, they have every right to be anxious because that's they're, you know you're looking at a person's livelihood, their family, you know even,

PROVIDER: I do understand. Hmm hmm. [provider cuts him off here, politely (it was clear SM was going to keep talking if not interrupted—context—entire call is 35 minutes because the SM talks so much]

SM: you know and, and I appreciate that, cause like I said if somebody's apprehensive, that's a normal feeling.

PROVIDER: Sure it is.

SM: my whole goal is not to really be painted like, oh my God, here's another PTSD guy, so you know I'm trying to get away from that. [audio jumps here, just a technical glitch] I don't want to be the ordinary guy having a PTSD, you know? You know I want to make sure that that really is the problem and not everybody is trying to get out of the Army on PTSD cause I know it's a trend, it's a fad thing but I'm trying to make sure that hey look I want to stay in and if that's the problem I would like, I would *really* like and you know to remain dep-, a deployable asset.

PROVIDER: You know if that's a concern for you, um, I assure you that . . . none of those things that you've expressed are concerns that you do need to be worried about, but I can still hear that you're concerned. [Provider takes a breath, like she's about to say more, but SM answers]

SM: Oh, absolutely. Yeah, well the only thing I wanna do you know is really just sit down and talk I mean, but you don't think I should be out of the military on that?

PROVIDER: [pause, around 2 seconds] the whole point of going through this survey and speaking with me,

SM: Hmm hmm.

PROVIDER: is so that any problems that you are having can be addressed and dealt with before they get to the point where you might have to leave the military. They don't want that to happen. They wanna help you before you even get anywhere close to that. Okay?

SM: Yeah. Well I'm nowhere, I mean I'm nowhere close to that, I mean I know that.

PROVIDER: Hmm hmm. So don't worry that you will be penalized in any way for seeking help,

SM: Hmm hmm.

PROVIDER: that is the exact opposite of the whole point of this program.

SM: Okay. [sounds hesitant/ a little dubious]

PROVIDER: Okay?

SM: All right. [sounds hesitant/ a little dubious]

PROVIDER: Okay. I really want you to rest assured on that and be comfortable with that.

SM: mmm hmm. [Provider doesn't really pause between previous and next sentence—SM just inserts the mmm hmm as she's taking a breath]

PROVIDER: That is not the point of this program at all.

SM: Oh, okay. [still doesn't sound very sure]

PROVIDER: Yeah. The point is to identify problems and take care of them while they're small so that they don't really negatively impact your career, your family, your health, any of those things.

SM: Yeah, now in, like in your, let's just say if you had a personal opinion, you don't think it sounds like, like just some of the things I've said . . . and I hear a lot of hardcore soldiers say this, but it's, it's not a point of me being a whiner is it?

PROVIDER: No. Absolutely not. [Said very clearly and with emphasis (but calmly)]

SM: Okay. [Sounds relieved, said kind of snappily—all of his preceding "okays" and "all rights" sound a little uncertain—this one sounds accepting] Well at least that's good to know, so that way I can go ahead and know I can feel a little bit better to go ahead and clear these matters up and then I could be . . . furthermore productive.

PROVIDER: Absolutely.

Appendix F: External Meeting Schedule for Year Two

Table F.1 includes Planning Meetings (Task 6), Expert Panel Meetings (Task 5), and other meetings conducted for educational or informational purposes during Year 1.

Table F. 1 External meeting schedule for year one

Date	Format	Purpose	Attendees*
30-Sep-10	In-Person	Planning— Develop plan for conducting intervention based on information received about NDAA policy.	VU, Purdue
06-Oct-10	Teleconference	Weekly Planning—Discuss status of AFHSC data request.	VU, FHP&R, Purdue
13-Oct-10	Teleconference	Weekly Planning/Presentation—Present proposed intervention and research design to FHP&R for discussion.	VU, FHP&R, Purdue
25-Oct-10	Teleconference	Weekly Planning—Continue discussion of the proposed intervention and research design.	VU, FHP&R, Purdue
27-Oct-10	Teleconference	Presentation/Informational—To solicit feedback on proposed intervention and research design with regards to feasibility in relation to NDAA.	VU, FHP&R, FHP&R Journal Club
03-Nov-10	Teleconference	Weekly Planning—Discuss AFHSC and services data requests and project timeline.	VU, FHP&R, Purdue
09-Nov-10	Teleconference	Weekly Planning—Discuss AFHSC data request and project scope.	VU, FHP&R
18-Nov-10	Teleconference	Weekly Planning—Discuss progress and next steps for intervention development.	VU, FHP&R, Purdue
01-Dec-10	Teleconference	Weekly Planning—Discuss use of standardized patient in intervention.	VU, FHP&R
03-Dec-10	Teleconference	Planning—Continue intervention planning discussion	VU, FHP&R
09-Dec-10	Teleconference	Weekly Planning—Discuss intervention and research design and status of Services Data Requests	VU, FHP&R
13-Dec-10	Teleconference	Informational—To learn more about Army implementation of NDAA	VU, FHP&R, Army
21-Dec-10	Teleconference	Informational—To explore the possibility of using RIAS coding with a standardized patient methodology during our intervention.	VU, RIASWorks
22-Dec-10	Teleconference	Weekly Planning—Discuss AFHSC processing of data request and future Expert Panel meeting	VU, FHP&R, Purdue
30-Dec-10	In-Person	Informational—Discuss possibility of using standardized patients in the intervention.	VU, VU Center for Experiential Learning and Assessment (CELA)
05-Jan-11	Teleconference	Weekly Planning—Discuss plans for gathering Expert Panel feedback on intervention design.	VU, FHP&R

Date	Format	Purpose	Attendees*
12-Jan-11	Teleconference	Weekly Planning—refine intervention design and discuss abstracts being submitted for presentations based on secondary data analysis.	VU, FHP&R, Purdue
21-Jan-11	Teleconference	Weekly Planning—Intensive two hour meeting to refine intervention and research design.	VU, FHP&R
26-Jan-11	Teleconference	Informational—to explore pre-existing communications training workshops that could be adapted for this study.	VU, Oncotalk
28-Jan-11	Teleconference	Informational—to explore pre-existing communications training workshops that could be adapted for this study.	VU, SEGUE Framework
28-Jan-11	Teleconference	Informational—to explore pre-existing communications training workshops that could be adapted for this study.	VU, Institute for Communication in Healthcare (ICH)
28-Jan-11	Teleconference	Informational—to explore pre-existing communications training workshops that could be adapted for this study.	VU, American Academy on Communication in Healthcare (AACH)
28-Jan-11	Teleconference	Informational—to explore pre-existing communications training workshops that could be adapted for this study.	VU, Kaiser Permanente
02-Feb-11	Teleconference*	Presentation—for MRMC MOMRP PTSD IPR (*scheduled to take place in person, but changed to teleconference due to the airline's last minute cancellation of VU's flight).	VU, Medical Research and Materiel Command (MRMC)
09-Feb-11	Teleconference	Weekly Planning— Discuss survey administration logistics.	VU, FHP&R, Purdue
14-Feb-11	Teleconference	Planning—Discuss problems of and solutions for merging data from AFHSC and VA for Purdue's research.	VU, FHP&R, AFHSC, Purdue, VA
23-Feb-11	Teleconference	Weekly Planning—Discuss research design and process for obtaining approval for changes to project's scope of work.	VU, FHP&R, Purdue
2-Mar-11	Teleconference	Weekly Planning—Discuss IRB protocols.	VU, FHP&R
9-Mar-11	Teleconference	Weekly Planning—Discuss preparation of the tasker to request information on Army Installations that could participate in the training.	VU, FHP&R
30-Mar-11	Teleconference	Planning—Discuss development of a standardized patient (SP) for use in the provider training workshop.	VU, VU Center for Experiential Learning and Assessment (CELA)
31-Mar-11	Teleconference	Weekly Planning— Discuss logistics for collecting data from installations.	VU, FHP&R

Date	Format	Purpose	Attendees*
31-Mar-11	Teleconference	Informational—Discuss ICH communications training workshop.	VU, ICH
5-Apr-11	Teleconference	Informational—Discuss AACH communications training workshop	VU, AACH
6- Apr -11	Teleconference	Weekly Planning— Discuss training development and IRB submissions.	VU, FHP&R, Purdue
7- Apr -11	Teleconference	Planning—To discuss the role of CELA in training simulated patients (SPs).	VU, CELA
8- Apr -11	In-Person	Planning—To discuss Dr. Webb's role in training development.	VU, Dr. Lynn Webb of Vanderbilt University Medical Center (VUMC)
13- Apr -11	Teleconference	Weekly Planning— modification to Army Data Use Agreement (DUA).	VU, FHP&R
21- Apr -11	In-Person	Planning—Provider training development.	VU, CELA
28-Apr-11	Teleconference	Weekly Planning—Discuss training and update on progress.	VU, FHP&R, Purdue
4-May-11	Teleconference	Weekly Planning—Discuss process of selecting Army sites to participate in the training.	VU, FHP&R, Army Office of the Surgeon General (OTSG)
6-May-11	In-Person	Planning—Provider training development	VU, CELA, VUMC
11-May-11	Teleconference	Weekly Planning—Share updates on progress of approvals and tasker preparation.	VU, FHP&R, OTSG, Purdue
12-May-11	In-Person	Planning—Provider training development	VU, CELA, VUMC
18-May-11	In-Person	Planning—Provider training development	VU, CELA, VUMC
20-May-11	Teleconference	Weekly Planning—Discuss training development and protocol for contacting sites.	VU, FHP&R, OTSG
1-Jun-11	Teleconference	Weekly Planning—Discuss process for developing SP back story and process for soliciting feedback from PDHRA experts.	VU, FHP&R
1-Jun-11	In-Person	Planning—Training development	VU, VUMC
2-Jun-11	Teleconference	Approvals—For VU to answer questions about submitted protocols	VU, MRMC
8-Jun-11	Teleconference	Weekly Planning—Discuss potential site visit locations with regional medical commands (RMCs).	VU, FHP&R, OTSG, RMCs
15-Jun-11	Teleconference	Weekly Planning—Hear WRMC's feedback on the proposed training and discuss development of SP back stories with Dr. Victoria Bruner (WRAMC)	VU, FHP&R, OTSG, Western Region Medical Command (WRMC), Walter Reed Army Medical Center (WRAMC)

Date	Format	Purpose	Attendees*
29-Jun-11	Teleconference	Weekly Planning—Share updates on approvals progress and on transfer of data from VU to Purdue.	VU, FHP&R, OTSG, WRMC
12-Jul-11	In-Person	Planning—Training development	VU, CELA, VUMC
14-Jul-11	Teleconference	Weekly Planning—Share updates on approvals, site selection, and Purdue data.	VU, FHP&R, OTSG
21-Jul-11	In-Person	Planning—Training Development	VU, CELA, VUMC
21-Jul-11	Teleconference	Planning—Development of standardized patient back stories	VU, FHP&R, WRAMC
22-Jul-11	Teleconference	Planning—Development of standardized patient back stories	VU, WRAMC
27-Jul-11	Teleconference	Weekly Planning—Share updates and discuss possibility of VU visiting an Army installation to observe during PDHRA event.	VU, FHP&R, OTSG
28-Jul-11	In-Person	Planning—Training development	VU, VUMC
2-Aug-11	Teleconference	Planning—Development of standardized patient back stories	VU, FHP&R, WRMC, Fort Carson
3-Aug-11	Teleconference	Weekly Planning—Share audio cases developed for training and solicit feedback from FHP&R.	VU, FHP&R, OTSG
4-Aug-11	In-Person	Planning—Training development	VU, CELA, VUMC
8-Aug-11	In-Person	Informational/Planning—Discuss process for hiring actors to record audio case examples for the training.	VU, Vanderbilt Department of Media Operations
9-Aug-11	Teleconference	Informational—Clarify the nature of data fields in Air Force dataset.	VU, Air Force Medical Support Agency
9-Aug-11	Teleconference	Planning—Development of standardized patient back stories.	VU, FHP&R, CELA, WRMC, Fort Carson
9-Aug-11	Teleconference	Informational— Clarify the nature of data fields in Army dataset.	VU, Army data manager
10-Aug-11	Teleconference	Weekly Planning—Share updates on site identification and interpretation of data received from the Services.	VU, FHP&R, OTSG
11-Aug-11	Teleconference	Informational—Discuss use of FileMaker program for administration of Service Member (SM) survey.	VU, Peabody Research Institute (Vanderbilt)
11-Aug-11	Teleconference	Informational—Clarify the nature of data fields in the Navy dataset.	VU, Navy data manager
17-Aug-11	Teleconference	Planning—Development of standardized patient back stories	VU, CELA, FHP&R, WRMC, Fort Carson
17-Aug-11	Teleconference	Weekly Planning—Discuss scheduling of Expert Panel meeting	VU, FHP&R, OTSG
18-Aug-11	In-Person	Planning—Training development	VU, CELA, VUMC
23-Aug-11	In-Person	Planning—Training development	VU, VUMC

Date	Format	Purpose	Attendees*
24-Aug-11	Teleconference	Weekly Planning—Discuss training site selection and scheduling of Expert Panel meeting.	VU, FHP&R, OTSG
24-Aug-11	Teleconference	Planning—Discuss secondary analysis and publication development.	VU, Purdue
26-Aug-11	Teleconference	Informational/Planning—Informational meeting focusing on current PDHRA practice, logistics, and content.	VU, VUMC, Fort Belvoir Medical Treatment Facility, OTSG
27-Aug-11	In-Person	Planning—Record audio case examples for use in the training.	VU, Vanderbilt Department of Media Operations
30-Aug-11	Teleconference	Informational/Planning—coordinate directly with Fort Carson leadership about possibility of conducting the training there.	VU, FHP&R, OTSG, Fort Carson
31-Aug-11	Teleconference	Weekly Planning—Discuss training site selection and format of Expert Panel meeting.	VU, FHP&R, OTSG
02-Sep-11	In-Person	Informational/Planning—coordinate directly with Fort Campbell leadership about possibility of conducting the training there.	VU, Fort Campbell
06-Sep-11	In-Person	Planning—Training of standardized patients who will be used in the provider communication training.	VU, CELA, VUMC
07-Sep-11	Teleconference	Weekly Planning—Discuss training site selection and Tasking timeline.	VU, FHP&R, OTSG
09-Sep-11	In-Person	Planning—Training of standardized patients.	VU, CELA, VUMC
14-Sep-11	Teleconference	Weekly Planning—Discuss training site selection.	VU, FHP&R, OTSG
15-Sep-11	Teleconference	Expert Panel Meeting—Present finalized communication workshop	VU, FHP&R, OTSG, Expert Panel
21-Sep-11	Teleconference	Weekly Planning—Discuss training site selection.	VU, FHP&R, OTSG
22-Sep-11	Teleconference	Informational/Planning—coordinate directly with Fort Stewart leadership regarding training logistics.	VU, OTSG, Fort Stewart
26-Sep-11	Teleconference	Informational/Planning—coordinate directly with Fort Campbell leadership regarding training logistics.	VU, OTSG, Fort Campbell
28-Sep-11	In-Person	Informational/Planning—Present details of the study to medical leadership at Fort Campbell.	VU, Fort Campbell, FHP&R (FHP&R via telephone)
28-Sep-11	Teleconference	Weekly Planning—discuss training schedule and next steps for coordination with sites.	VU, FHP&R, OTSG

* Key to Attendees:

VU typically includes Dr. Susan Kelley, Dr. Melanie Leslie, and Ms. Stephanie Boyd

OTSG typically includes Ms. Amanda Wagner and LTC Michelle Mango
FHP&R typically includes CDR Nicole Frazer, Dr. Mark Paris, and Ms. Melissa Fraine
CELA typically includes Ms. Lisa Rawn, Ms. Darlene Whetsel, and Mr. Alan Johnstone

Appendix G: Standardized Patient Cases

Introduction:
This appendix includes the four standardized patient (SP) cases that will be used during the training. These materials will be distributed to actors learning to play the parts of soldiers taking part in a PDHRA interview. Each case includes the following components:

1. **Description of the PDHRA Process**: This section details what the day of the PDHRA is like from the soldier's point of view. Each SP will receive the same information, which is only included once in this appendix. (The other three sections differ for each SP).

2. **Summary Sheet**—This is a single page overview of the case.

3. **Case Details—**A longer case description which is written as a guide for the actor who will take on the role of this SP during the training. Not all of the information in this section is expected to come up during the interviews, but it serves to help give the actor a deeper understanding of the person he or she is portraying. This section also contains guidance on the types of questions the provider is likely to ask the SP and on appropriate answers, which will vary dependent on the provider's communication techniques.

4. **Form DD 2900 Self-Report**—The three pages of the DD Form 2900 that make up the SM Self-Report portion of the PDHRA interview. These have been completed to reflect the answers each soldier being portrayed would give, and during the training, the provider conducting the practice interview will receive this form. (The provider will receive all five pages, though only the three filled out by the soldier are included here).

Description of the PDHRA Process

There are three components to this section. The first describes how the SM would experience the process at a large SRP, while the second describes what the process would be like at a small medical clinic. The third component is a general guide to the types of questions that SPs can expect providers to ask during interviews.

PDHRA Experience at a Large Processing Center:

You filled out the PDHRA online 2 days ago. Your task for the day is to complete the PDHRA interview along with other deployment readiness tasks, including dental and vision checks, and immunizations. You do this with the rest of your unit at the Soldier Readiness Processing (SRP) site, which is a large open gymnasium-type building. The entire process will take about half a day (4 hours). You are motivated to complete the process quickly.

When you arrive at the SRP site, you check in and receive papers that you will carry around with you to get everything taken care of. Each activity (PDHRA, dental, etc.) is set up as a station around the very large room. You wind your way through the stations, waiting in line at each one. For the PDHRA, there is a long line to talk with the providers. There are only a few providers, and many Soldiers waiting to see them.

Your commander supports the PDHRA, but also is also concerned about the time spent at the SRP site because it is time away from critical training drills that will prepare your unit to deploy again. In your mind, the PDHRA is an item on a checklist that needs to be completed so you can deploy again.

The actual interview is typically only a few minutes (5-7 min), but waiting in line to see the provider might take 30 min to an hour. The providers are in cubicles that are private, but the cubicle doors are in view of the Soldiers waiting in line. Thus, others might notice if you take a long time talking to the provider, possibly revealing that something is wrong.

PDHRA Experience at a Small Medical Clinic:

You filled out the PDHRA online 2 days ago. You have been tasked this morning to get you PDHRA interview completed. You do this at a small medical clinic on the base; you have an appointment to be there at a specific time. The rest of your unit is also completing today; each with his or her own appointment. The entire process might take you an hour. You are motivated to complete the process quickly.

When you arrive at the clinic, you check in and sit in the waiting room with a few other Soldiers who are also waiting to talk to the provider.

Your commander supports the PDHRA, but also is also concerned about the time spent at the clinic because it is time away from critical training drills that will prepare your unit to deploy again. In your mind, the PDHRA is an item on a checklist that needs to be completed so you can deploy again.

The actual interview is typically only a few minutes (5-7 min), but waiting to see the provider might take 10-20 min. The providers are in private rooms in the back, but everyone must enter and exit through the waiting room, so others will see how long you were talked with the provider

Dialogue to Expect while Clinician Reviews Self-Report with You:
Typical closed-ended questions about your self-report might be asked for each question you endorsed. For example, the provider might ask "is that still a problem?" If you respond yes, they might ask "are you in treatment?" If your respond yes, they might ask "are you satisfied with treatment?"

- Qx -2 so it says here your health is good, but somewhat worse than before you deployed, is that right?
- Qx 3-4 And it says it's been very difficult for you physically, and also you've had some emotional problems. Is that something you'd like a referral for? Or Tell me more about that.
- Qx 8 You marked you're having trouble with joint pain, ringing in the ears, and also problems sleeping and that you're irritable, is that right? Are you in treatment for that? Would you like a referral to get that taken care of?
- Qx 9 If items are endorsed: Have you been evaluated for TBI (traumatic brain injury)? Your symptoms might indicate a TBI, let's get you seen for that.
- Qx 10: same as 8, except for exposure concerns
- Qx 12: If items endorsed – You've had nightmares and thought about an experience when you didn't want to. These symptoms could be consistent with PTSD, have you been evaluated for that? Would you like to talk with someone about these symptoms?
- Qx 14: If endorsed— You indicated you've experienced little pleasure or interested in doing things and that you've felt down or hopeless few or several days in the past month. Would you like to talk with someone about that?
- Qx 15-18: I see you'd like to make an apt with a healthcare provider to discuss your health concerns..... I can give you a referral to make that apt.
- Clinician section**:**
    - Qx2-3 Will ask questions about harm to self or others verbatim (or nearly so)
    - Qx4-5: based on responses of SM to qx 9 and 13 clinician will evaluate risk for alcohol and TBI
    - Qx 7-8: provider will indicate where he/she has a concern, whether SM is already under care, and what referrals are provided.

Summary Sheet—Case 1

Working title: "Barriers to Care"

Demographics:

- White male, 20 yrs
- Never married, girlfriend 2 years, no children
- 1 deployment to Afghanistan, 9 mo, returned 5 months ago.
- E3 (Private First Class)
- 1.5 years service total
- Very religious; high moral standards

Deployment Experience:

- Field 11B – Infantryman
- Concerned about exposures to noise, sand, burning trash, and fog/oils – coughing, headaches, tired; also injured ankle during a firefight and it has continued to cause problems
- Two buddies in his unit died in front of him from an IED; some associated PTSD symptoms – feels distant and detached; emotionally confused

Motivation:

- Feels anxious about physical concerns and thinks if he could get these addressed he'd feel better
- Things are emotionally confusing for him right now, but he blames this mostly on frustration with his physical injuries. He is aware that he's different than before he left but unsure how much of this would just be a normal reaction that he should accept.

Demeanor during Interview:

- Pleasant and friendly; a "good kid"
- Doesn't want to complain, but wants to get physical injuries taken care of
- Willing to talk about emotional issues honestly, but somewhat reticent; he's not sure what he'll get out of telling the provider all his problems. Concerned about confidentiality.

Presenting Issue(s):

- Ankle injury, ringing in ears, coughing, headaches, tiredness
- Anxiety, but if asked might have difficulty explaining the reason, or will say it's probably due to his frustration with physical symptoms

Emotional/Behavioral Issues to Uncover:

- Feels detached from girlfriend, sometimes trouble sleeping, some depressive symptoms (feeling down, experiencing little joy)
- Concerned about confidentiality of revealing emotional concerns or getting treatment

Key Communication Strategies Addressed:

- Key words at key times: Using open-ended prompts and questions to increase opportunities for Soldier disclosure
- Using legitimizing statements to normalize deployment and reintegration experiences as well as common barriers to disclosure
- Using empathic statements to build the relationship
- Providing brief psychoeducation to encourage future utilization of healthcare and support resources

Case Details

General Service Member Information:

20 year old white male; well groomed, shaven, neat. Wearing military uniform

Social History

You were born and raised in Alabama to an in-tact family.

You live alone and have a girlfriend of 2 years. She is supportive, but doesn't understand your deployment experience. Neither of you have children. You talk with your parents weekly by phone, but they are out of state (Alabama). You talk with some friends from high school through face book and other social media, but don't talk about deployment much because they don't understand. You are friendly with guys in your unit, but you all mostly joke around and don't share deep feelings, especially ones that make you feel vulnerable You are close with some unit members, but are uncertain of their reaction if you were to admit to mental health problems. You are concerned you would be perceived as weak or lose the respect of your peers.

Military History

- Rank – E3 (private first class); 1.5 years total service
- Deployment history – one deployment to Afghanistan '10-'11; 9 months long
- Job – Infantryman - The infantry is the main land combat force and backbone of the Army. It's equally important in peacetime and in combat. The Infantryman's role is to be ready to defend our country in peacetime and to capture, destroy and repel enemy ground forces during combat.

Duties You Perform

- Assists in the performance of reconnaissance operations. Employs, fires, and recovers anti-personnel and anti-tank mines. Locates and neutralizes mines. Operates, mounts/dismounts, zeros, and engages targets using night vision sight. Operates and maintains communications equipment and operates in a radio net. Operates in a NBC contaminated area. Constructs field expedient firing aids for infantry weapons. Performs as a member of a fire team during a movement to contact, reconnaissance, and security, an attack, defense, situational training exercises and all infantry dismounted battle drills. Processes prisoners of war and captured documents.
- Leads an infantry team in combat operations, providing tactical and technical guidance to subordinates and professional support to both superiors and subordinates in the accomplishment of their duties. Leads, supervises, and trains subordinate personnel. Calls for and adjusts indirect fire. Evaluates terrain and selects weapon emplacement. Controls organic fires. Installs and recovers anti-handing devices on anti-tank mines and electrical and non-electrical demolition charges. Supervises construction of hasty fortifications and receipt, storage, and issue of ammunition. Records operational information on maps. Receives and implements combat orders, directs deployment of personnel in offensive, defensive, and retro grade operations. Requests, observes, and adjusts direct supporting fire. Evaluates terrain and supervises the emplacement of sighting and firing all assigned weapons. Uses maps and map overlays, performs

intersection and resection, and determines elevation and grid azimuths. Leads a fire team during a movement to contact, reconnaissance and security, an attack, defense, situational training exercises, and all infantry dismounted battle drills.

Deployment Experience (most recent deployment)

- This deployment is the first time you have been away from home for a significant period of time, and the first time out of the country.
- 2 members of your unit were killed in IED attack, but you were not personally wounded. You saw these men die; one "turned into pink mist," the other had severe shrapnel wounds. This is the first time you have seen anyone dying or dead.
- The IED that killed your friends left you feeling dazed and confused.
- Later in your deployment you gave some beanie babies your girlfriend had sent you in a care package to some kids. You heard later that kids and their families were often killed for accepting gifts like that, and you often wondered if that family had had trouble because you never saw them again.
- You were exposed to noise (artillery), sand, burning trash, and fog oils.
- Near the end of your deployment you injured your ankle (bad sprain) during a fire fight and are still experiencing soreness that interferes with his duties. You are concerned about your physical health.

Physical and Emotional Symptoms

- Your ankle is sore, especially during physical activity like running or weight lifting. This has restricted your duties, which is upsetting to you.
- You experience coughing, headaches, and fatigue and you wonder if those could be due to the exposures.
- You feel detached from your girlfriend, she complains you are not as much fun as you used to be, and not as loving.
- You suffer from anxiety, but attribute it to physical problems (i.e., not being able to do the things you want to do).
- You think about the IED incident when you don't want to and have trouble sleeping due to rumination. You get 5-6 hours of sleep most nights, but at least once a week, you only get 3-4 hours. This is due both to trouble falling asleep and to waking up in the middle of the night.

Your Motivation

- You want to get your physical concerns addressed and resolved. You are worried that your ankle will not heal or that you'll continue to feel sick due to something you were exposed to. You feel anxious, but you attribute this to concern over physical symptoms.
- You don't want to admit mental health problems, but do feel "different" than before deployment.
- You are concerned about confidentiality if you disclose mental health problems.

Behavior/Demeanor during interview

- You are calm, friendly, but somewhat shy. You'll smile when you greet the provider, and you're friendly. If the provider asks how you are, you'd ask the same question back. (i.e. "I'm good, thanks. How are you?" You call the provider sir or ma'am, and at least in

the beginning of the interview, your demeanor is somewhat "lively" or "snappy." (You're "on the job" and that sets your demeanor).

- You are willing to talk about deployment experiences if asked, but mainly physical symptoms. You might not elaborate on mental health symptoms because you are concerned about stigma, and also because you are not really sure what's going on with you.
- You are generally not willing to disclose mental health problems. You are concerned about seeming weak or being ostracized in his unit.
- You would be willing to get professional help if you knew it could be confidential and helpful, but you need to be convinced of this.
- You believe mental health problems are embarrassing and indicate a weakness. You aren't sure how effective treatment would be and fear the stigma attached to having 'mental health' issues. You have no coping strategies.

Previous Treatment

- You had no physical or emotional symptoms before deployment.
- About 3 months ago you went to your primary care doctor about your ankle and the coughing/headaches/tiredness.
  i. For your ankle, the doctor restricted your duties, prescribed ibuprofen (800mg 3x per day), gave you a sheet with some strengthening exercises to try, and told you to ice for soreness 3x per day. The ankle is still sore and you cannot resume your normal drills.
  ii. For the coughing/headaches/tiredness, the severity was low to moderate, and the doctor suggested these things would improve with time, so he did not prescribe anything. The coughing has improved somewhat, but the headaches and tiredness are persistent.
  iii. You did not mention your mental health symptoms (feeling detached, anxiety, flashbacks about IED, trouble sleeping)

Potential Dialogue during Interview

You will not elaborate on any mental health symptoms unless reassured by provider that it will remain confidential and that treatment could help your symptoms. You see yourself mostly as having physical problems that are irritating.

Criteria for dialogue during the interview

Goal: The purpose of this interview is for the provider to practice helping the SM recognize his mental health symptoms and getting him to accept a referral despite the SM's concerns about stigma and confidentiality.

- If asked what's making things difficult for him (e.g., in response to qx 3 or 4 or any behavioral health problems) he'd answer in disorganized way.
  - "Well, I just haven't really felt like myself; it's just sort of different than before, but I guess that's all normal post-deployment stuff." "I just get frustrated with my ankle and the headaches and stuff; I think I'd feel better if that were taken care of"

- If asked if you are on profile, the answer is "yes, I'm on limited duty." If provider asked for specific profile, the answer would be L2 (limited duty due to mild/moderate lower extremity problems.
- For SM to accept referral, provider must educate him that he might have a mental health problem, and also convince him that a referral will remain confidential.
    - Regarding having a mental health problem, the provider might say: we see a lot of people come back with these symptoms and it's something we can help you with
- Provider then needs to tell SM it's confidential. However, SM shouldn't say directly that he wants the referral to be confidential. This SM would say instead that he doesn't want his buddies to know, etc.
    - SM - "well, this won't get back to my unit, right? I mean, I don't want people thinking I'm a whiner"
    - Provider – it's intended to help you before there's a problem and won't be used against you. We want to help you get healthy so you can remain deployable
    - After the reassurance that the referral is confidential, we recommend that the SP say something like "are you sure?" before accepting. (He doesn't need more details or information—just one more reassurance).
- If the provider asks whether the SP has talked to anyone about the explosion, he might say something like "no, not really." Use a response like this if the provider asks if you've talked to anyone on base about being stressed, or anything similar.
- If provider doesn't give any reassurance, SM would not accept referral ("no, I don't think I need a referral now").
- In response to a general question about qx 11 (family conflict) – if provider asks "what do you mean by that" [unsure response] he would mention problems relating to girlfriend – "she says I'm different"; "harder for us to understand each other."
- If any probing questions about mental health (beyond what's on the form) – he'd talk about thinking about IED, and trouble sleeping
- If asked about stigma concerns, soldier would say "I don't want to be seen as weak . . . 'cause I'm not."
- If discussing opinions about treatment, soldier would *not* make a strong statement like "I know none of that stuff works." He would say things like "well, it's just normal to feel like this, isn't it? I don't see how treatment would help."

Form DD 2900 Self-Report Below

1_Young Enlisted

This form must be completed electronically. Handwritten forms will not be accepted.

POST-DEPLOYMENT HEALTH RE-ASSESSMENT (PDHRA)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, 1074f, 3013, 5013, 8013 and E.O. 9397.

PRINCIPAL PURPOSE(S): To assess your state of health after deployment in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care you may need. The information you provide may result in a referral for additional healthcare that may include medical, dental or behavioral healthcare or diverse community support services.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, to other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

DISCLOSURE: Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before entering your response or marking your selection. **YOU ARE ENCOURAGED TO ANSWER EACH QUESTION.** Withholding or providing inaccurate information may impair a healthcare provider's ability to identify health problems and refer you to appropriate sources for additional evaluation or treatment. If you do not understand a question, please ask for help. Please respond based on your **MOST RECENT DEPLOYMENT**.

DEMOGRAPHICS

Last Name | **First Name** | **Middle Initial**

Social Security Number | **Date of Birth** *(dd/mmm/yyyy)* | **Today's Date** *(dd/mmm/yyyy)*

Date arrived theater *(dd/mmm/yyyy)* | **Date departed theater** *(dd/mmm/yyyy)*

Gender
- (●) Male
- ( ) Female

Marital Status
- (●) Never Married
- ( ) Married
- ( ) Separated
- ( ) Divorced
- ( ) Widowed

Service Branch
- ( ) Air Force
- (●) Army
- ( ) Navy
- ( ) Marine Corps
- ( ) Coast Guard
- ( ) Civilian Employee
- ( ) Other

Status Prior to Deployment
- (●) Active Duty
- ( ) Selected Reserves - Reserve - Unit
- ( ) Selected Reserves - Reserve - AGR
- ( ) Selected Reserves - Reserve - IMA
- ( ) Selected Reserves - National Guard - Unit
- ( ) Selected Reserves - National Guard - AGR
- ( ) Ready Reserves - IRR
- ( ) Ready Reserves - ING
- ( ) Civilian Government Employee
- ( ) Other

Pay Grade

( ) E1	( ) O1	( ) W1
( ) E2	( ) O2	( ) W2
(●) E3	( ) O3	( ) W3
( ) E4	( ) O4	( ) W4
( ) E5	( ) O5	( ) W5
( ) E6	( ) O6	
( ) E7	( ) O7	( ) Other
( ) E8	( ) O8	
( ) E9	( ) O9	
	( ) O10	

Location of Operation

To what areas were you mainly deployed *(land-based operations more than 30 days)*? Please mark all that apply, including the number of months spent at each location.

(●) Country 1	Afghanistan	Months	9
( ) Country 2		Months	
( ) Country 3		Months	
( ) Country 4		Months	
( ) Country 5		Months	

Since return from deployment I have:
- (●) Maintained/returned to previous status
- ( ) Transitioned to Selected Reserves
- ( ) Transitioned to IRR
- ( ) Transitioned to ING
- ( ) Retired from Military Service
- ( ) Separated from Military Service

Current Contact Information:

Phone:
Cell:
DSN:
Email:
Address:

Total Deployments in Past 5 Years:

OIF	OEF	Other
( ) 1	(●) 1	( ) 1
( ) 2	( ) 2	( ) 2
( ) 3	( ) 3	( ) 3
( ) 4	( ) 4	( ) 4
( ) 5 or more	( ) 5 or more	( ) 5 or more

Current Unit of Assignment

Current Assignment Location

Point of Contact who can always reach you:

Name:
Phone:
Email:
Mailing Address:

1_Young Enlisted

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

1. **Overall, how would you rate your health during the PAST MONTH?**
   - ○ Excellent
   - ○ Very Good
   - ● Good
   - ○ Fair
   - ○ Poor

2. **Compared to before your most recent deployment, how would you rate your health in general now?**
   - ○ Much better now than before I deployed
   - ○ Somewhat better now than before I deployed
   - ○ About the same as before I deployed
   - ● Somewhat worse now than before I deployed
   - ○ Much worse now than before I deployed

3. **During the past 4 weeks, how difficult have physical health problems** *(illness or injury)* **made it for you to do your work or other regular daily activities?**
   - ○ Not difficult at all
   - ○ Somewhat difficult
   - ● Very difficult
   - ○ Extremely difficult

4. **During the past 4 weeks, how difficult have emotional problems** *(such as feeling depressed or anxious)* **made it for you to do your work, take care of things at home, or get along with other people?**
   - ○ Not difficult at all
   - ● Somewhat difficult
   - ○ Very difficult
   - ○ Extremely difficult

5. **Since you returned from deployment, about how many times have you seen a healthcare provider for any reason, such as in sick call, emergency room, primary care, family doctor, or mental health provider?**
   - ○ No visits
   - ○ 1 visit
   - ● 2-3 visits
   - ○ 4-5 visits
   - ○ 6 or more

6. **Since you returned from deployment, have you been hospitalized?** ○ Yes ● No

7. **During your deployment, were you wounded, injured, assaulted or otherwise physically hurt?** ● Yes ○ No

   If **NO**, skip to Question 8.

   7a. If **YES**, are you still having problems related to this wound, assault, or injury? ● Yes ○ No ○ Unsure

8. **In addition to wounds or injuries you listed in question 7., do you currently have a health concern or condition that you feel is related to your deployment?** ○ Yes ○ No ● Unsure

   If **NO**, skip to Question 9.

8a. If **YES**, please mark the item(s) that best describe your deployment-related condition or concern:

○ Fever	○ Dimming of vision, like the lights were going out
● Cough lasting more than 3 weeks	● Chest pain or pressure
● Trouble breathing	● Dizzy, light headed, passed out
● Bad headaches	○ Diarrhea, vomiting, or frequent indigestion/heartburn
○ Generally feeling weak	● Problems sleeping or still feeling tired after sleeping
○ Muscle aches	○ Trouble concentrating, easily distracted
● Swollen, stiff or painful joints	○ Forgetful or trouble remembering things
○ Back pain	○ Hard to make up your mind or make decisions
○ Numbness or tingling in hands or feet	● Increased irritability
○ Trouble hearing	○ Taking more risks such as driving faster
● Ringing in the ears	○ Skin diseases or rashes
○ Watery, red eyes	○ Other *(please list)*: _____

9a. During this deployment, did you experience any of the following events? *(Mark all that apply)*

	Yes	No
(1) Blast or explosion *(IED, RPG, land mine, grenade, etc.)*	●	○
(2) Vehicular accident/crash *(any vehicle, including aircraft)*	○	●
(3) Fragment wound or bullet wound above your shoulders	○	●
(4) Fall	○	●
(5) Other event *(for example, a sports injury to your head)*. Describe:	○	●

9b. Did any of the following happen to you, or were you told happened to you, IMMEDIATELY after any of the event(s) you just noted in question 9a.? *(Mark all that apply)*

	Yes	No
(1) Lost consciousness or got "knocked out"	○	●
(2) Felt dazed, confused, or "saw stars"	●	○
(3) Didn't remember the event	○	●
(4) Had a concussion	○	●
(5) Had a head injury	○	●

c. Did any of the following problems begin or get worse after the event(s) you noted in question 9a.? *(Mark all that apply)*

	Yes	No
(1) Memory problems or lapses	○	●
(2) Balance problems or dizziness	○	●
(3) Ringing in the ears	○	●
(4) Sensitivity to bright light	○	●
(5) Irritability	●	○
(6) Headaches	○	●
(7) Sleep problems	●	○

d. In the past week, have you had any of the symptoms you indicated in 9c.? *(Mark all that apply)*

	Yes	No
(1) Memory problems or lapses	○	●
(2) Balance problems or dizziness	○	●
(3) Ringing in the ears	○	●
(4) Sensitivity to bright light	○	●
(5) Irritability	●	○
(6) Headaches	○	●
(7) Sleep problems	●	○

1_Young Enlisted

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

10. Do you have any persistent major concerns regarding the health effects of something you believe you may have been exposed to or encountered while deployed? ● Yes ○ No
If **NO**, skip to question 11.

10a. If **YES,** please mark the item(s) that best describe your concern:

○ Animal bites	● Loud noises
○ Animal bodies *(dead)*	○ Paints
○ Chlorine gas	○ Pesticides
○ Depleted uranium *(If yes, explain)* _____	○ Radar/Microwaves
○ Excessive vibration	● Sand/dust
● Fog oils (smoke screen	● Smoke from burning trash or feces
○ Garbage	○ Smoke from oil fire
○ Human blood, body fluids, body parts, or dead bodies	○ Solvents
○ Industrial pollution	○ Tent heater smoke
○ Insect bites	○ Vehicle or truck exhaust fumes
○ Ionizing radiation	○ Other exposures to toxic chemicals or materials, such as ammonia, nitric acid, etc.: *(If yes, explain)*
○ JP8 or other fuels	_____
○ Lasers	

11. Since return from your deployment, have you had serious conflicts with your spouse, family members, close friends, or at work that continue to cause you worry or concern? ○ Yes ○ No ● Unsure

12. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you ....

a. Have had nightmares about it or thought about it when you did not want to? ○ Yes ● No

b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? ○ Yes ● No

c. Were constantly on guard, watchful, or easily startled? ○ Yes ● No

d. Felt numb or detached from others, activities, or your surroundings? ○ Yes ● No

13a. In the PAST MONTH, Did you use alcohol more than you meant to? ○ Yes ● No

b. In the PAST MONTH, have you felt that you wanted to or needed to cut down on your drinking? ○ Yes ● No

c. How often do you have a drink containing alcohol?
● Never ○ Monthly or less ○ 2 to 4 times a month ○ 2 to 3 times a week ○ 4 or more times a week

d. How many drinks containing alcohol do you have on a typical day when you are drinking?
○ 1 or 2 ○ 3 or 4 ○ 5 or 6 ○ 7 to 9 ○ 10 or more

e. How often do you have six or more drinks on one occasion?
● Never ○ Less than monthly ○ Monthly ○ Weekly ○ Daily

14. Over the PAST MONTH, have you been bothered by the following problems?	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	●	○	○	○
b. Feeling down, depressed, or hopeless	●	○	○	○

15. Would you like to schedule a visit with a healthcare provider to further discuss your health concern(s)? ● Yes ○ No

16. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? ○ Yes ● No

17. Are you currently interested in receiving assistance for a family or relationship concern? ○ Yes ● No

18. Would you like to schedule a visit with a chaplain or a community support counselor? ○ Yes ● No

Summary Sheet—Case 2

Working title: Avoidance and Denial

Demographics:

- White male, 27 yrs
- Married 7 years, no children
- E5 (Sgt)
- 2 deployments to Afghanistan '04-'05 and '10-'11, 1 year each
- 8 years of service total

Deployment Experience:

- Worked in field artillery; including drawing fire from enemy, working as first responder
- Experienced daily mortar attacks at the FOB
- Korengal Valley was most recent deployment ("worst place on earth")
- Unit leaders rely on him heavily
- He also acted as a first responder and treated severely burned local children who had been wounded by land mines
- Lost several buddies in deployment

Motivation:

- Chief complaint is medically unexplained pain in low back and knees. He'd really like to figure out what the problem is and get it fixed so he can deploy again. He doesn't believe he has a mental health issue beyond mild anxiety.

Demeanor during Interview:

- Taciturn
- Gives one word answers and does not elaborate easily
- Pleasant
- Quite reserved; doesn't like to talk about his mental health problems much
- Physically presents as very still but can't seem to help jiggling his leg (and doesn't seem to notice it)

Presenting Issue(s):

- Medically unexplained pain in knees and low back
- insomnia
- Head aches
- GI symptoms
- Mild anxiety

Emotional/Behavioral Issues to Uncover:

- Little enjoyment from things that used to be enjoyable
- Erectile dysfunction
- Nightmares of burned and wounded children being brought to him (he calls them dreams)
- Socially isolated except for his wife and immediate family (moth and grandfather)

Key Communication Strategies Addressed:

- Key words at key times: Using open-ended prompts and questions to increase opportunities for Soldier disclosure

Partnering with the Soldier in your summary

Case Details

General Service Member Information:

27 year old white male; well groomed, shaven, neat. Wearing military uniform

Social History

You are Sergeant Robert Woodson, born and raised in Alabama. You have been married 7 years and your wife is very supportive. Your parents are still together and you are very close with your mom and grandfather. You stay connected with your friends on Facebook and other social media, but mostly talk only with your mom, wife, and grandfather, but not about deployment experiences.

Unit support and cohesion: You've been switched to non-physical administrative duty and can't do many drills with your unit, and therefore are not close with unit members. You think the people you currently work with (on admin duty) are "idiots."

Military History

- Rank – E5 (Sergeant); 8 years service all together
- Deployment history – 2 deployments to Afghanistan (OEF) in '04-'05 and '08-'09. Each deployment 1 year long
- Job – MOS (military occupational specialty) is 13B (field artillery, cannon crew member). SM calls it "doing everyone else's job." Cannon Crewmembers work on cannons known as 'howitzers,' a heavy artillery machine piece with single-barrel firing capability.

Duties You Perform

Integral member of a crew that operates high technology cannon artillery weapon systems. Loads and fires howitzers. Sets fuse and charge on a variety of munitions, including high explosive artillery rounds, laser guided projectiles, scatterable mines, and rocket assisted projectiles. Uses computer generated fire direction data to set elevation of cannon tube for loading and firing. Employs rifles, machine guns, and grenade and rocket launchers in offensive and defensive operations. Drives and operates heavy and light wheeled trucks and tracked vehicles. Transports and manages artillery ammunition. Participates in reconnaissance operations to include security operations and position preparation. Operates in reduced visibility environments with infrared and starlight enhancing night vision devices and other equipment. Coordinates movement into position. Camouflages position area. Communicates using voice and digital wire and radio equipment. Uses critical combat survival skills to operate in a hostile environment. Maintains operational readiness of vehicles and equipment.

Supervises handling, transportation, accountability, and distribution of ammunition. Assists section chief in supervision of howitzer operations, maintenance, and training. Lays weapon for direction, conducts bore sighting and basic periodic tests. Supervises the operation, loading, and maintenance of the Field Artillery Ammunition Support Vehicle.

Deployment Experience (most recent deployment)

- As part of your duties you worked as first responder. You had to care for local Afghan children who came in having stepped on land mines. They were severely burned and injured.
- You also had to drive 20 mi/hour through dangerous areas to draw fire from insurgents so the soldiers coming behind could shoot them; you were very frightened.
- You served in *Korengal Valley*, the most dangerous place to be in Afghanistan. The terrain makes it so dangerous because it's mountainous and unpopulated. Insurgents can easily hide and are difficult to find. You were very scared while there.
- You lost several buddies while deployed, and killed about 50 insurgents. You report being happy about killing them because they were the ones who killed your buddies.
- You were exposed to daily mortar attacks on FOB, but not personally wounded

Physical and Emotional Symptoms

- Your physical symptoms are medically unexplained bilateral knee and low back pain. The pain has not responded to opiates; you had surgery on one knee, but the pain in still present. You are on limited duty due to this pain (Profile L3).
- You have an inability to focus and have several unfinished projects around the house.
- You are experiencing erectile dysfunction (haven't had penetrating sex with your wife in some time, but it's not causing a problem in your relationship yet. Your wife is supportive and is aware of problems commonly faced during reintegration. She's been through the post-deployment readjustment before, and she is close to other military spouses who have shared experiences). She has commented to you about your more general symptoms like being jumpy and worrying too much, and while she hasn't yet pushed hard for you to get treatment, she would hope that addressing general issues might help the ED.
- You feel angry about your physical injuries.
- You have had 2 panic attacks (but you don't recognize them as such) and fear having more (symptoms are chest tightness, difficulty breathing, dizziness).
- Your anxiety is heightened in crowds or with loud noises, but you can regain composure in a couple of minutes. (You will not describe these experiences if you are not asked, though).
- You also experience headaches and GI symptoms (irritable bowel syndrome).
- You experience no pleasure from things you used to enjoy such as fishing and hunting; you feel down often. You are having insomnia and sleep 3-4 hours a night, slightly more with Lunesta. You are having nightmares (you call them dreams) about severely burned and wounded children being brought to you; in your dreams you have to hold them.
- You have little pleasure or motivation to do the things you once enjoyed (e.g., fishing, hunting). However, you don't think of this as depression—you "just feel down sometimes."

Motivation

Your chief complaint is medically unexplained pain in your lower back and knees. You would really like to figure out what the problem is and get it fixed so you can deploy again. You don't believe you have a mental health issue beyond mild anxiety.

Behavior/Demeanor during interview

- You are pleasant, but not very talkative. The only hint of anxiety is that you bite your nails. You mostly give one word answers. To get more the provider really has to pull it out of you.
- *Willingness to disclose*: You are basically honest, but taciturn. Don't elaborate easily.
- *Willingness to seek professional help:* You might be willing to talk to a professional, but you don't believe you have mental health issues beyond mild anxiety. You have no experience with group therapy, but if asked you would say you don't think you'd like it. You're quite a reserved person; don't like to talk about your problems much.
- You do not have much experience on which to base a judgment, but you are not particularly opinionated about MH problems and treatment. You are open to being educated about it and possibly open to treatment
- You don't recognize the potential severity of your mental health problems, nor recognize the potential link between your mental health, sleep problems, and physical problems.

Coping strategies

You take Lunesta for sleep. Your wife and family are supportive, but they don't really understand your experiences.

Previous Treatment

About 4 months ago you sought treatment for knee and back pain. You had surgery on one knee at that time, but it did not help. Three separate MRI scans showed no abnormality in your back, so both the knee and back pain are not medically explained. You also tried taking opioids for the pain (e.g., Vicadin), but it did not help, so you are still in pain most of the time. The doctor gave you some back stretches to try, but that also has not helped.
Three months ago you talked to your doctor about difficulty sleeping and the doctor prescribed Lunesta as a sleep aid. It helped, but you still only sleep 5-6 hours a night.
You have not sought treatment for IBS or erectile dysfunction

Potential Dialogue during Interview

- Overall you say you're doing ok.
- You say "I'm having some mild anxiety, but I'm mostly concerned about this knee pain and low back pain."
- You also have headaches and concerns on GI (IBS) and urology (erectile dysfunction) symptoms. The pain in your knees and back is severe, but medically unexplained.
- You believe your main problem is persistent and medically unexplained bilateral knee and low back pain. You had surgery on one knee 2009, but still have pain. Multiple MRIs have failed to find anything wrong with your back. You've been treated in two pain clinics, including injections in lower back, but it hasn't helped. The majority of your pain is not helped by opioids. You're not getting any relief from your pain.
- You also have some anxiety. The anxiety manifests as startling and jumpiness, but you are able to regain composure in a minute or two. You have had 2 panic attacks and fear having more.

- You have insomnia and sleep only 3-4 hours per night; a little more with Lunesta. You have "dreams" (you do not call them nightmares) of girls being brought to him with severe burns and injuries and you have to hold them.
- You have depressive symptoms, you don't enjoy the things you used to like fishing and hunting. You have trouble concentrating, including about 10 unfinished projects in the garage. You have no suicidal or homicidal ideation. If the provider asks if you are depressed, you will say no. You "just feel down" sometimes.
- You would not directly state that you are experiencing anxiety, nor would you bring up the symptoms of it unless asked directly.
    - Instead, if provider asks you about emotional symptoms, say: "well, my wife says I'm kind of jumpy sometimes but it's nothing major."
    - SP shouldn't mention anxiety until the provider does and shouldn't talk about specific symptoms like having trouble in crowds unless the provider asks. He might say the above line if the provider says something like "on the form you said emotional problems have made things somewhat difficult. Can you tell me more about that?" Then, if provider asks what the SP thinks his wife means, he might say that he's always on guard at the mall.

Criteria for dialogue during the interview:
Goal: The goal for this interview is for the provider to practice getting the SM to open up by using open-ended questions and probing, getting SM to recognize his mental health symptoms, and helping him accept a referral by convincing him that there are effective treatments for his mental health symptoms.

- If asked an open ended question about behavioral health, he at first will focus on physical problems. For example, he might admit feeling some anxiety, but will attribute this to his knee and back pain. If probed further would begin to discuss behavioral health problems.
    - How's it going since you've been home?" – it's ok, I'd like to get my knees and back taken care of
    - What about with your personal life? How are you feeling? - I've been a little anxious, and have had some trouble sleeping, but the Lunesta helps with that.
- To get him to accept a referral, provider will have to help him recognize that his symptoms could be more indicative of a behavioral health problem, and that treatment could be effective.
    - Well, these symptoms you've marked are consistent with some possible behavioral concerns that we can easily get treatment for. Treatments are very effective; lots of people have these problems.
    - The dizziness, trouble breathing, chest pain could actually be a panic attack.
    - Plus you've been near a blast (mortar attacks), and that could lead to some mild brain trauma – possibly related to behavior. We have effective treatments for that.
- If provider does not give education like in the examples above, SP will accept a referral only for physical symptoms, but decline any referral for the anxiety or sleeping problems.

Form DD 2900 Self-Report Below

2_E5 Sgt

This form must be completed electronically. Handwritten forms will not be accepted.

POST-DEPLOYMENT HEALTH RE-ASSESSMENT (PDHRA)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, 1074f, 3013, 5013, 8013 and E.O. 9397.

PRINCIPAL PURPOSE(S): To assess your state of health after deployment in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care you may need. The information you provide may result in a referral for additional healthcare that may include medical, dental or behavioral healthcare or diverse community support services.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, to other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

DISCLOSURE: Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before entering your response or marking your selection. **YOU ARE ENCOURAGED TO ANSWER EACH QUESTION.** Withholding or providing inaccurate information may impair a healthcare provider's ability to identify health problems and refer you to appropriate sources for additional evaluation or treatment. If you do not understand a question, please ask for help. Please respond based on your **MOST RECENT DEPLOYMENT**.

DEMOGRAPHICS

Last Name | **First Name** | **Middle Initial**

Social Security Number | **Date of Birth** *(dd/mmm/yyyy)* | **Today's Date** *(dd/mmm/yyyy)*

Date arrived theater *(dd/mmm/yyyy)* | **Date departed theater** *(dd/mmm/yyyy)*

Gender
- (●) Male
- ( ) Female

Marital Status
- ( ) Never Married
- (●) Married
- ( ) Separated
- ( ) Divorced
- ( ) Widowed

Service Branch
- ( ) Air Force
- (●) Army
- ( ) Navy
- ( ) Marine Corps
- ( ) Coast Guard
- ( ) Civilian Employee
- ( ) Other

Status Prior to Deployment
- (●) Active Duty
- ( ) Selected Reserves - Reserve - Unit
- ( ) Selected Reserves - Reserve - AGR
- ( ) Selected Reserves - Reserve - IMA
- ( ) Selected Reserves - National Guard - Unit
- ( ) Selected Reserves - National Guard - AGR
- ( ) Ready Reserves - IRR
- ( ) Ready Reserves - ING
- ( ) Civilian Government Employee
- ( ) Other

Pay Grade

( ) E1	( ) O1	( ) W1
( ) E2	( ) O2	( ) W2
( ) E3	( ) O3	( ) W3
( ) E4	( ) O4	( ) W4
(●) E5	( ) O5	( ) W5
( ) E6	( ) O6	
( ) E7	( ) O7	( ) Other
( ) E8	( ) O8	
( ) E9	( ) O9	
	( ) O10	

Location of Operation

To what areas were you mainly deployed *(land-based operations more than 30 days)*? Please mark all that apply, including the number of months spent at each location.

(●) Country 1	Afghanistan	Months	12
( ) Country 2		Months	
( ) Country 3		Months	
( ) Country 4		Months	
( ) Country 5		Months	

Since return from deployment I have:
- (●) Maintained/returned to previous status
- ( ) Transitioned to Selected Reserves
- ( ) Transitioned to IRR
- ( ) Transitioned to ING
- ( ) Retired from Military Service
- ( ) Separated from Military Service

Current Contact Information:

Phone:
Cell:
DSN:
Email:
Address:

Total Deployments in Past 5 Years:

OIF	OEF	Other
( ) 1	( ) 1	( ) 1
( ) 2	(●) 2	( ) 2
( ) 3	( ) 3	( ) 3
( ) 4	( ) 4	( ) 4
( ) 5 or more	( ) 5 or more	( ) 5 or more

Current Unit of Assignment

Current Assignment Location

Point of Contact who can always reach you:

Name:
Phone:
Email:
Mailing Address:

2_E5 Sgt

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

1. **Overall, how would you rate your health during the PAST MONTH?**
   - ○ Excellent
   - ○ Very Good
   - ○ Good
   - ● Fair
   - ○ Poor

2. **Compared to before your most recent deployment, how would you rate your health in general now?**
   - ○ Much better now than before I deployed
   - ○ Somewhat better now than before I deployed
   - ○ About the same as before I deployed
   - ● Somewhat worse now than before I deployed
   - ○ Much worse now than before I deployed

3. **During the past 4 weeks, how difficult have physical health problems** *(illness or injury)* **made it for you to do your work or other regular daily activities?**
   - ○ Not difficult at all
   - ○ Somewhat difficult
   - ● Very difficult
   - ○ Extremely difficult

4. **During the past 4 weeks, how difficult have emotional problems** *(such as feeling depressed or anxious)* **made it for you to do your work, take care of things at home, or get along with other people?**
   - ○ Not difficult at all
   - ● Somewhat difficult
   - ○ Very difficult
   - ○ Extremely difficult

5. **Since you returned from deployment, about how many times have you seen a healthcare provider for any reason, such as in sick call, emergency room, primary care, family doctor, or mental health provider?**
   - ○ No visits
   - ○ 1 visit
   - ○ 2-3 visits
   - ● 4-5 visits
   - ○ 6 or more

6. **Since you returned from deployment, have you been hospitalized?** ● Yes ○ No

7. **During your deployment, were you wounded, injured, assaulted or otherwise physically hurt?** ○ Yes ● No

   If **NO**, skip to Question 8.

7a. If **YES**, are you still having problems related to this wound, assault, or injury? ○ Yes ○ No ● Unsure

8. **In addition to wounds or injuries you listed in question 7., do you currently have a health concern or condition that you feel is related to your deployment?** ○ Yes ○ No ● Unsure

   If **NO**, skip to Question 9.

8a. If **YES**, please mark the item(s) that best describe your deployment-related condition or concern:

○ Fever	○ Dimming of vision, like the lights were going out
○ Cough lasting more than 3 weeks	● Chest pain or pressure
● Trouble breathing	● Dizzy, light headed, passed out
● Bad headaches	○ Diarrhea, vomiting, or frequent indigestion/heartburn
○ Generally feeling weak	● Problems sleeping or still feeling tired after sleeping
○ Muscle aches	○ Trouble concentrating, easily distracted
● Swollen, stiff or painful joints	○ Forgetful or trouble remembering things
● Back pain	○ Hard to make up your mind or make decisions
○ Numbness or tingling in hands or feet	○ Increased irritability
○ Trouble hearing	○ Taking more risks such as driving faster
○ Ringing in the ears	○ Skin diseases or rashes
○ Watery, red eyes	○ Other *(please list)*: _____

9a. During this deployment, did you experience any of the following events? *(Mark all that apply)*

	Yes	No
(1) Blast or explosion *(IED, RPG, land mine, grenade, etc.)*	●	○
(2) Vehicular accident/crash *(any vehicle, including aircraft)*	○	●
(3) Fragment wound or bullet wound above your shoulders	○	●
(4) Fall	○	●
(5) Other event *(for example, a sports injury to your head)*. Describe:	○	●

9b. Did any of the following happen to you, or were you told happened to you, IMMEDIATELY after any of the event(s) you just noted in question 9a.? *(Mark all that apply)*

	Yes	No
(1) Lost consciousness or got "knocked out"	○	○
(2) Felt dazed, confused, or "saw stars"	○	○
(3) Didn't remember the event	○	○
(4) Had a concussion	○	○
(5) Had a head injury	○	○

c. Did any of the following problems begin or get worse after the event(s) you noted in question 9a.? *(Mark all that apply)*

	Yes	No
(1) Memory problems or lapses	○	○
(2) Balance problems or dizziness	○	○
(3) Ringing in the ears	○	○
(4) Sensitivity to bright light	○	○
(5) Irritability	○	○
(6) Headaches	○	○
(7) Sleep problems	○	○

d. In the past week, have you had any of the symptoms you indicated in 9c.? *(Mark all that apply)*

	Yes	No
(1) Memory problems or lapses	○	○
(2) Balance problems or dizziness	○	○
(3) Ringing in the ears	○	○
(4) Sensitivity to bright light	○	○
(5) Irritability	○	○
(6) Headaches	○	○
(7) Sleep problems	○	○

2_E5 Sgt

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

10. Do you have any persistent major concerns regarding the health effects of something you believe you may have been exposed to or encountered while deployed? ○ Yes ● No

If **NO**, skip to question 11.

10a. If **YES,** please mark the item(s) that best describe your concern:

○ Animal bites	○ Loud noises
○ Animal bodies *(dead)*	○ Paints
○ Chlorine gas	○ Pesticides
○ Depleted uranium *(if yes, explain)* _____	○ Radar/Microwaves
○ Excessive vibration	○ Sand/dust
○ Fog oils (smoke screen	○ Smoke from burning trash or feces
○ Garbage	○ Smoke from oil fire
○ Human blood, body fluids, body parts, or dead bodies	○ Solvents
○ Industrial pollution	○ Tent heater smoke
○ Insect bites	○ Vehicle or truck exhaust fumes
○ Ionizing radiation	○ Other exposures to toxic chemicals or materials, such as ammonia, nitric acid, etc.: *(If yes, explain)*
○ JP8 or other fuels	
○ Lasers	_____

11. Since return from your deployment, have you had serious conflicts with your spouse, family members, close friends, or at work that continue to cause you worry or concern? ○ Yes ● No ○ Unsure

12. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you ....

a. Have had nightmares about it or thought about it when you did not want to? ○ Yes ● No

b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? ● Yes ○ No

c. Were constantly on guard, watchful, or easily startled? ○ Yes ● No

d. Felt numb or detached from others, activities, or your surroundings? ● Yes ○ No

13a. In the PAST MONTH, Did you use alcohol more than you meant to? ○ Yes ● No

b. In the PAST MONTH, have you felt that you wanted to or needed to cut down on your drinking? ○ Yes ● No

c. How often do you have a drink containing alcohol?
○ Never ○ Monthly or less ● 2 to 4 times a month ○ 2 to 3 times a week ○ 4 or more times a week

d. How many drinks containing alcohol do you have on a typical day when you are drinking?
○ 1 or 2 ● 3 or 4 ○ 5 or 6 ○ 7 to 9 ○ 10 or more

e. How often do you have six or more drinks on one occasion?
○ Never ● Less than monthly ○ Monthly ○ Weekly ○ Daily

14. Over the PAST MONTH, have you been bothered by the following problems?	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	○	●	○	○
b. Feeling down, depressed, or hopeless	○	●	○	○

15. Would you like to schedule a visit with a healthcare provider to further discuss your health concern(s)? ● Yes ○ No

16. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? ○ Yes ● No

17. Are you currently interested in receiving assistance for a family or relationship concern? ○ Yes ● No

18. Would you like to schedule a visit with a chaplain or a community support counselor? ○ Yes ● No

Summary Sheet—Case 3

Working title: "Career Concerns"

Demographics:

- Latina female, 40yrs
- Never married, no children
- Officer (O-5)
- 20 years service total

Deployment Experience:

- Civil affairs officer – meet with locals, helps guard schools, deal with needs and relating with the local population
- Has never been physically injured herself, but feels responsible for the deaths of several civilians with whom she had interactions. Insurgents likely killed these people for interacting with an American.
- Her brother also died from an IED in Iraq while she was there; she was able to see him before he died, but he was burned beyond recognition and she questioned why they had let him live at all.

Motivation:

- She wants to get out of the interview without a referral, and without admitting any health problems. Her military career is extremely important to her and she doesn't want to jeopardize it. She also sees herself as a role model for female officers and feels admitting concerns could harm the reputation of all female officers.

Demeanor during Interview:

- Pleasant, amiable
- Might become tearful if asked to tell more about her deployment or if asked how she feels about her deployment. This may only be elicited by establishing a therapeutic rapport and asking open-ended questions (e.g., "how do you feel about your deployment? How are things going now?", not just by going through the form.

Presenting Issue(s):

- Some trouble sleeping and increased irritability
- Reports mild depression symptoms (feeling down and having little interest few days in past month)

Emotional/Behavioral Issues to Uncover:

- Extreme guilt and feelings of responsibility over civilians who were killed for interacting with her during her deployment
- Experiencing moderately severe depression symptoms (tearful, lack of enjoyment, isolated, trouble sleeping)
- Very concerned about impact of treatment on career

Key Communication Strategies Addressed:

- Key words at key times: Using open-ended prompts and questions to increase opportunities for Soldier disclosure
- Using legitimizing statements to normalize deployment and reintegration experiences as well as common barriers to disclosure
- Providing brief psychoeducation to encourage future utilization of healthcare and support resources

Case Details

General Service Member Information:

42 year-old Latina female. Neat, well groomed. Hair pulled back tightly in a bun, military style. Military uniform.

Social History

- You are Colonel Diana Perez and the 6th of 9 siblings. You were born and partially raised in the Dominican Republic, and your father died when you were 3. At some point in later childhood, your family moved to a tough neighborhood in New York. You have no significant other, have never been married and have no children. You are close with your mother.
- You have a few friends, but they aren't soldiers, so they don't really understand your situation. You avoid speaking about OIF because "people are ignorant . . . and I don't want to get angry about that."
- Unit support and cohesion: Poor; You asked to be transferred out of your unit because seeing those people daily was too painful a reminder of past events. Your rank is Colonel—so there might not be people of comparable rank for support even if you were willing to talk with someone. Seeking support from subordinates would not be possible.

Military History

- Rank – Lieutenant Colonel (O-5); 20 years service overall
- Deployment history – 2 deployments to Iraq, '04-'05 (12 mo) and '07-'09 (15 months)
- Job – Civil Affairs Officer. For this job you meet with locals, help guard schools, deal with needs and relating with the local population. You're not a war fighter, but a person who helps locals. Background on this job: Locals who have anything to do with the US Military are often targets and may be punished by insurgents for the association.

Deployment Experience (most recent deployment)

- You barely missed an IED blast that killed several members of your convoy because the gun in your vehicle wasn't working. You sent the convoy ahead while you fixed it, and most of them were killed. You saw them after the explosion, horribly mutilated.
- You have 3 brothers in the Army or Marines. One was killed by IED blast in Iraq while you were also there. You got to see him before he died. You were called to the hospital where he was, and he was burned beyond recognition. He died the day after you saw him. You questioned why they had let him live at all.
- Once you distributed toys that had been collected by your church. You gave them to a local you knew who you thought could distribute them. Then later, there was a holdup on the highway, and you sent your driver to find out what it was. It was a whole family who had been shot and killed, and each child had a beanie baby in his or her lap. You felt responsible for that. (And it is likely that this family indeed was shot for possession of the beanie babies).
- You also feel responsible for the death of one of your translators, who you were helping get to the U.S. You helped her get a visa to go to the US with her family, going through

Jordan. They were on their way to Jordan and they were kidnapped and never found; no one heard from them again.

- You also befriended another one of your interpreters whose daughter was handicapped. You got a wheelchair for the daughter, and the interpreter was shot in front of his family as a lesson for accepting that.

Physical and Emotional Symptoms

- You avoid formerly enjoyable activities like weight lifting and being outdoors—you don't enjoy these things anymore.
- Your mood is "very down"- you feel love but not happiness or joy.
- You are hypervigilent, but you say you were already naturally like this, due to living in a tough neighborhood while growing up. (You do not feel that this symptom is deployment-related).
- You exhibit self-isolating behaviors, suffer from irritability and insomnia/difficulty sleeping.
- You have no physical symptoms (neither from injuries—you have no deployment-related injury history—nor somatization).
- You have unwanted memories, especially in June, which is full of anniversaries of sad events. (Many deaths of people you worked with and of your brother)
- You frequently think about past events, analyze situations again to see if there is anything you could have done to stop deaths from happening. You frequently call up Google Earth to analyze routes, to see if you could have taken your team down different road and not run over the IED. You stay up late at night looking at Google Earth maps of Iraq.
- You have nightmares.

Motivation

You are very concerned about impact to your career. You need to feel strong, you feel it's especially important because you're a woman officer. You need to show that women are just as capable as men and are concerned you will be perceived as weak.

You want to protect your job. Your motivation is to get through the interview without showing you have any problems or getting a referral. However, you are aware that you are having difficulty and might admit the problems if pressed. For example, you find yourself crying frequently and are afraid it will happen in front of your soldiers. (So fears of not being able to do your job). Alternatively, you might not accept any referral, but could benefit from education about how to seek help on your own (especially confidentiality), about effectiveness of treatments, and legitimizing to feel more comfortable.

Behavior/Demeanor during interview

- Very pleasant, very kind, soft. The person this case was based on cried during private office visits, but in the PDHRA context, you will be stoic. You would not outright lie about your symptoms, but would downplay them and not voluntarily divulge. You may admit more problems and interest in treatment depending on how the interview goes.

- Willingness to disclose: Generally you are unwilling to disclose. You say your health is fine, you may disclose a couple of symptoms, but not many, and would downplay severity.
- Willingness to seek professional help:
  - You are unwilling because of fear that it would jeopardize your career.
  - You might only do so if it could be confidential, and if convinced it would help you do your job better instead of harming your career
- Beliefs about mental health problems and treatment: You do believe admitting mental health problems would affect your career and make you seem weak. You think treatment would be too time-consuming.
- Potential barriers to care:
  - As a woman you feel that you must be doubly strong, and that seeking help might jeopardize your career. You feel that if you give in and get help, you'll be considered weak. You also feel a responsibility to defend women officers in general—i.e. getting help could make others believe females in general are not suited to be officers, less able to put up with hardships of war. You have carefully avoided getting help in the past. You want to be a woman who makes it in the Army as a Colonel and gets promoted above that—don't want to be seen as weak.
  - You don't want to miss any work. You want to find a yoga class or something you can do to help relax.

Coping strategies

- Prayer. Prays to God for solace and relief.
- Walks
- Reads (fiction, but also the Bible)

Previous Treatment

You have strenuously avoided seeking treatment for your mental health problems.

Potential Dialogue during Interview

- You are "tired, distracted, and irritable." These would all be things you would be willing to admit on PDHRA, at least in qx 8, the large symptom block.
- No risk-taking (either admitted or in reality).
- No serious conflicts (and this would be true). You have little skirmishes with your mom, but nothing serious—you know your mom doesn't understand, so you don't get into it.
- PTSD screen—The real answer is yes to all, but you have not filled out your form this way and would deny most symptoms during the interview. Might admit to the second one "tried hard not to think about"
- Alcohol—you don't drink (this is true and you would also deny on PDHRA.
- Depression screen (qx 14)—might say "few or several days" for both, but wouldn't say any more than that.
- Desire for referrals—you would not want a referral.
- You will not elaborate on any mental health symptoms unless reassured by provider that it will remain confidential and that treatment could help your symptoms.

- See below for further details on dialogue relating to disclosure of symptoms

Criteria for dialogue during the interview:
There are going to be two ways for the provider to "succeed" in this case. The first option is that the provider does so well that you disclose symptoms and accept a referral. The second is that the provider does not achieve this but DOES give you good education that later causes you to seek help on your own. Neither case requires you to change very much of how you act. Criteria for both are described below.

SUCCESS OPTION 1—YOU DISCLOSE AND ACCEPT REFERRAL
In order for you to elaborate on your symptoms, the provider needs to do a very, very good job. The provider will need to make normalizing statements about how common problems are, and will have to be SPECIFIC about this. Before the interview, this provider is going to be told that your unit suffered heavy casualties and that several members of your unit were killed. The provider will NOT know anything about your personal experience or whether you were present yourself for any difficult events, but he or she will know that your unit did not have an easy time. If the provider specifically references this in a normalizing statement somehow, you will disclose more.

Example: "are you sure you aren't experiencing any emotional problems? Your unit suffered heavy casualties—we've been hearing about that from so many of your people, and it's kind of rare for someone to experience that and not have any of these symptoms. We see it all the time, every day, and with everything that happened while you were deployed, it would be more the norm to be having some symptoms now."

You would NOT disclose if the provider just said something like "lots of soldiers have problems" without doing some specific probing.

If you disclose, the way you did it during practice was perfect. Keep demeanor the same, and also the way you did it gradually. You first opened up just a little, and then upon follow-up you disclosed a little more. All we've done is narrow the range of provider behavior that will cause you to do this.

The above was all about disclosure—there is still the referral to get through. For that, there are no changes to the case. If the provider gets you to disclose, use the same criteria as before for accepting a referral—you need to be assured of confidentiality and/or that it won't hurt your chances for promotion. Even if you have disclosed, if the provider doesn't address these concerns, you will NOT accept the referral.

SUCCESS OPTION 2—You do NOT accept referral, but you do later get care on your own.
This doesn't really change how you act very much. You just have to go through the script, and you will not actually tell the provider that you will seek care on your own. You will simply thank the provider for information if it has been given and complete the interview as normal. AFTER the interview is complete,

Susie and Lynn will be the ones who decide whether the provider did a good enough job that you went and got care on your own later on. The section below outlines how this dialogue might go.

Even if you have not disclosed, or you disclosed but didn't accept a referral, the provider may provide you with education. This could include:

- Information on how to know if you need help later. Examples: "You know, if later on you start finding you feel down a lot, you can still get help at any time." Or "if you keep on thinking about some of your deployment experiences or having nightmares, that could mean that you'd benefit from some help to address that." Or "time doesn't heal everything. If this keeps happening, there are lots of good people who can help." You would politely thank the provider for the information and assure the provider you'll keep that information in mind.
- Information on how to get help later if you need it. This would include advice on resources you can use. It might be an anonymous phone line, the name of a program, the name of some military facility, etc. This could also include information on how to make an appointment. If the provider gives you specific information like this, you can write it down—that will give the provider a positive cue that he or she is making a good move and you are receptive. (It's also possible the provider could pretend to be giving you a brochure or information sheet. If that happens, just pretend to take it as well as possible through a screen).
- Normalizing statements. This provider may not have done this well enough to get you to disclose then and there, but a general "emotional problems are really common after deployment" could still be helpful in convincing you to seek care later. If the provider makes a statement like this, just acknowledge it as appropriate. (You can just make a small, polite acknowledgement, something like "okay."
- Education on the fact that effective treatments are available. (e.g. "if you do need help later, there are a lot of treatment options now, and they work.") Again, just thank the provider for the information and/or say you'll keep it in mind.

Form DD 2900 Self-Report Below

Form DD 2900 Self-Report

3_Latina Female

This form must be completed electronically. Handwritten forms will not be accepted.

POST-DEPLOYMENT HEALTH RE-ASSESSMENT (PDHRA)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, 1074f, 3013, 5013, 8013 and E.O. 9397.

PRINCIPAL PURPOSE(S): To assess your state of health after deployment in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care you may need. The information you provide may result in a referral for additional healthcare that may include medical, dental or behavioral healthcare or diverse community support services.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, to other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

DISCLOSURE: Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before entering your response or marking your selection. **YOU ARE ENCOURAGED TO ANSWER EACH QUESTION.** Withholding or providing inaccurate information may impair a healthcare provider's ability to identify health problems and refer you to appropriate sources for additional evaluation or treatment. If you do not understand a question, please ask for help. Please respond based on your **MOST RECENT DEPLOYMENT**.

DEMOGRAPHICS

Last Name | **First Name** | **Middle Initial**

Social Security Number | **Date of Birth** *(dd/mmm/yyyy)* | **Today's Date** *(dd/mmm/yyyy)*

SAMPLE

Date arrived theater *(dd/mmm/yyyy)* | **Date departed theater** *(dd/mmm/yyyy)*

Gender
- ○ Male
- ● Female

Service Branch
- ○ Air Force
- ● Army
- ○ Navy
- ○ Marine Corps
- ○ Coast Guard
- ○ Civilian Employee
- ○ Other

Marital Status
- ● Never Married
- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed

Status Prior to Deployment
- ● Active Duty
- ○ Selected Reserves - Reserve - Unit
- ○ Selected Reserves - Reserve - AGR
- ○ Selected Reserves - Reserve - IMA
- ○ Selected Reserves - National Guard - Unit
- ○ Selected Reserves - National Guard - AGR
- ○ Ready Reserves - IRR
- ○ Ready Reserves - ING
- ○ Civilian Government Employee
- ○ Other

Pay Grade

○ E1	○ O1	○ W1
○ E2	○ O2	○ W2
○ E3	○ O3	○ W3
○ E4	○ O4	○ W4
○ E5	● O5	○ W5
○ E6	○ O6	
○ E7	○ O7	○ Other
○ E8	○ O8	
○ E9	○ O9	
	○ O10	

Location of Operation

To what areas were you mainly deployed *(land-based operations more than 30 days)*? Please mark all that apply, including the number of months spent at each location.

● Country 1	Iraq	Months	12
○ Country 2		Months	
○ Country 3		Months	
○ Country 4		Months	
○ Country 5		Months	

Since return from deployment I have:
- ● Maintained/returned to previous status
- ○ Transitioned to Selected Reserves
- ○ Transitioned to IRR
- ○ Transitioned to ING
- ○ Retired from Military Service
- ○ Separated from Military Service

Current Contact Information:

Phone:
Cell:
DSN:
Email:
Address:

Total Deployments in Past 5 Years:

OIF	OEF	Other
○ 1	○ 1	○ 1
● 2	○ 2	○ 2
○ 3	○ 3	○ 3
○ 4	○ 4	○ 4
○ 5 or more	○ 5 or more	○ 5 or more

Current Unit of Assignment

Current Assignment Location

Point of Contact who can always reach you:

Name:
Phone:
Email:
Mailing Address:

3_Latina Female

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

1. **Overall, how would you rate your health during the PAST MONTH?**
   - ○ Excellent
   - ○ Very Good
   - ● Good
   - ○ Fair
   - ○ Poor

2. **Compared to before your most recent deployment, how would you rate your health in general now?**
   - ○ Much better now than before I deployed
   - ○ Somewhat better now than before I deployed
   - ● About the same as before I deployed
   - ○ Somewhat worse now than before I deployed
   - ○ Much worse now than before I deployed

3. **During the past 4 weeks, how difficult have physical health problems** *(illness or injury)* **made it for you to do your work or other regular daily activities?**
   - ● Not difficult at all
   - ○ Somewhat difficult
   - ○ Very difficult
   - ○ Extremely difficult

4. **During the past 4 weeks, how difficult have emotional problems** *(such as feeling depressed or anxious)* **made it for you to do your work, take care of things at home, or get along with other people?**
   - ● Not difficult at all
   - ○ Somewhat difficult
   - ○ Very difficult
   - ○ Extremely difficult

5. **Since you returned from deployment, about how many times have you seen a healthcare provider for any reason, such as in sick call, emergency room, primary care, family doctor, or mental health provider?**
   - ● No visits
   - ○ 1 visit
   - ○ 2-3 visits
   - ○ 4-5 visits
   - ○ 6 or more

6. **Since you returned from deployment, have you been hospitalized?** ○ Yes ● No

7. **During your deployment, were you wounded, injured, assaulted or otherwise physically hurt?** ○ Yes ● No
   If **NO**, skip to Question 8.

7a. If **YES**, are you still having problems related to this wound, assault, or injury? ○ Yes ○ No ○ Unsure

8. **In addition to wounds or injuries you listed in question 7., do you currently have a health concern or condition that you feel is related to your deployment?** ○ Yes ○ No ● Unsure
   If **NO**, skip to Question 9.

8a. If **YES**, please mark the item(s) that best describe your deployment-related condition or concern:

○ Fever	○ Dimming of vision, like the lights were going out
○ Cough lasting more than 3 weeks	○ Chest pain or pressure
○ Trouble breathing	○ Dizzy, light headed, passed out
○ Bad headaches	○ Diarrhea, vomiting, or frequent indigestion/heartburn
○ Generally feeling weak	● Problems sleeping or still feeling tired after sleeping
○ Muscle aches	○ Trouble concentrating, easily distracted
○ Swollen, stiff or painful joints	○ Forgetful or trouble remembering things
○ Back pain	○ Hard to make up your mind or make decisions
○ Numbness or tingling in hands or feet	● Increased irritability
○ Trouble hearing	○ Taking more risks such as driving faster
○ Ringing in the ears	○ Skin diseases or rashes
○ Watery, red eyes	○ Other *(please list)*: _____

9a. During this deployment, did you experience any of the following events? *(Mark all that apply)*

	Yes	No
(1) Blast or explosion *(IED, RPG, land mine, grenade, etc.)*	○	●
(2) Vehicular accident/crash *(any vehicle, including aircraft)*	○	●
(3) Fragment wound or bullet wound above your shoulders	○	●
(4) Fall	○	●
(5) Other event *(for example, a sports injury to your head)*. Describe: _____	○	●

9b. Did any of the following happen to you, or were you told happened to you, IMMEDIATELY after any of the event(s) you just noted in question 9a.? *(Mark all that apply)*

	Yes	No
(1) Lost consciousness or got "knocked out"	○	○
(2) Felt dazed, confused, or "saw stars"	○	○
(3) Didn't remember the event	○	○
(4) Had a concussion	○	○
(5) Had a head injury	○	○

c. Did any of the following problems begin or get worse after the event(s) you noted in question 9a.? *(Mark all that apply)*

	Yes	No
(1) Memory problems or lapses	○	○
(2) Balance problems or dizziness	○	○
(3) Ringing in the ears	○	○
(4) Sensitivity to bright light	○	○
(5) Irritability	○	○
(6) Headaches	○	○
(7) Sleep problems	○	○

d. In the past week, have you had any of the symptoms you indicated in 9c.? *(Mark all that apply)*

	Yes	No
(1) Memory problems or lapses	○	○
(2) Balance problems or dizziness	○	○
(3) Ringing in the ears	○	○
(4) Sensitivity to bright light	○	○
(5) Irritability	○	○
(6) Headaches	○	○
(7) Sleep problems	○	○

3_Latina Female

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Service Member's Social Security Number:

10. Do you have any persistent major concerns regarding the health effects of something you believe you may have been exposed to or encountered while deployed? ● Yes ○ No

If **NO**, skip to question 11.

10a. If **YES,** please mark the item(s) that best describe your concern:

○ Animal bites	○ Loud noises
○ Animal bodies *(dead)*	○ Paints
○ Chlorine gas	○ Pesticides
○ Depleted uranium *(if yes, explain)* _____	○ Radar/Microwaves
○ Excessive vibration	○ Sand/dust
○ Fog oils (smoke screen	○ Smoke from burning trash or feces
● Garbage	○ Smoke from oil fire
○ Human blood, body fluids, body parts, or dead bodies	○ Solvents
○ Industrial pollution	○ Tent heater smoke
○ Insect bites	○ Vehicle or truck exhaust fumes
○ Ionizing radiation	○ Other exposures to toxic chemicals or materials, such as ammonia, nitric acid, etc.: *(If yes, explain)*
○ JP8 or other fuels	
○ Lasers	_____

11. Since return from your deployment, have you had serious conflicts with your spouse, family members, close friends, or at work that continue to cause you worry or concern? ○ Yes ● No ○ Unsure

12. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you ....

a. Have had nightmares about it or thought about it when you did not want to? ○ Yes ● No

b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? ● Yes ○ No

c. Were constantly on guard, watchful, or easily startled? ○ Yes ● No

d. Felt numb or detached from others, activities, or your surroundings? ○ Yes ● No

13a. In the PAST MONTH, Did you use alcohol more than you meant to? ○ Yes ● No

b. In the PAST MONTH, have you felt that you wanted to or needed to cut down on your drinking? ○ Yes ● No

c. How often do you have a drink containing alcohol?

● Never ○ Monthly or less ○ 2 to 4 times a month ○ 2 to 3 times a week ○ 4 or more times a week

d. How many drinks containing alcohol do you have on a typical day when you are drinking?

○ 1 or 2 ○ 3 or 4 ○ 5 or 6 ○ 7 to 9 ○ 10 or more

e. How often do you have six or more drinks on one occasion?

● Never ○ Less than monthly ○ Monthly ○ Weekly ○ Daily

14. Over the PAST MONTH, have you been bothered by the following problems?	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	●	○	○	○
b. Feeling down, depressed, or hopeless	●	○	○	○

15. Would you like to schedule a visit with a healthcare provider to further discuss your health concern(s)? ○ Yes ● No

16. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? ○ Yes ● No

17. Are you currently interested in receiving assistance for a family or relationship concern? ○ Yes ● No

18. Would you like to schedule a visit with a chaplain or a community support counselor? ○ Yes ● No

Summary Sheet—Case 4

Working title: "Time Management"

Demographics:

- Male, 40 yrs
- Married 9 years, separated, 2 kids
- E7 (Sergeant First Class)
- 3 deployments total (1 Iraq in 2002-03 – 12 months, Afghanistan 04-05 – 12 months, 09-11 – 15 months)

Deployment Experience:

- Job was field artillery, in most recent deployment to Afghanistan he was in Korengal Valley (known in the military to be "the most dangerous place in the world")
- Experienced daily mortar attacks at the FOB
- He also acted as a first responder and treated severely burned local children who had been wounded by land mines
- Also acted as "bait" to draw fire from insurgents
- Lost several buddies in deployment
- Experienced a blast from an IED ("like being hit in the head with a bat"), and fell from a tower injuring shoulder and back

Motivation:

- Wants to be heard and to tell his story, which includes physical and emotional difficulty
- Would like help for physical and emotional problems, but uncertain what would help
- He's beside himself with rage at his estranged wife, who will not let him see or talk to his sons.

Demeanor During Interview:

- Extremely talkative, elaborates on every question the provider asks; often brings conversation back around to his anger at his wife
- Somewhat agitated, but not severely
- Might become tearful or choked up when describing difficulties with wife

Presenting Issue(s):

- Shoulder and back pain
- Distraught over relationship problems
- Sleep problems
- Irritability/anger

Emotional/Behavioral Issues to Uncover:

- Provider must uncover that the most prominent problems are with anger and possible depression, TBI, or PTSD.
- Risk management

Key Communication Strategies Addressed:

- Orienting/introducing interview
- Using empathic statements to build the relationship
- Partnering with the Soldier in your summary of current concerns and referral recommendations
- Managing interview flow

Case Details

General Service Member Information

Well groomed, shaven, neat. Wearing military uniform

Social History

- You are 40 year old, Sergeant David Thompson, born and raised in Alabama to an in-tact family.
- You have been married for 9 years, but are currently living apart from your wife who is in another state, and she will not let you see the your children. She won't answer your calls and when you call to talk with your son, she won't let you speak with him. You also suspect she is having an affair. You are very angry. You feel your wife is totally influenced by her mother. You have two sons together. You have no other family nearby and no friends nearby who are not military.
- Unit support and cohesion: You are friendly with people in your unit, but they don't talk about very personal things.

Military History

- Rank – E7 (sergeant first class)
- Deployment history – 1 deployment to Iraq ('02-'03; 2 deployments to Afghanistan, 04-05, 07-09). First two 1 year long, most recent was 15 mo.
- Job – Field Artillery senior sergeant
  - Field artillery senior sergeant leads in the fire support, operations/intelligence, and target acquisition activities in a field artillery battalion, brigade, division artillery, or corps artillery. Other major duties are leading soldiers performing duties in field artillery MOS performs principal duties for SQI "M." Leads soldiers performing duties in field artillery MOS. Leads and supervises the operation of the unit command post in accordance with directives. Leads, supervises, and participates in coordination and implementation of cannon, missile, rocket, or target acquisition operations, training programs, administrative matters, and communication activities, providing tactical and technical guidance to subordinates, and professional support to lower and higher grade soldiers in the accomplishment of their duties. Monitors, inspects, and evaluates FA training programs.
  - Leads and supervises the preparation and distribution of maps, operational information, operational reports, and training materials. Supervises the maintenance of staff journals, files, records, and training materials. Serves as the principal NCO of FA battalion, brigade, division artillery, or Corps artillery operations activity and supervises the processing operations and intelligence information. Prepares operational SOP.
  - Supervises and maintains classified files, records, processing of individual security clearances. Leads, supervises, and participates in identifying and indicating location, strength, tactical deployment, and emplacement of enemy units.

Deployment Experience (most recent deployment)

- You experienced an IED about 40 feet away. You say it felt like being hit in the head with a baseball bat, but you did not lose consciousness. You saw a couple of buddies "turned into pink mist," meaning totally obliterated right in front of you.
- You fell off of a tower during a fire fight, injuring your shoulder and back. You also feel like you failed your unit by falling. As a senior enlisted person you feel responsible for the people in your unit.

Physical and Emotional Symptoms

- You have lots of physical problems, very bad pain in your shoulder and back.
- You dislocated your shoulder when you fell off a tower in Iraq. You grabbed a rope while falling, so your shoulder and back snapped—now you have chronic shoulder and back pain.
- You experienced a blast injury from a rocket explosion about 40 feet away from you. You say it was like a baseball bat to the back of the head.
- You have lots of bad memories that you have a hard time with. You have flashbacks once or twice a week and frequently get emotionally upset.
- You had a procedure to relieve physical pain recently.
- You have tremors in his hands and break out with hives and blotches.
- You feel detached from most people.
- You used alcohol heavily right after deployment but have tried to cut back recently with some success.
- You remember only some details of events—falling off tower, seeing friends blown up. (it's a little "sketchy.") This could indicate symptoms of TBI and/or PTSD
- You just stay in your room; you have no social life and avoid people and crowds
- You don't have nightmares because you take medication (Prazosin, which is used to treat anxiety/nightmares), however you do experience insomnia.
- You experience depression symptoms, but haven't been diagnosed.
- You have a lot of anger and agitation.

Your Motivation

You are definitely reaching out for help, but you are so angry about your wife that you don't have a clear narrative of what your specific problems are (and thus it's difficult for the provider to determine what problems to document). Your motivation is to talk about your problems and have someone listen.

Behavior/Demeanor during interview

- You are very talkative and difficult to corral. You elaborate heavily on each question the provider asks. You would definitely like some help, but you are not sure what kind or how helpful it would be (i.e., need some education on what you need). You become agitated when talking about your estranged relationship with your wife. Your anger is obvious, but it is never directed at the provider.
- Willingness to disclose: Generally willing to disclose.

- Willingness to seek professional help: Would like professional help. However, might refuse the first referral offer—not so much because you are against the idea as that you will not focus on the topic.
- You have no personal experience with mental illness or treatment, so you are unsure of the effectiveness of treatments.

Coping Strategies

None

Previous Treatment

- You had a buddy taking Prazosin for nightmares, so you asked your doctor for it about 2 months ago. It has helped; you no longer have nightmares.
- Three months ago you had a minor surgery to relieve pain in shoulder. It was successful, but you still have some pain.
- You have been going to AA meetings to cut back on drinking and you've been moderately successful.

Potential Dialogue during Interview

- You are "tangential (digressing from one thought to another)" and difficult to corral. You always go off in other directions in response to the screening questions. You are very talkative, can't focus on the questions. You expound on each thing a lot. i.e.
    - "Was there ever a time you thought you might die?"→ "oh my goodness, where to begin! I don't even know where to begin! . . ."
    - Do you feel distant or cut off from other people? → "oh my goodness, I don't see anyone, and she won't let me see my kids, and they need me, and I think my wife's cheating on me . . ."
    - "Have there been times you thought you didn't need to plan for the future or that your future might be cut short"→ "well, I'm not suicidal, but I don't think I'm going to have a future. I just don't think so, I think my life is going to be short. I'm very self destructive, sometimes I just drink, and go off the deep end and just don't want to do anything with my life. Without my children, there's no point in living" You aren't going to kill yourself but feel depressed when you think about your future—it's bleak, you doesn't want a divorce because your wife might prevent you from seeing the children again.
- As the provider begins to review the form, the SP talks for at least 30 seconds following provider's question.
- The SP will directly answer the provider's questions if he/she returns to the question and asks it again very directly (e.g., you are having these symptoms, correct?).
- If provider offers sympathy (without immediately returning to the question) or engages in conversation the SP will continue to talk for another 30 seconds if given the opportunity.
- Symptoms listed in Qx 8a:

  - Provider might interpret qx 8 symptoms as indicating panic attacks. If asked about chest pain, dizziness, breathing; he'd say it just happens sometimes, not due to exercise; sometimes happens in crowds, like at the mall
- Provider Qx 2&3 (risk assessment). Based on your comments about your wife, the provider is likely to spend extra time on these questions.
  - Harm to self – "Well, I'm not suicidal, but I don't think I'm going to have a future. I just don't think so, I think my life is going to be short. I'm very self-destructive, sometimes I just drink, and go off the deep end and just don't want to do anything with my life. Without my children, there's no point in living" (will deny (truthfully) having a plan for how he would kill himself)
  - Harm to others – "no, no, I would never do that. I mean, believe me, I'd like to go up there and give it to her [his wife], but I never would; it's against regulations." (Note: In spite of some of your statements, you are not really a violent person and are not likely to harm your wife or anyone else).
- You wake up in the night and just pace, you can't go back to sleep no matter what.
- You might become choked up or tearful when describing your children or in anger at your wife.
- You are beside yourself with rage at your wife (which is often the tangent you go off on in response to questions).
- You don't respond to subtle social cues from the provider to stick to the PDHRA format, but you might respond positively to the provider summarizing and using empathy to show you are being heard.
- You also has several physical problems; you might elaborate on that first leaving little time for mental health problems. Your main mental health problem is your anger at your wife and being distraught about not being able to see your kids.
- When referral is first mentioned, you might at first say something like this: You may say something like "***I*** don't need a referral! My WIFE's the one who needs a referral. ***I*** just want my kids back!"

Form DD 2900 Self-Report Below

2_Talkative Male

This form must be completed electronically. Handwritten forms will not be accepted.

POST-DEPLOYMENT HEALTH RE-ASSESSMENT (PDHRA)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, 1074f, 3013, 5013, 8013 and E.O. 9397.

PRINCIPAL PURPOSE(S): To assess your state of health after deployment in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care you may need. The information you provide may result in a referral for additional healthcare that may include medical, dental or behavioral healthcare or diverse community support services.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, to other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

DISCLOSURE: Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before entering your response or marking your selection. **YOU ARE ENCOURAGED TO ANSWER EACH QUESTION.** Withholding or providing inaccurate information may impair a healthcare provider's ability to identify health problems and refer you to appropriate sources for additional evaluation or treatment. If you do not understand a question, please ask for help. Please respond based on your **MOST RECENT DEPLOYMENT**.

DEMOGRAPHICS

Last Name _____ **First Name** _____ **Middle Initial** _____

Social Security Number _____ **Date of Birth** *(dd/mmm/yyyy)* _____ **Today's Date** *(dd/mmm/yyyy)* _____

Date arrived theater *(dd/mmm/yyyy)* _____ **Date departed theater** *(dd/mmm/yyyy)* _____

Gender
- (●) Male
- ( ) Female

Marital Status
- ( ) Never Married
- ( ) Married
- (●) Separated
- ( ) Divorced
- ( ) Widowed

Service Branch
- ( ) Air Force
- (●) Army
- ( ) Navy
- ( ) Marine Corps
- ( ) Coast Guard
- ( ) Civilian Employee
- ( ) Other

Status Prior to Deployment
- (●) Active Duty
- ( ) Selected Reserves - Reserve - Unit
- ( ) Selected Reserves - Reserve - AGR
- ( ) Selected Reserves - Reserve - IMA
- ( ) Selected Reserves - National Guard - Unit
- ( ) Selected Reserves - National Guard - AGR
- ( ) Ready Reserves - IRR
- ( ) Ready Reserves - ING
- ( ) Civilian Government Employee
- ( ) Other

Pay Grade

( ) E1	( ) O1	( ) W1
( ) E2	( ) O2	( ) W2
( ) E3	( ) O3	( ) W3
( ) E4	( ) O4	( ) W4
( ) E5	( ) O5	( ) W5
( ) E6	( ) O6	
(●) E7	( ) O7	( ) Other
( ) E8	( ) O8	
( ) E9	( ) O9	
	( ) O10	

Location of Operation

To what areas were you mainly deployed *(land-based operations more than 30 days)*? Please mark all that apply, including the number of months spent at each location.

(●) Country 1	Afghanistan	Months	12
( ) Country 2		Months	
( ) Country 3		Months	
( ) Country 4		Months	
( ) Country 5		Months	

Since return from deployment I have:
- (●) Maintained/returned to previous status
- ( ) Transitioned to Selected Reserves
- ( ) Transitioned to IRR
- ( ) Transitioned to ING
- ( ) Retired from Military Service
- ( ) Separated from Military Service

Current Contact Information:

Phone: _____
Cell: _____
DSN: _____
Email: _____
Address: _____

Total Deployments in Past 5 Years:

OIF	OEF	Other
( ) 1	(●) 1	( ) 1
( ) 2	( ) 2	( ) 2
( ) 3	( ) 3	( ) 3
( ) 4	( ) 4	( ) 4
( ) 5 or more	( ) 5 or more	( ) 5 or more

Current Unit of Assignment _____

Current Assignment Location _____

Point of Contact who can always reach you:

Name: _____
Phone: _____
Email: _____
Mailing Address: _____

DD FORM 2900, JAN 2008 PREVIOUS EDITION IS OBSOLETE.

2_Talkative Male

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

1. **Overall, how would you rate your health during the PAST MONTH?**
   - ○ Excellent
   - ○ Very Good
   - ○ Good
   - ● Fair
   - ○ Poor

2. **Compared to before your most recent deployment, how would you rate your health in general now?**
   - ○ Much better now than before I deployed
   - ○ Somewhat better now than before I deployed
   - ○ About the same as before I deployed
   - ● Somewhat worse now than before I deployed
   - ○ Much worse now than before I deployed

3. **During the past 4 weeks, how difficult have physical health problems** *(illness or injury)* **made it for you to do your work or other regular daily activities?**
   - ○ Not difficult at all
   - ○ Very difficult
   - ● Somewhat difficult
   - ○ Extremely difficult

4. **During the past 4 weeks, how difficult have emotional problems** *(such as feeling depressed or anxious)* **made it for you to do your work, take care of things at home, or get along with other people?**
   - ○ Not difficult at all
   - ● Very difficult
   - ○ Somewhat difficult
   - ○ Extremely difficult

5. **Since you returned from deployment, about how many times have you seen a healthcare provider for any reason, such as in sick call, emergency room, primary care, family doctor, or mental health provider?**
   - ○ No visits ○ 1 visit ● 2-3 visits ○ 4-5 visits ○ 6 or more

6. **Since you returned from deployment, have you been hospitalized?** ● Yes ○ No

7. **During your deployment, were you wounded, injured, assaulted or otherwise physically hurt?** ● Yes ○ No

   If **NO**, skip to Question 8.

7a. If **YES**, are you still having problems related to this wound, assault, or injury? ● Yes ○ No ○ Unsure

8. **In addition to wounds or injuries you listed in question 7., do you currently have a health concern or condition that you feel is related to your deployment?** ● Yes ○ No ○ Unsure

   If **NO**, skip to Question 9.

8a. If **YES**, please mark the item(s) that best describe your deployment-related condition or concern:

○ Fever	○ Dimming of vision, like the lights were going out
○ Cough lasting more than 3 weeks	○ Chest pain or pressure
○ Trouble breathing	○ Dizzy, light headed, passed out
○ Bad headaches	○ Diarrhea, vomiting, or frequent indigestion/heartburn
○ Generally feeling weak	○ Problems sleeping or still feeling tired after sleeping
● Muscle aches	● Trouble concentrating, easily distracted
○ Swollen, stiff or painful joints	○ Forgetful or trouble remembering things
● Back pain	○ Hard to make up your mind or make decisions
○ Numbness or tingling in hands or feet	● Increased irritability
○ Trouble hearing	○ Taking more risks such as driving faster
○ Ringing in the ears	○ Skin diseases or rashes
○ Watery, red eyes	○ Other *(please list)*: _____

9a. During this deployment, did you experience any of the following events? *(Mark all that apply)*

	Yes	No
(1) Blast or explosion *(IED, RPG, land mine, grenade, etc.)*	●	○
(2) Vehicular accident/crash *(any vehicle, including aircraft)*	○	●
(3) Fragment wound or bullet wound above your shoulders	○	●
(4) Fall	●	○
(5) Other event *(for example, a sports injury to your head)*. Describe:	○	●

9b. Did any of the following happen to you, or were you told happened to you, IMMEDIATELY after any of the event(s) you just noted in question 9a.? *(Mark all that apply)*

	Yes	No
(1) Lost consciousness or got "knocked out"	○	●
(2) Felt dazed, confused, or "saw stars"	○	●
(3) Didn't remember the event	●	○
(4) Had a concussion	○	●
(5) Had a head injury	○	●

c. Did any of the following problems begin or get worse after the event(s) you noted in question 9a.? *(Mark all that apply)*

	Yes	No
(1) Memory problems or lapses	○	●
(2) Balance problems or dizziness	○	●
(3) Ringing in the ears	○	●
(4) Sensitivity to bright light	○	●
(5) Irritability	○	●
(6) Headaches	○	●
(7) Sleep problems	●	○

d. In the past week, have you had any of the symptoms you indicated in 9c.? *(Mark all that apply)*

	Yes	No
(1) Memory problems or lapses	○	●
(2) Balance problems or dizziness	○	●
(3) Ringing in the ears	○	●
(4) Sensitivity to bright light	○	●
(5) Irritability	○	●
(6) Headaches	○	●
(7) Sleep problems	●	○

2_Talkative Male

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

10. Do you have any persistent major concerns regarding the health effects of something you believe you may have been exposed to or encountered while deployed? ● Yes ○ No

If **NO**, skip to question 11.

10a. If **YES,** please mark the item(s) that best describe your concern:

○ Animal bites	● Loud noises
○ Animal bodies *(dead)*	○ Paints
○ Chlorine gas	○ Pesticides
○ Depleted uranium *(If yes, explain)* _____	○ Radar/Microwaves
○ Excessive vibration	○ Sand/dust
● Fog oils (smoke screen	○ Smoke from burning trash or feces
○ Garbage	○ Smoke from oil fire
● Human blood, body fluids, body parts, or dead bodies	○ Solvents
○ Industrial pollution	○ Tent heater smoke
○ Insect bites	● Vehicle or truck exhaust fumes
○ Ionizing radiation	○ Other exposures to toxic chemicals or materials, such as ammonia, nitric acid, etc.: *(If yes, explain)*
○ JP8 or other fuels	_____
○ Lasers	

11. Since return from your deployment, have you had serious conflicts with your spouse, family members, close friends, or at work that continue to cause you worry or concern? ● Yes ○ No ○ Unsure

12. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you ....

a. Have had nightmares about it or thought about it when you did not want to? ● Yes ○ No

b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? ● Yes ○ No

c. Were constantly on guard, watchful, or easily startled? ● Yes ○ No

d. Felt numb or detached from others, activities, or your surroundings? ● Yes ○ No

13a. In the PAST MONTH, Did you use alcohol more than you meant to? ● Yes ○ No

b. In the PAST MONTH, have you felt that you wanted to or needed to cut down on your drinking? ● Yes ○ No

c. How often do you have a drink containing alcohol?
○ Never ○ Monthly or less ○ 2 to 4 times a month ○ 2 to 3 times a week ● 4 or more times a week

d. How many drinks containing alcohol do you have on a typical day when you are drinking?
○ 1 or 2 ○ 3 or 4 ● 5 or 6 ○ 7 to 9 ○ 10 or more

e. How often do you have six or more drinks on one occasion?
○ Never ● Less than monthly ○ Monthly ○ Weekly ○ Daily

14. Over the PAST MONTH, have you been bothered by the following problems?	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	○	○	●	○
b. Feeling down, depressed, or hopeless	○	○	●	○

15. Would you like to schedule a visit with a healthcare provider to further discuss your health concern(s)? ● Yes ○ No

16. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? ● Yes ○ No

17. Are you currently interested in receiving assistance for a family or relationship concern? ● Yes ○ No

18. Would you like to schedule a visit with a chaplain or a community support counselor? ○ Yes ● No

Appendix H: Provider Background Survey

Provider ID/Name:	
Date:	**Site**:

Instructions

For all questions below, please choose the option that best matches your answer.

Demographics and Professional Background

1. **Year of Birth**	2. **Gender**	3. **Professional Background and/or Degree**	4. **Specialty**
19_____	☐ Male ☐ Female	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner ☐ Advanced Practice Nurse ☐ Independent Duty Corpsman ☐ Special Forces Medical Sergeant ☐ Independent Duty Medical Technician ☐ Independent Health Services Technician ☐ Behavioral Health Therapist (BHT) ☐ Other (please specify): _____	☐ General Practice ☐ Behavioral Health ☐ Other (please specify): _____

5. **How long have you been a practicing health care provider?**
(Months/Years)_____

6. **How long have you been conducting Post-Deployment Health Reassessment (PDHRA) assessments?**
(Months/Years) _____

7. **On average**, about how many hours per week do you spend conducting PDHRA assessments?					
☐ 0	☐ 1-5	☐ 6-10	☐ 11-20	☐ 21-30	☐ 31 or more

8. **During large PDHRA events**, about how many hours per week do you spend conducting PDHRA assessments?					
☐ 0	☐ 1-5	☐ 6-10	☐ 11-20	☐ 21-30	☐ 31 or more

9. **What is your role? Are you paid as a:**	10. **What is your military background?**
☐ Military provider at an MTF ☐ Military Provider associated with a specific unit ☐ Civilian provider paid by the government ☐ Civilian provider paid by an outside company	☐ Currently in the military ☐ Formerly in the military but not serving now ☐ Have never been in the military (***If you choose this answer, skip to question 12).***

11. **Have you ever been deployed overseas?** **Yes** ☐ **No** ☐ ***(If no, skip to question 12)***
11a. If Yes, where was your most recent deployment, and when did you return? Location: _____ Year of Return: _____
11b. As a health care provider, did you provide urgent care in a combat situation? Yes ☐ No ☐

The rest of this questionnaire will focus on your practices and thoughts related to the PDHRA process. For all questions that follow, please remember that ***we are asking you to answer based only on your experience with PDHRA interviews.*** *We know that the PDHRA is a unique clinical encounter, and that some of your answers may differ from what you would answer if considering other types of patient encounters.*

Please rate how confident you feel in your ability to successfully manage each of these situations during PDHRA interviews.	**Not at all Confident**	**Not very Confident**	**Somewhat Confident**	**Totally Confident**
12. Initiate a discussion with a patient about his or her concerns	☐	☐	☐	☐
13. Encourage a patient to talk about emotional concerns	☐	☐	☐	☐
14. Explore a patient's intense feelings like anger	☐	☐	☐	☐
15. Conclude a patient interview with an agreed problem list and a plan of action	☐	☐	☐	☐
16. Appropriately challenge a patient who I suspect is experiencing mental health problems even when he or she denies experiencing them when I ask.	☐	☐	☐	☐
17. Help a patient handle a difficult situation	☐	☐	☐	☐
18. Assess symptoms of depression during the PDHRA interview	☐	☐	☐	☐
19. Assess symptoms of PTSD during the PDHRA interview	☐	☐	☐	☐
20. Assess symptoms of risky alcohol use during the PDHRA interview	☐	☐	☐	☐
21. Assess symptoms of traumatic brain injury (TBI) during the PDHRA interview	☐	☐	☐	☐
22. Assess symptoms of physical health concerns (other than head trauma) during the PDHRA interview	☐	☐	☐	☐
23. Assess symptoms of exposure concerns during the PDHRA interview	☐	☐	☐	☐
24. Quickly establish a relationship of trust between yourself and the soldier during the PDHRA assessment	☐	☐	☐	☐
25. Reassure soldiers who have concerns about follow-up care	☐	☐	☐	☐
26. Conduct a brief intervention with a soldier at risk for problem drinking	☐	☐	☐	☐
27. Recognize when fear of stigmatization might be making a soldier reluctant to disclose mental health symptoms.	☐	☐	☐	☐
28. Help reduce the stigma soldiers may feel about experiencing mental health symptoms	☐	☐	☐	☐
29. Decide when a soldier with mental health concerns needs a referral, even when it is not obvious from their responses on the DD Form 2900.	☐	☐	☐	☐

Please indicate how strongly you agree or disagree with the following statements.	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
30. It's sometimes difficult for me to see things from the soldier's point of view during the short time allowed for the PDHRA interview.	☐	☐	☐	☐
31. When conducting PDHRA assessments, I find it hard to keep track of the way I am communicating with body language and word choices	☐	☐	☐	☐
32. PDHRA interviews have better outcomes when health care providers are able to show empathy for the soldier's situation.	☐	☐	☐	☐

When conducting PDHRA assessments, how often would you estimate that you do each of the following?	Almost Never	Occasionally	Often	Almost always
33. Ask soldiers about mental health symptoms when a soldier has NOT reported them on DD Form 2900	☐	☐	☐	☐
34. Ask soldiers about physical health symptoms when a soldier has NOT reported them on DD Form 2900	☐	☐	☐	☐
35. Use humor to help put a soldier at ease	☐	☐	☐	☐
36. Educate soldiers about common mental health concerns (e.g. describe common symptoms or coping strategies)	☐	☐	☐	☐
When conducting PDHRA assessments, how often would you estimate that you do each of the following?	**Almost Never**	**Occasionally**	**Often**	**Almost always**
37. Begin interviews by telling soldiers what they can expect to happen during their time with you	☐	☐	☐	☐
38. Tell soldiers that mental health concerns are common	☐	☐	☐	☐
39. Ask soldiers whether there are trusted people (e.g., buddies, friends, relatives) to whom they can talk about their deployment experiences	☐	☐	☐	☐
40. Use open-ended questions that result in a statement instead of yes/no answers	☐	☐	☐	☐
41. Periodically summarize what the soldier is telling me	☐	☐	☐	☐
42. Express empathy for a soldier's concerns	☐	☐	☐	☐
43. Provide reassurance for a soldier's concerns	☐	☐	☐	☐
44. Make statements to normalize mental health concerns	☐	☐	☐	☐
45. Ask the soldier for input	☐	☐	☐	☐
46. Use partnership statements	☐	☐	☐	☐
47. Ask the soldier about his or her understanding of the purpose of the PDHRA	☐	☐	☐	☐
48. Briefly counsel soldiers on how to access mental health care if they need it later	☐	☐	☐	☐
49. For soldiers who report mental health concerns, ask about previous treatment	☐	☐	☐	☐
50. For soldiers who report mental health concerns, inquire about their concerns related to barriers to care	☐	☐	☐	☐
51. For soldiers who report mental health concerns, provide brief education about effectiveness of treatment for their problem(s)	☐	☐	☐	☐
52. For soldiers with referrals, check their understanding of how to access the referred care	☐	☐	☐	☐

Please indicate how strongly you agree or disagree with the following statements.

When conducting PDHRA assessments, it is the health care provider's role to . . .	Strongly Disagree	Disagree	Agree	Strongly Agree
53. Clarify and confirm the soldier's responses on DD Form 2900	☐	☐	☐	☐
54. Ask soldiers whether they are experiencing common problems even if they are not reported on DD Form 2900	☐	☐	☐	☐
55. Make sure every soldier has information on how to receive care in the future if it becomes necessary	☐	☐	☐	☐
56. Make referrals to soldiers who screen positive for mental health concerns	☐	☐	☐	☐
57. Determine what type of referral soldiers should receive	☐	☐	☐	☐

58. Provide brief intervention for minor mental health concerns	☐	☐	☐	☐
59. Decide whether soldiers who do not screen positive for mental health concerns but who report some symptoms should receive a referral	☐	☐	☐	☐

Thinking about the PDHRA interview, please indicate how much you disagree or agree with each of the following statements.	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
60. My patients do not want me to investigate psychosocial concerns	☐	☐	☐	☐
61. I cannot help patients with problems I have not experienced myself	☐	☐	☐	☐
62. I focus on organic disease because I cannot help with psychosocial concerns	☐	☐	☐	☐
63. If I address psychological issues, patients will reject these issues and won't seek care if they need it in the future.	☐	☐	☐	☐
64. I feel guilty probing the psychosocial concerns of my patients.	☐	☐	☐	☐
Thinking about the PDHRA interview, please indicate how much you disagree or agree with each of the following statements.	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
65. I find great satisfaction in helping patients get treatment for psychosocial concerns.	☐	☐	☐	☐
66. I cannot help a patient with a psychosocial problem I have not resolved myself.	☐	☐	☐	☐
67. The psychosocial concerns we all experience do not significantly influence the onset or course of disease.	☐	☐	☐	☐
68. One reason I do not always spend a lot of time asking soldiers about psychosocial concerns is the limited time I have available.	☐	☐	☐	☐
69. Evaluating psychosocial concerns more extensively will cause me to be more overburdened.	☐	☐	☐	☐
70. So many issues have to be investigated when seeing patients that I do not always spend a lot of time considering psychosocial factors.	☐	☐	☐	☐
71. Extensively investigating issues of psychosocial concerns decreases my efficiency.	☐	☐	☐	☐
72. Exploring psychosocial issues with the patient often causes me pain.	☐	☐	☐	☐

73. **Are there any common symptoms or health issues that you nearly always ask soldiers about, even if not reported on DD Form 2900?**

74. **Is there any general advice or guidance that you nearly always give soldiers, regardless of what they reported on DD Form 2900?**

75. **In your experience, what is the shortest amount of time in which a PDHRA interview can be completed?**
About _____ minutes.

76. **About how long would you say your longest PDHRA interviews take?**
About _____ minutes.

77. **What factors influence the length of your PDHRA interviews? That is, what causes them to be long or short?**

78. **We know that sometimes, providers might believe a soldier could benefit from a referral for mental health concerns but have good reasons for not actually making one. In your experience, what are some reasons to refrain from a referral even when the soldier might benefit from further evaluation?**

Appendix I: Provider Workshop Evaluation

Provider ID/Name:	
Date:	**Site**:

Workshop Evaluation

For all questions below, please choose the option that best matches your answer.

The workshop today . . .	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
1. Addressed issues I wanted to know about.	☐	☐	☐	☐
2. Taught me useful techniques and skills.	☐	☐	☐	☐
3. Provided me a chance to share my ideas.	☐	☐	☐	☐
4. Distributed materials that were pertinent and useful.	☐	☐	☐	☐
5. Was the right amount of time to cover the material.	☐	☐	☐	☐
6. Allowed me ample opportunity to practice the material that was covered.	☐	☐	☐	☐

The workshop leaders . . .	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
7. Were knowledgeable about the materials.	☐	☐	☐	☐
8. Effectively presented the material in a clear and organized manner.	☐	☐	☐	☐
9. Provided answers to my questions.	☐	☐	☐	☐
10. Provided good training aids and visual demonstrations.	☐	☐	☐	☐

Please indicate how much you agree or disagree with the following statements.	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
11. This workshop was relevant to my work.	☐	☐	☐	☐
12. I left this workshop with new ideas for communicating with soldiers who seem reluctant to disclose mental health symptoms.	☐	☐	☐	☐
13. Attending this workshop has helped me identify at least some of my strengths and weaknesses regarding communication with soldiers during the PDHRA process.	☐	☐	☐	☐
14. The communication practices covered in this workshop will fit in well with the culture of my workplace.	☐	☐	☐	☐
15. The communication practices covered in the workshop are worth trying.	☐	☐	☐	☐
16. I am concerned that using these communication skills will increase the length of the PDHRA interview beyond acceptable limits.	☐	☐	☐	☐
17. I think that using these communication skills will help me be more effective in eliciting soldier concerns about mental health issues, even from those who may be reluctant to disclose.	☐	☐	☐	☐
18. I think I will be supported in using these communication skills by the installation leadership.	☐	☐	☐	☐

19. I intend to use some of the skills discussed in this workshop when conducting PDHRA interviews.	☐	☐	☐	☐

Learning Objectives

Please indicate how much you agree that each learning objective listed below was met.

Participants will demonstrate . . .	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
20. Enhanced awareness of the PDHRA interview as an opportunity for new discovery of behavioral health concerns in addition to clarifying Soldier responses on the DD Form 2900	☐	☐	+++ +++ +++ +++ +☐	☐
21. Applied knowledge of key communication strategies to enhance opportunities for Soldier disclosure of behavioral health concerns within the PDHRA encounter	☐	☐	☐	☐
22. Applied knowledge of strategies for anticipatory guidance to normalize the deployment and reintegration experience appropriate to a brief encounter	☐	☐	☐	☐

23. **What part of the workshop did you find the <u>most</u> useful?**

24. **What could be improved to make the workshop more useful?**

25. **Please tell us about any concerns that you have about trying to incorporate these communication practices into your PDHRA interviews.**

26. **Please use the space below to include any additional comments.**

Appendix J: Provider Post-Intervention Evaluation

Provider ID/Name:	
Date:	**Site**:

Instructions

For all questions that follow, please remember that **we are asking you to answer based only on your experience with PDHRA interviews.** We know that the PDHRA is a unique clinical encounter, and that some of your answers may differ from what you would answer if considering other types of patient encounters.

Please rate how confident you feel in your ability to successfully manage each of these situations during PDHRA interviews.	**Not at all Confident**	**Not very Confident**	**Somewhat Confident**	**Totally Confident**
1. Initiate a discussion with a patient about his or her concerns	☐	☐	☐	☐
2. Encourage a patient to talk about emotional concerns	☐	☐	☐	☐
3. Explore a patient's intense feelings like anger	☐	☐	☐	☐
4. Conclude a patient interview with an agreed problem list and a plan of action	☐	☐	☐	☐
5. Appropriately challenge a patient who I suspect is experiencing mental health problems even when he or she denies experiencing them when I ask	☐	☐	☐	☐
6. Help a patient handle a difficult situation	☐	☐	☐	☐
7. Assess symptoms of depression during the PDHRA interview	☐	☐	☐	☐
8. Assess symptoms of PTSD during the PDHRA interview	☐	☐	☐	☐
9. Assess symptoms of risky alcohol use during the PDHRA interview	☐	☐	☐	☐
10. Assess symptoms of traumatic brain injury (TBI) during the PDHRA interview	☐	☐	☐	☐
11. Assess symptoms of physical health concerns (other than head trauma) during the PDHRA interview	☐	☐	☐	☐
12. Assess symptoms of exposure concerns during the PDHRA interview	☐	☐	☐	☐
13. Quickly establish a relationship of trust between yourself and the soldier during the PDHRA assessment	☐	☐	☐	☐
14. Reassure soldiers who have concerns about follow-up care	☐	☐	☐	☐
15. Conduct a brief intervention with a soldier at risk for problem drinking	☐	☐	☐	☐
16. Recognize when fear of stigmatization might be making a soldier reluctant to disclose mental health symptoms	☐	☐	☐	☐
17. Help reduce the stigma soldiers may feel about experiencing mental health symptoms	☐	☐	☐	☐
18. Decide when a soldier with mental health concerns needs a referral, even when it is not obvious from their responses on the DD Form 2900	☐	☐	☐	☐

Please indicate how strongly you agree or disagree with the following statements.	Strongly Disagree	Disagree	Agree	Strongly Agree
19. It's sometimes difficult for me to see things from the soldier's point of view during the short time allowed for the PDHRA interview.	☐	☐	☐	☐
20. When conducting PDHRA assessments, I find it hard to keep track of the way I am communicating with body language and word choices.	☐	☐	☐	☐
21. PDHRA interviews have better outcomes when health care providers are able to show empathy for the soldier's situation.	☐	☐	☐	☐

When conducting PDHRA assessments since the workshop, how often would you estimate that you did each of the following?	Almost Never	Occasionally	Often	Almost always
28. Ask soldiers about mental health symptoms when a soldier has NOT reported them on DD Form 2900	☐	☐	☐	☐
29. Ask soldiers about physical health symptoms when a soldier has NOT reported them on DD Form 2900	☐	☐	☐	☐
30. Use humor to help put a soldier at ease	☐	☐	☐	☐
31. Educate soldiers about common mental health concerns (e.g. describe common symptoms or coping strategies)	☐	☐	☐	☐
32. Begin interviews by telling soldiers what they can expect to happen during their time with you	☐	☐	☐	☐
33. Tell soldiers that mental health concerns are common	☐	☐	☐	☐
34. Ask soldiers whether there are trusted people (e.g., buddies, friends, relatives) to whom they can talk about their deployment experiences	☐	☐	☐	☐
35. Use open-ended questions that result in a statement instead of yes/no answers	☐	☐	☐	☐
36. Periodically summarize what the soldier is telling me	☐	☐	☐	☐
37. Express empathy for a soldier's concerns	☐	☐	☐	☐
38. Provide reassurance for a soldier's concerns	☐	☐	☐	☐
39. Make statements to normalize mental health concerns	☐	☐	☐	☐
40. Ask the soldier for input	☐	☐	☐	☐
41. Use partnership statements	☐	☐	☐	☐
42. Ask the soldier about his or her understanding of the purpose of the PDHRA	☐	☐	☐	☐
43. Briefly counsel soldiers on how to access mental health care if they need it later	☐	☐	☐	☐
44. For soldiers who report mental health concerns, ask about previous treatment	☐	☐	☐	☐
45. For soldiers who report mental health concerns, inquire about their concerns related to barriers to care	☐	☐	☐	☐
46. For soldiers who report mental health concerns, provide brief	☐	☐	☐	☐

education about effectiveness of treatment for their problem(s)				
47. For soldiers with referrals, check their understanding of how to access the referred care	☐	☐	☐	☐

Please indicate how strongly you agree or disagree with the following statements.

When conducting PDHRA assessments, it is the health care provider's role to . . .	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
22. Clarify and confirm the soldier's responses on DD Form 2900	☐	☐	☐	☐
23. Ask soldiers whether they are experiencing common problems even if they are not reported on DD Form 2900	☐	☐	☐	☐
24. Make sure every soldier has information on how to receive care in the future if it becomes necessary	☐	☐	☐	☐
25. Make referrals to soldiers who screen positive for mental health concerns	☐	☐	☐	☐
26. Determine what type of referral soldiers should receive	☐	☐	☐	☐
27. Provide brief intervention for minor mental health concerns	☐	☐	☐	☐
28. Decide whether soldiers who do not screen positive for mental health concerns but who report some symptoms should receive a referral	☐	☐	☐	☐

Please indicate how much you disagree or agree with each of the following statements.	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
29. My patients do not want me to investigate psychosocial concerns	☐	☐	☐	☐
30. I cannot help patients with problems I have not experienced myself	☐	☐	☐	☐
31. I focus on organic disease because I cannot help with psychosocial concerns	☐	☐	☐	☐
32. If I address psychological issues, patients will reject these issues and won't seek care if they need it in the future.	☐	☐	☐	☐

Please indicate how much you disagree or agree with each of the following statements.	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
33. I feel guilty probing the psychosocial concerns of my patients.	☐	☐	☐	☐
34. I find great satisfaction in helping patients get treatment for psychosocial concerns.	☐	☐	☐	☐
35. I cannot help a patient with a psychosocial problem I have not resolved myself.	☐	☐	☐	☐
36. The psychosocial concerns we all experience do not significantly influence the onset or course of disease.	☐	☐	☐	☐
37. One reason I do not always spend a lot of time asking soldiers about psychosocial concerns is the limited time I have available.	☐	☐	☐	☐
38. Evaluating psychosocial concerns more extensively will cause me to be more overburdened.	☐	☐	☐	☐

39. So many issues have to be investigated when seeing patients that I do not always spend a lot of time considering psychosocial factors.	☐	☐	☐	☐
40. Extensively investigating issues of psychosocial concerns decreases my efficiency.	☐	☐	☐	☐
41. Exploring psychosocial issues with the patient often causes me pain.	☐	☐	☐	☐

42. **When you used the communication strategies that were included in the workshop, did you notice an increase in the average length of time the interviews took?**
☐ Yes, it added about _____ minutes on average.
☐ No ***Please skip to Question 56.***
☐ N/A (I did not find many opportunities to use these communication strategies after the workshop) ***Please skip to Question 56.***

43. **If the length of your interviews increased, was this within acceptable limits? If it was not, please explain what problems the increased interview length caused.**
☐ Yes
☐ No (Please explain:

44. **Did you experience any barriers to using the communication behaviors covered in the training? These could be logistical problems, problems related to standard operating procedure at your MTF, or problems you encountered with soldiers. If you did encounter any problems or barriers, please describe them here.**

Appendix K: Provider Post-PDHRA Survey

Provider Name/ID:
Site:
Date:

serial no. 01234

Post-PDHRA Provider Survey

Instructions
For each item below, please choose the option that best matches your answer. Remember that all questions are asking only about mental health symptoms.

During the interview, was there any discussion of mental health concerns/symptoms that the soldier had not already reported on DD Form 2900?

- ☐ Yes
- ☐ No

During the interview, do you think this soldier disclosed all of the mental health concerns/symptoms that he or she is experiencing?

- ☐ Yes
- ☐ No, this soldier under-reported symptoms
- ☐ No, this soldier exaggerated symptoms

3 *We know that sometimes a provider may believe a referral is warranted but have good reasons for not making one (e.g. the soldier is already under mental health care). Please answer this question regardless of whether you actually gave a referral.*

I believe that this soldier could benefit from further evaluation for mental health symptoms.

- ☐ Strongly disagree
- ☐ Somewhat disagree
- ☐ Somewhat agree
- ☐ Strongly agree

Appendix L: Program Manager Interview Guide

PDHRA Program Manager Interview 1

Interviewer Name: _____ **ID:** _____

Date: _____ **Time Start:** _____ **Stop:** _____

Installation: _____ **City/State:** _____

 # People Interviewed:_____

Prior to Interview Start

Thank you for making time for us to meet today. Your comments and opinions will be extremely useful to us as we pilot and evaluate the feasibility and effectiveness of a communication training for PDHRA providers. As a part of this research, we're hoping to learn more about how the PDHRA process is implemented at your installation. Just a few comments before we get started.

We estimate this interview will last about 30 minutes. Your participation is completely voluntary, and you are free to withdraw at any time. You are also free to skip any questions. So that we can keep this interview anonymous, we will refrain from using your name. We ask that you refrain from using any Service Member or provider names in the course of the interview. Please use a pseudonym in any sample cases that you might share.

I will be taking written notes during the interview. However, in order to better capture what you are saying, I'd like to record the interview with a digital audio-recorder. Any transcriptions and my written notes will not contain any information that would identify you. The digital audio recordings will be stored on a password-protected computer in our office at Vanderbilt University. Any written documents related to this interview will be stored in a locked cabinet at Vanderbilt. For any written documents that result from this interview, we will use pseudonyms to protect your identity.

Person#1: Mgr Person#2: Asst Mgr

Do I have your permission to audio-record this interview?
Person#1: _____ Yes _____ No Person#2: _____ Yes _____ No

When you have an event scheduled, about how many hours per week do you spend managing the PDHRA process?
Person#1:____ (# hrs/wk) Person#2:____ (# hrs/wk)

Can you tell me how long you've been managing the PDHRA process?
Person#1:____ (# mo) Person#2:____ (# mo)

For most of this interview, I'll be asking questions about the most recent typical PDHRA event that was held at your installation.

Can you tell me when the last typical PDHRA event occurred?
Date (mm/dd/yyyy) _____

About how many SMs were assessed during that event? _____

General PDHRA Background

Where is the PDHRA typically completed? *(same location as Readiness Processing, same location as In/Out Processing, MTF/Primary care clinic, Cafeteria or gym, stand-alone, other)*

Is the location for the PDHRA a fixed site?
If yes, for how long?
If no, how is the location determined?

How long is a typical clinician assessment?

Here (or at nearest MTF/clinic) are there any special programs in place to increase the use of behavioral health care in primary care settings? For example, the Army has special training for primary care providers called RESPECT-MIL. If yes, do you know when these special programs started?

PDHRA Implementation

The following questions are all about how the (date) PDHRA event was implemented.

How did SMs typically complete the self-report section of the DD Form 2900?
Prompts:
Group/individual
On/off duty
Online/other

How were SMs scheduled for the clinician assessment portion of the PDHRA?
Prompts:
Walk-in/scheduled, individual/group, unit/large group
How were SMs informed?

Where did SMs go for the clinician assessment?
Prompts:
Location
Privacy
Walk-in availability
Was the self-report section of the DD Form 2900 used to determine what health care provider (HCP) was assigned to do that assessment (e.g., BH specialist, traumatic brain injury (TBI), other)? If yes, describe.

Was any procedure in place to tailor PDHRA events to the anticipated needs of a unit before interviews began? For example, based on prior knowledge of combat exposure for a particular unit?

Prompts:
Briefing of providers
Scheduling extra staff or specialists

Did the PDHRA occur at the same time as other activities? (e.g. Readiness Processing, In/Out Processing, Immunization/vision/dental/etc, Physical examinations) If yes, describe.

Were there any additional protocols, programs, or personnel in place aside from those specified in policies/OPORDERS for the way the PDHRA was conducted? *(e.g. special programs, additional forms/clinical instruments, additional personnel such as BH specialist, drug & alcohol coordinator, Military OneSource, etc).*

SM Pre-Briefing and Education

This question is about any pre-briefings or deployment cycle education associated with the (date) PDHRA event.

Are you aware of any pre-briefings or deployment cycle education provided to SMs as part of the PDHRA process? If yes, describe.

Prompts:
Content (PDHRA-specific; deployment cycle problems, coping, where to seek help)
*Format (*may overlap with question above)*
Who led the pre-briefing (Chain of command, other)
When did it occur (prior to SR, after the SR but prior to CA)
Length (about how long)
Educational material format, content

Command Support

The following questions are all about Command support for the (date) PDHRA event.

What were the responsibilities taken by the Unit Leadership (Officers and NCOs) for the PDHRA for those SMs? Please describe Officer's and NCO's responsibilities separately.

Is any information about individual SMs relevant to the PDHRA provided to Unit Leaders? *(e.g. compliance, problems/concerns, referrals).* If yes, describe.

Were the Unit Leaders involved in any pre-briefing of SMs for the PDHRA? If yes, when did this happen? Who was involved (Officer, NCO)? **Note may overlap with pre-briefing question above*

Are Unit Leaders involved in ensuring SM compliance with the PDHRA? If yes, describe. How helpful do you think this is?

What are leadership attitudes toward the PDHRA?

Prompts:
Medical Program
Commanders' Program
"Just a form to check off"

Referrals

The following questions are all about the referral process associated with the (date) PDHRA event.

For SMs who received referrals from the PDHRA, is there a process in place to assist with referrals? If yes, describe

Provide SM with contact information to set up appointment
MTF staff makes appointment at time of PDHRA
Referral provider calls SM to schedule an appointment
Some appointments available immediately
Is there any difficulty ensuring privacy if SM goes to immediate appointment?

What about referrals to sources outside the MTF/clinic? *(Military OneSource, Chaplain, Other)*

Is there a process in place to verify that appointments were provided to SMs that are consistent with page 5 of the DD Form 2900? If yes, how and in what time period?

Who verifies?
How is it recorded?
Within 24 hours *Within 7 days* *Within 30 days*

Does your installation track completion of PDHRA referrals? If yes, how?

Prompts:
Electronic record of referral completion
Referrals entered into medical records system (e.g., AHLTA for Army)
Any follow-up with SMs failing to keep appointments
Commanders notified of referral completion

Are there any guidelines, whether formal or just implied, that influence the referrals that are made through the PDHRA process? If yes, describe.

Prompts:
Joint decision with SM
Type of referral (e.g., PCP instead of specialist because of long wait time; chaplain, M1Source)
Lack of availability of any particular specialists
Noted difficulties obtaining specialty care (wait time, distance)

Clinicians Conducting PDHRA Assessment

The following questions are about the health care providers (HCPs) who conducted the clinician assessment at the (date) PDHRA event.

How many HCPs were available for the clinician assessment portion of the DD Form 2900?
Approximate estimate, not exact

How many SMs can typically be assessed by one HCP per eight hour day?

What was the professional background of the HCPs conducting the clinician assessment?
(Physician assistant (PA), nurse practitioner (NP), medical doctor (MD), BH Specialist, Other)

What role(s) do the HCPs hold who conduct the clinician assessment?

Prompts:
Organic? (Military/civilian, contractor)

If organic:
MTF or associated with Unit? Deployed with unit?
Other duties?
Any perceived differences in clinician assessment based on roles?

What was the procedure for selecting HCPs to conduct the clinician assessment?

Prompts:
Preference for role (organic, deployed, civilian; matching with SM, etc.)
Awareness of any opinions or concerns about the role of the assessment providers

Was there any specialized training on identifying signs and symptoms of physical or mental problems related to combat experience available to assist HCPs? If yes, describe

Prompts:
Documentation of HCP participation in training
OPORDERS, Policies, Local-developed

Is the HCP given guidance on how to interpret the PDHRA self-report form? If yes, describe.

Prompts:
Scoring algorithms or criteria
Documentation of HCP participation in training
Can we get copies of guidance materials?

Was there any specialized training provided in how to complete the clinician section of the DD Form 2900? If yes, describe.

Prompts:
Ongoing training or one time?
Training on interview technique while completing DD Form 2900?
Documentation of HCP participation in training

Are HCPs provided with any feedback regarding their performance in the PDHRA process? If yes, describe.

Prompts:
Formal/informal
Frequency
Peer Review
If yes, does any of this feedback address interview communication techniques

Are there regular meetings or staffings with providers at your installation?

Prompts:
Frequency and format
Who attends
Topics discussed
Discuss adverse events or difficult cases?

Utilization Management and Reporting

The following questions are about utilization management and reporting associated with the (date) PDHRA event.

Is there a process for capturing how many PDHRAs are completed? If yes, describe.

Prompts:
Tracking of SMs completed (Self report, clinician assessment)
Tracking of SMs referred
How often?

Is there a process for reviewing SM compliance with referrals? If yes, describe.

Prompts:
Individual follow-up for SMs not attending group events/missing appointments
Follow-up for SMs past the window
How often?

What is the current compliance rate for SMs who receive referrals?

Prompts:
Date range
How calculated (numerator, denominator)

Are there any mechanisms in place for regular reporting of PDHRA-related information, such as compliance rates or referrals? If yes, describe.

Prompts:
Reports (to whom, how often, content)
Meetings (who involved, how often, content)
Follow-up/action steps

Is any information related to the PDHRA (and PDHA) used to manage health care services available to SMs in general? For example, if a large percentage of SMs were indicating sleep problems on the PDHA or PDHRA, using that information to put resources into a sleep disorder clinic. If yes, describe.

PDHA Review

I have one question about the PDHA (post-deployment health assessment) completed by SMs who participated in the (date) PDHRA event.

Was the PDHA available to the HCPs who conducted the PDHRA clinician assessment? If yes, describe.

Prompt:
Frequently accessed by HCPs

Recent PDHRA Changes and Special Circumstances

The following questions are about circumstances that might cause PDHRAs to be conducted differently from what you've been describing so far. We'd also like to find out if the upcoming PDHRA event is expected to be conducted in a way that is typical of how your installation usually conducts major PDHRA events.

At this point, have your installation's procedures been changed very much in response to the NDAA 708 legislation*?
If yes, how recently have these changes occurred? _____
Please describe.

Prompts:
Training
Algorithms/forms

Staff changes
Referrals (number, types)
If unclear, clarify whether the PDHRA event described so far reflected these changes.

**Note for Interviewer: The NDAA 708 legislation was passed in 2009. It mandated substantial revisions to the health risk appraisal process and instituted new requirements for provider training. NDAA training slides are currently available online, but not all providers have completed the training yet, and not all changes mandated in NDAA have been rolled out at all sites.*

(Interviewer Note: Only ask if event being described above is not the current event) Now, I'd like you to switch from thinking of the (date) event and consider the PDHRA event that is beginning on (date). Are there any big differences in how the upcoming PDHRA is being implemented, compared to the event you've told me about already?

Prompts:
Locations and scheduling
Pre-briefings and deployment cycle education
Command Support
Referral procedures
Significant changes in health care providers (high turnover recently?)
Utilization management and reporting

General Barriers and Facilitators – Interview Close

At your installation, what are the biggest strengths regarding the PDHRA?
Prompts:
Support
Guidance
Integration with other health care and/or assessments (PHA, PDHA)
Access to health care
Military readiness

Is this strength specific to your installation or does it generalize to other installations?

At your installation, what are the biggest challenges regarding the PDHRA?
Prompts:
Support
Guidance
Integration with other health care and/or assessments (PHA, PDHA)
Access to health care
Military readiness

Is this challenge specific to your installation or does it generalize to other installations?

What would be the most effective in reducing or eliminating those challenges?

In your experience, what are the factors that contribute to the success of the PDHRA process?

Is there anything that could change in the PDHRA process to make your time better spent?

Are there any questions or issues that you think are important but that we have not talked about so far?

Would it be possible to have copies of any materials that you mentioned in this interview?

Prompt:

If yes, agree on a plan to receive these materials.

Appendix M: Service Member Survey

Instructions

This study is being conducted by Vanderbilt University, which has been funded by the U.S. Army Medical Research and Acquisition Activity (USAMRAA)to evaluate the effectiveness of a training program for health care providers who conduct post-deployment screenings. Your opinions and experience will help us evaluate the effectiveness of the training. This questionnaire will take about 15 minutes or less to finish, and your participation is voluntary. You can skip any questions or refuse to answer any questions. ***Your answers will remain confidential and will not be connected to who you are.***

This survey is about the interview you just came out of and the self-report form (DD 2900) that you discussed with the provider there. *Please answer these survey questions only with regard to the interview and form you just completed and not regarding any previous post-deployment screenings you might have experienced.*

Please mark your answers by putting an 'X' in <u>one</u> box for each numbered item*. If you would like to change an answer, you already marked, please fill in the entire box of the incorrect answer and mark the appropriate answer with an 'X'.*

1. **Age**	2. **Gender**	3. **Grade / Rank**	4. **Branch**	5. **Component**
☐ 18-24 ☐ 25-29 ☐ 30-39 ☐ 40 or over	☐ Male ☐ Female	☐ E1-E4 ☐ O1-O3 ☐ E5-E6 ☐ O4-O9 ☐ E7-E9 ☐ W01-W05	☐ Army ☐ Air Force ☐ Navy ☐ Coast Guard ☐ Marine Corps	☐ Active Duty ☐ Reserve ☐ National Guard

6. **Did you know the provider who completed your DD 2900 interview before this contact?**	Yes ☐	No ☐
6b. If *yes*, was the provider associated with your unit when you were deployed?	Yes ☐	No ☐

7. **How long was the interview you just completed with the provider?**				
Less than 5 minutes ☐	5 – 10 minutes ☐	11 – 15 minutes ☐	16 – 25 minutes ☐	More than 25 minutes ☐

8. **How long did you wait in line to see the provider?**				
Less than 5 minutes ☐	5 – 10 minutes ☐	11 – 15 minutes ☐	16 – 25 minutes ☐	More than 25 minutes ☐

How much do you DISAGREE or AGREE with the statements below?	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	
9. I was comfortable with the amount of time I waited to see the provider.	☐	☐	☐	☐	
10. Completing the DD Form 2900 helped me identify my concerns.	☐	☐	☐	☐	☐ **N/A** (I had no concerns)

Please use the following scale to rate the way the health care provider communicated with you.

This provider . . .	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
11. Greeted me in a way that made me feel comfortable	☐	☐	☐	☐	☐
12. Treated me with respect	☐	☐	☐	☐	☐
13. Showed interest in my ideas about my health	☐	☐	☐	☐	☐
14. Understood my main health concerns	☐	☐	☐	☐	☐

15. Paid attention to me (looked at me, listened carefully)	☐	☐	☐	☐	☐
16. Let me talk without interruptions	☐	☐	☐	☐	☐
17. Gave me as much information as I wanted	☐	☐	☐	☐	☐
18. Talked in terms I could understand	☐	☐	☐	☐	☐
19. Checked to be sure I understood everything	☐	☐	☐	☐	☐
20. Encouraged me to ask questions	☐	☐	☐	☐	☐
This provider . . .	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
21. Involved me in decisions as much as I wanted	☐	☐	☐	☐	☐
22. Discussed next steps, including any follow-up plans	☐	☐	☐	☐	☐
23. Showed care and concern	☐	☐	☐	☐	☐
24. Spent the right amount of time with me	☐	☐	☐	☐	☐

This provider . . .	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
25. Was in a hurry	☐	☐	☐	☐
26. Expressed concern for my feelings and needs, not just my physical status	☐	☐	☐	☐
27. Asked how I was doing	☐	☐	☐	☐
28. Made uncaring remarks or did something I found offensive	☐	☐	☐	☐
29. Was short tempered or abrupt	☐	☐	☐	☐
30. Seemed knowledgeable about common post-deployment concerns and symptoms	☐	☐	☐	☐

This provider . . .	**Yes**	**No**	
31. Asked me about my physical health	☐	☐	
32. Asked me about my emotional health	☐	☐	
33. Asked me about my alcohol use	☐	☐	
34. Helped me understand how to recognize symptoms of common deployment-related health problems	☐	☐	
35. Told me about the effectiveness of treatments available for deployment-related health problems	☐	☐	
36. Gave me advice on how to access medical care if I need it later	☐	☐	
37. Talked with me about common reintegration issues	☐	☐	
38. Asked me if I was already getting treatment for any problems I reported on the form	☐	☐	**N/A** ☐ I did not report any problems on the form
39. Asked me how satisfied I was with treatment I was already getting for any problems I reported on the form	☐	☐	**N/A** ☐ I did not report getting any previous treatment

Remember, all responses are CONFIDENTIAL.

Since returning from your last deployment . . .	Yes	No
40. Have you experienced an emotional, alcohol, stress, or relationship problem?	☐	☐
41. Have any friends or family suggested that you seek help from a professional (such as a counselor, doctor, clergy, etc.) for an emotional, alcohol, stress, or relationship problem?	☐	☐

When you filled out DD Form 2900 (the online self-report), did you report ALL of your concerns about...	Yes	No	N/A (I had no concerns)
42. Your physical health	☐	☐	☐
43. Your emotional health	☐	☐	☐
44. Any conflicts with family, friends, or work colleagues	☐	☐	☐
45. Your alcohol use	☐	☐	☐

During the INTERVIEW you just completed, did you and the provider talk about ALL concerns you reported on DD Form 2900 regarding . . .	Yes	No	N/A (I had no concerns)
46. Your physical health	☐	☐	☐
47. Your emotional health	☐	☐	☐
48. Any conflicts with family, friends, or work colleagues	☐	☐	☐
49. Your alcohol use	☐	☐	☐

During the interview, did you and the provider talk about ANY concerns that you had NOT already reported on DD Form 2900? Please answer for each of the following.	Yes	No
50. Physical health concerns	☐	☐
51. Emotional health concerns	☐	☐
52. Conflicts with family, friends, or work colleagues	☐	☐
53. Alcohol use concerns	☐	☐

54. Did the provider suggest that you get follow-up care for any problems?	Yes ☐	No ☐

55. **If the provider suggested that you get follow-up care, do you think you will follow that advice?**
Probably will ☐ Probably will NOT ☐ Haven't decided ☐ N/A (no follow-up was suggested) ☐

Now we would like to ask some general background questions.

Please mark 'Yes' or 'No' for each of the following. . .	Yes	No
56. At least one NCO or Officer from my current unit was in theater with me on my last deployment	☐	☐
57. At least one unit NCO or Officer briefed my unit on the DD 2900 process	☐	☐
58. Are you planning to separate from the military in the next 6 months?	☐	☐
59. Are you seeking promotion within the military in the next 6 months?	☐	☐

How much do you DISAGREE or AGREE with the statements below…	Strongly Disagree	Disagree	Agree	Strongly Agree

60. I am willing to tell others my distressing thoughts	☐	☐	☐	☐
61. If I thought I needed it, I would get psychological counseling	☐	☐	☐	☐
62. If something unpleasant happens to me, I often look for someone to talk to	☐	☐	☐	☐
63. Among my friends or relatives, there is someone who makes me feel better if I am feeling down	☐	☐	☐	☐
64. If I feel depressed or sad, I tend to keep those feelings to myself	☐	☐	☐	☐
65. There are people to whom I can talk about my deployment experiences	☐	☐	☐	☐
66. If I were feeling upset or down for a long time I would want to get help	☐	☐	☐	☐
67. I am carefully listened to and understood by family members or friends	☐	☐	☐	☐
68. I prefer *not* to talk about my problems	☐	☐	☐	☐
69. Among my friends or relatives, there is someone I go to if I need good advice	☐	☐	☐	☐
70. The members of my unit know that they can depend on each other	☐	☐	☐	☐
71. If I were stressed or feeling down someone in my unit would be supportive	☐	☐	☐	☐
72. If I had an emotional or family problem someone in my unit would figure out a way to help me	☐	☐	☐	☐

How much do you DISAGREE or AGREE with the statements below...

My unit NCO…	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
73. Makes sure that there is time to attend appointments for physical, mental, or dental health	☐	☐	☐	☐
74. Encourages unit members to be open about any problems they might be experiencing on the DD Form 2900	☐	☐	☐	☐
75. Strongly supports the DD 2900 process	☐	☐	☐	☐
76. My answers to the above questions would be the same for my unit officer	☐	☐	☐	☐

For questions 69-80, please answer regardless of whether you have ever experienced any emotional or mental health problems yourself.

If I were to reveal any emotional or mental health problems on a DD 2900 (self-report or interview) it is likely that…	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
77. I could be denied a security clearance in the future	☐	☐	☐	☐
78. It would assist me in finding the help I need	☐	☐	☐	☐
79. It could harm my career	☐	☐	☐	☐
80. Members of my unit would have less confidence in me	☐	☐	☐	☐
81. My unit leadership would have doubts about my dependability	☐	☐	☐	☐

Being referred to a mental health provider would NOT be helpful because . . .	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
82. It would be too hard to get time off work	☐	☐	☐	☐
83. It would cost too much money	☐	☐	☐	☐

84. The visit would ***not*** remain confidential	☐	☐	☐	☐
85. The services provided are ***not*** effective	☐	☐	☐	☐
86. The medications that I might be given have too many bad side effects	☐	☐	☐	☐
87. Religious counseling would be more helpful than mental health treatment	☐	☐	☐	☐
88. I can handle problems on my own or with help from family or friends	☐	☐	☐	☐

Since returning from your last deployment, have you talked to any of the following individuals about any emotional, alcohol, stress, or relationship problems?	**Yes**	**No**
89. Medical professional	☐	☐
90. Mental health professional	☐	☐
91. Religious or spiritual leader	☐	☐
92. Family or friend	☐	☐

Thank you for taking the time to complete this questionnaire. Your responses will help us evaluate the PDHRA healthcare provider training that we have been conducting this week.

Please complete the card attached to this survey, separate it from the survey, and place it in the box labeled SURVEY CARDS.

Then give your survey to the Vanderbilt Researcher.

THANK YOU!

Appendix N: Expert Panel Membership Roster

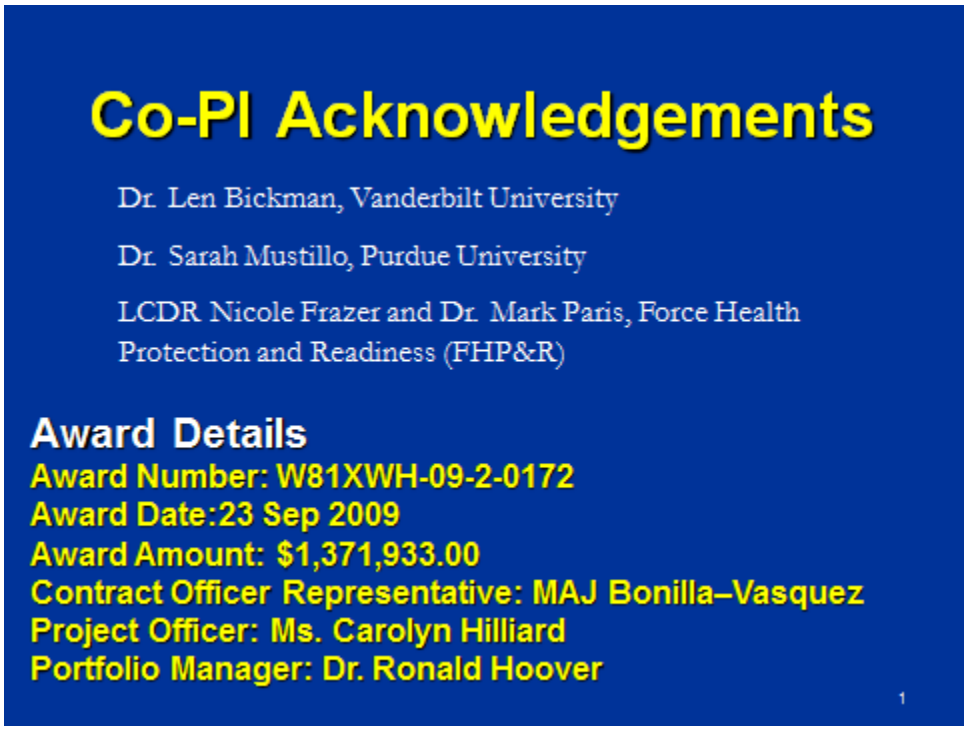
Table E.1 Expert Panel Members

Name	Role
Dr. Ivan Covas-Maldonado *	Staff Deployment Health Physician at Ft Carson TBI Center
COL Charles Engel	Director, DHCC at Walter Reed Army Medical Center, Senior Scientist at the Center for the Study of Traumatic Stress, and Associate Professor and Associate Chair at the Department of Psychiatry at the Uniformed Services University School of Medicine
Dr. Lucinda Frost	PDHRA Management
CAPT John Golden	Psychologist, Acting Deputy Director Psychological Health Clinical Standards of Care, DCoE
Dr. (Retired COL) Charles Hoge	Psychiatrist, Researcher
CAPT Sara Kass	Bureau of Medicine (Navy) and Navy Family Practice
Dr. (Retired COL) John Kugler	Head, Office of the Chief Medical Officer, TRICARE Management Activity
Lt Col Hans Ritschard	Director, DoD Psychological Health Strategic Operations, Force Health Protection and Readiness
COL Louis Smith	Physician's Assistant, Army
Dr. Brian Sugden	Project Manager, Reserve Health Readiness Program Force Health Protection and Readiness
COL Heidi Terrio*	Chief, Deployment Health, Western Regional Medical Command, Joint Base Lewis-McChord

** Denotes member added during Year 2*

Appendix O: Presentation for Military Operational Medicine PTSD In Progress Review


Improving Deployment-Related Primary Care Provider Assessments of PTSD and Other Mental Health Conditions
Susan Douglas Kelley, PhD
Vanderbilt University
1


Co-PI Acknowledgements
Dr. Len Bickman, Vanderbilt University
Dr. Sarah Mustillo, Purdue University
LCDR Nicole Frazer and Dr. Mark Paris, Force Health Protection and Readiness (FHP&R)
Award Details
Award Number: W81XWH-09-2-0172
Award Date:23 Sep 2009
Award Amount: $1,371,933.00
Contract Officer Representative: MAJ Bonilla–Vasquez
Project Officer: Ms. Carolyn Hilliard
Portfolio Manager: Dr. Ronald Hoover
1

Overview

- Focus on Post-deployment Health Re-assessment (PDHRA)
- Rationale for current study based on previous evaluation of DoD health risk appraisal process conducted by Vanderbilt University (VU)
- Current study consistent with original aims with modifications to timeline and design due to intervening events
  - Secondary analysis of existing data to improve assessment of SM behavioral health problems
  - Develop and evaluate the feasibility and effectiveness of a pilot intervention targeted to enhancing PDHRA provider communication skills related to SM behavioral health issues
- Proposed intervention design modified to be interrupted time series with non-equivalent controls
- Challenges faced
  - 2010 NDAA legislation (Sec. 708) mandated substantial revisions to health risk appraisal process and new requirements for provider training
  - Substantial delays in receiving data for secondary analysis
- Efforts to address challenges
  - Close cooperation with government partners (FHP&R)
  - Simplified research design
  - Kept project to date under-budget to allow for staff support during no-cost extension year

3

- SMs are under-reporting behavioral health problems on the PDHRA self-report
  - 10-14% admit to under-reporting
  - Almost half of those who anonymously report behavioral health problems did not report any such problem on the PDHRA
- The provider interview does little to increase discovery of un-documented problems (i.e., sensitivity)
  - SMs with concerns that were not documented on the PDHRA received five times fewer major concerns and three times fewer medical referrals than those who did disclose
  - Behavioral health topics were more likely to be discussed when symptoms were endorsed but in only 2/3 of cases. In contrast, physical health was mentioned regardless of symptoms in the majority of PDHRA interviews.
  - Probability of a medical referral best predicted by SM self-reported problems (R^2=0.20); relatively small contribution (R^2=0.07) due to provider documented risk assessment and concerns

*Bickman L, Kelley SD, Leslie MW, Vides De Andrade AR, Hargraves RP, Lambert WE, Breda CS, Tempesti T, Demoret DL, Lapare CE, Tenore B (2009). Program Evaluation of Post-Deployment Health Assessment (PDHA) and Reassessment (PDHRA) Processes (2009). Available online at the Defense Technical Information Center (DTIC) (http://handle.dtic.mil/100.2/ADA528063).

4

Study Background/Rationale (cont)*

- Providers are not using best practice communication strategies to establish rapport and encourage disclosure (from audio-recorded PDHRA interviews) (Bickman et al., 2009)
  - Closed-ended questions occurred five times more than open-ended questions
  - Rapport building statements (empathy, legitimation) occurred in < 6% of interviews
  - Education related to mental health issues occurred in 14% of all recorded interviews and in only 24% of interviews where a medical referral was given and a behavioral health concern noted
- Provider interviews are not conducted systematically (Bickman et al., 2009)
  - For PDHRAs completed within one week of each other for the same deployment (i.e., duplicates) correlation of the self-report is twice as high as for the provider section (0.88 vs. 0.46)
  - Systematic and sufficiently intensive clinician training specific to the PDHRA is lacking. Clinicians who were interviewed about the PDHRA process indicated that training specific to the PDHRA was generally limited to shadowing of other clinicians, and that structured feedback was not routinely provided
- Training providers in patient-centered communication can increase patient psychosocial disclosure and increase compliance with treatment regimen (e.g., Rao et al., 2007; Wissow et al., 2008)

Rao, J. K., Anderson, L. A., Inui, T. S., & Frankel, R. M. (2007). Communication interventions make a difference in conversations between physicians and patients - A systematic review of the evidence. *Medical Care, 45*(4), 340-349.

Wissow, L. S., Gadomski, A., Roter, D., Larson, S., Brown, J., Zachary, C., et al. (2008). Improving child and parent mental health in primary care: a cluster-randomized trial of communication skills training.(Report). *Pediatrics, 121*(2), 266(210).

5

Study Background/Rationale (cont)

- Leverage existing efforts for the military
  - PDHRA well-established component of deployment-related health risk appraisal process
  - Cooperative effort with DoD leadership (FHP&R, Expert Panel)
  - Pilot development informed by DoD efforts to implement 2010 NDAA Sec. 708
- Value added
  - Datasets of PDRHA and health care encounter information across Services will allow for clustered analysis (HLM); combine DoD and VA data
    - Identification of contributory factors associated with PTSD diagnosis
    - Identification of provider- and MTF-level variables that contribute to variation in referral for behavioral health problems
  - Training the providers to communicate more effectively will create a continuum of more accurate assessment and more compliance with resulting referrals.
  - Early and accurate identification of problems will help to reduce morbidity and improve treatment outcomes, returning more SMs to duty and more veterans to fulfilling lives.

6

Research Question(s)/Hypotheses

- **Consistent with original aims; timeline and design have changed**
- Aim 1: Determine key elements of and current impact of training programs for deployment related assessments
  - Identify PDHRA variables associated with the development of and recovery from PTSD (Purdue)
  - Identify SM, provider, and installation-level variables associated with behavioral problems and referrals documented in PDHRA
- Aim 2: Evaluate the effectiveness of a targeted training and feedback program on primary care provider's interview and clinical communication patterns related to SM behavioral health condition identification and referrals.
  - Can a brief intervention to enhance communication skills be implemented in the field?
    - If any increase in length of PDHRA interview, is it within acceptable range?
    - Do providers find the intervention relevant and acceptable?
  - Will this intervention help providers use the interview as an opportunity to identify SMs in need of assistance for behavioral health problems?
    - Increased provider concerns and referrals for behavioral health issues documented on PDHRA
    - Higher ratings of SM self-reported disclosure; intent to comply with referral; ratings of provider patient-centered communication
    - Higher ratings of provider-reported elicitation of behavioral health concerns

7

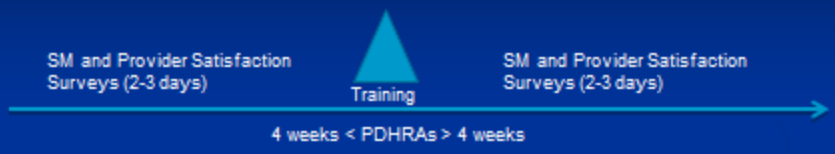
Design and Methodology (cont)

- Intervention
  - Brief workshop targeted to improving patient-centered communication skills
  - PDHRA context-specific
  - Evidence-supported quality characteristics
    - Skill demonstration
    - Supervised practice
    - Individualized feedback
- Sample target behaviors
  - Data gathering: Asking open-ended questions about behavioral health issues
  - Check SM understanding of PDHRA purpose/interview and address any concerns/questions about disclosure
  - General strategies
    - Attending
    - Re-framing and normalizing
    - Educating
    - Demonstrating empathy
    - Developing a trusting, positive partnership

8

Design and Methodology

Interrupted Time Series with non-equivalent control sites



- **Intervention sites (2-3)**
  - 10 providers needed to detect medium effect sizes
  - Sites selected based on # of providers, PDHRA flow through, and previous interest
- **Control sites**
  - Passive data collection only
  - Selected based on similarity to intervention sites
  - If possible collect one-time survey from providers on demographic/professional background characteristics

- **Research Timeline**
  - Intervention IRB protocol submitted February 2011
  - Approved April/May 2011
  - Army Tasker in April/May 2011
  - Intervention development Feb-May 2011
  - Intervention delivered June/July 2011
  - Data request to AFHSC/Services in August 2011 (PDHRA, provider & location ID, health care encounters)
  - Analyses and report-writing in no-cost extension year

9

Design and Methodology (cont)

Measures			
Data Source	**Intervention Site**	**Control Site**	**Duration/Frequency**
PDHRA	x	x	4 weeks before and after intervention (8 weeks total)
PDHA	x	x	Linked to PDHRA
Health care encounter data (HCE)	x	x	12 weeks before and 12 weeks after intervention (24 weeks total); linked to PDHRA
SM post-PDHRA satisfaction survey	x		2-3 days before and after intervention (4-6 days total)
Provider post-PDHRA satisfaction survey	x		2-3 days before and after intervention (4-6 days total)
Provider pre/post intervention evaluation	x		One time each before and after intervention (two times total)
Provider background/ self-efficacy survey	x	x	One time prior to intervention
NDAA training completion and final score	x	x	One time post-intervention
Program manager interview	x		One time prior to intervention
Duration of PDHRA interview	x		2-3 days before and after intervention (4-6 days total)

10

Study Deliverable & Dissemination/Transition Plan

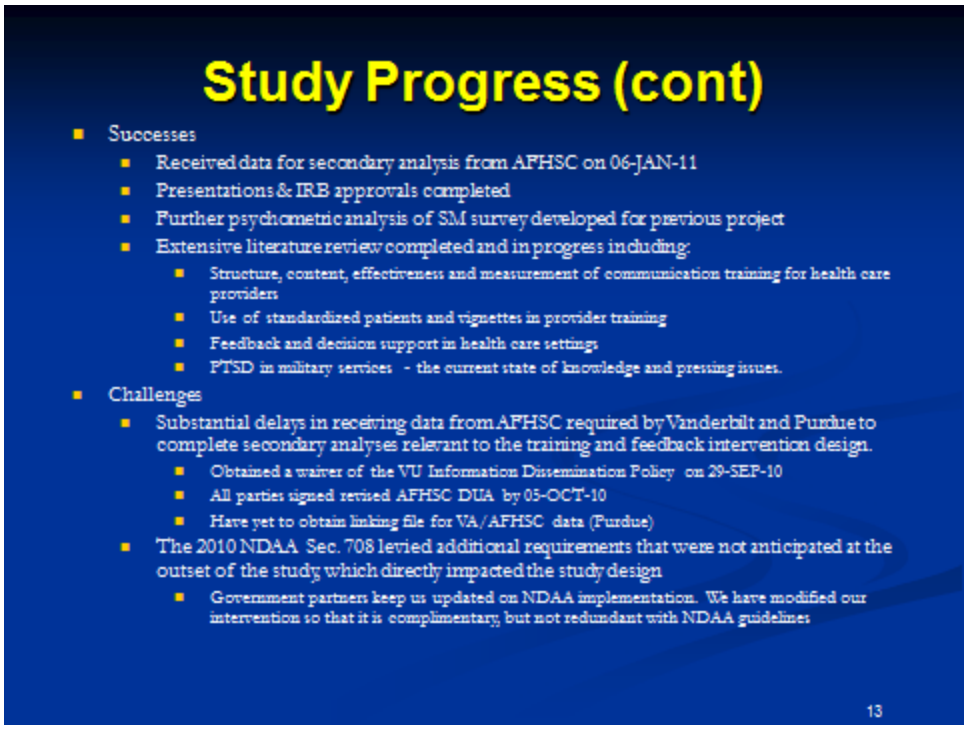
- Expected Outcomes
  - Acceptability and feasibility of a brief communications workshop for PDHRA providers
  - Effectiveness of training in helping providers use the interview as an opportunity to identify SMs in need of assistance for behavioral health problems
- Dissemination Plan
  - A series of articles will be developed and submitted to peer-reviewed journals. The articles will be submitted in the final report to USAMRAA
- Transition Plan
  - If efficacy and acceptability are established, the workshop could be adopted for training PDHRA providers across Services
  - It could be incorporated in the training being developed to comply with the NDAA legislation.

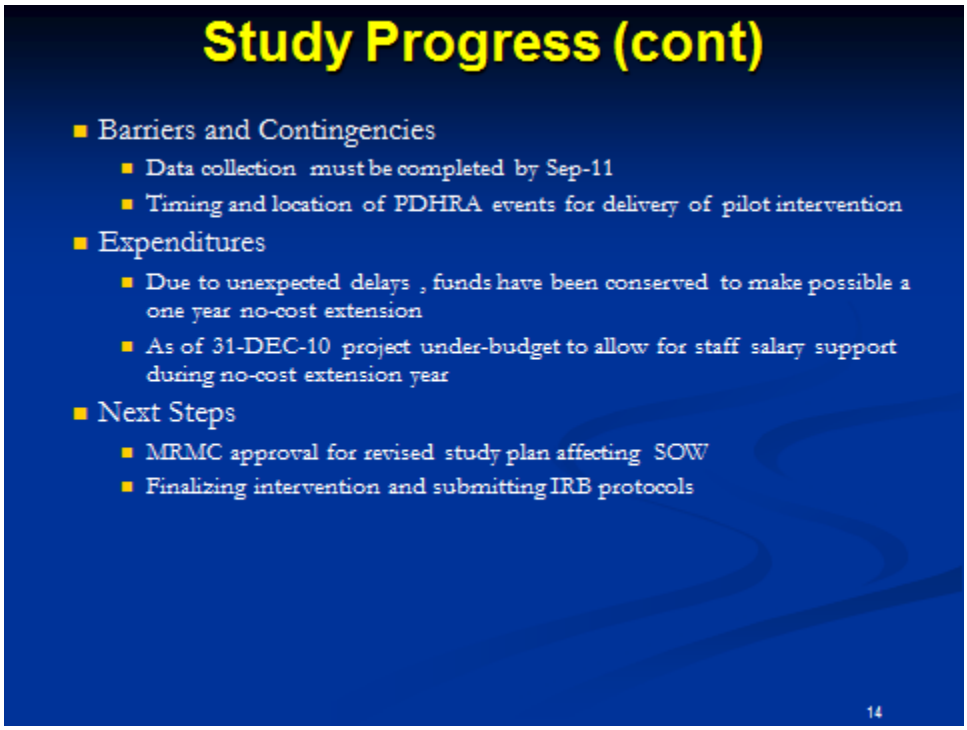
11

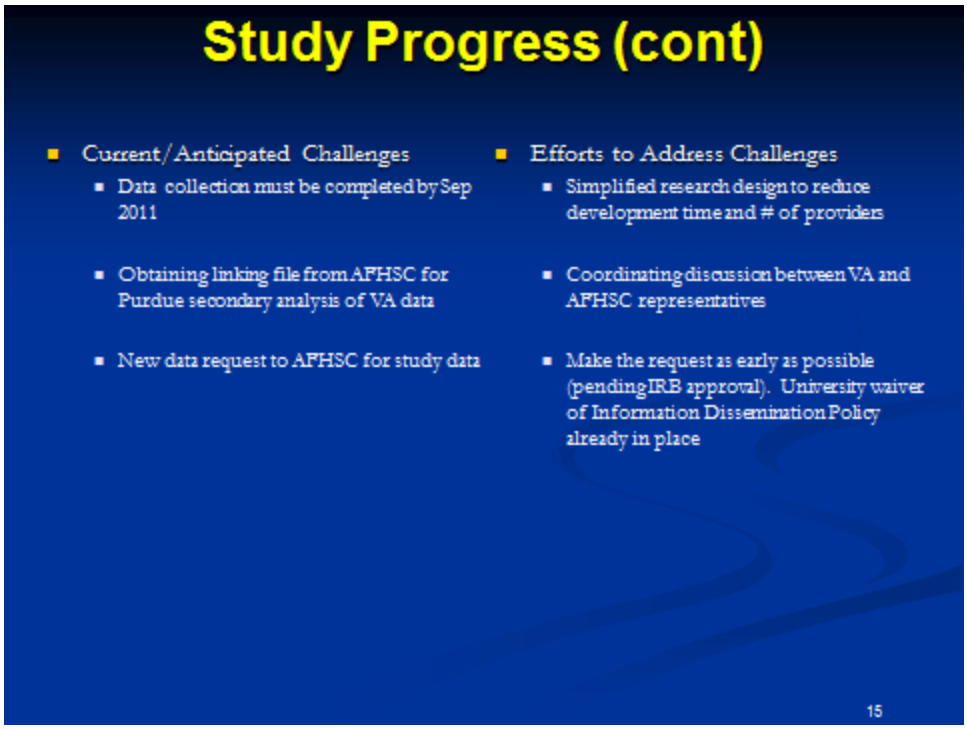
Study Progress

- Deliverables to date
  - IRB and MRMC approval for secondary analysis of PDHRA data (DEC-09, MAY-10)
  - IRB and MRMC approval for secondary analysis of VA data (NOV-10)
  - Presentation of findings from previous contract relevant to current grant (JAN-10 to FHP&R and Service representatives)
  - Invited presentation at the All Army PDRA conference, Falls Church, VA (FEB-10 Falls Church, VA).
  - Communication with Expert Panel
    - Formed by JUN-10 with additions in 09-10
    - 21-JUL-10 – Presentation of initial design (in-person)
    - 24-JAN-11 – Presentation of revised intervention and research design (electronic review)
  - Current research design in process of approval by FHP&R

12


Study Progress (cont)
Successes
Received data for secondary analysis from AFHSC on 06-JAN-11
Presentations & IRB approvals completed
Further psychometric analysis of SM survey developed for previous project
Extensive literature review completed and in progress including:
Structure, content, effectiveness and measurement of communication training for health care providers
Use of standardized patients and vignettes in provider training
Feedback and decision support in health care settings
PTSD in military services - the current state of knowledge and pressing issues.
Challenges
Substantial delays in receiving data from AFHSC required by Vanderbilt and Purdue to complete secondary analyses relevant to the training and feedback intervention design.
Obtained a waiver of the VU Information Dissemination Policy on 29-SEP-10
All parties signed revised AFHSC DUA by 05-OCT-10
Have yet to obtain linking file for VA/AFHSC data (Purdue)
The 2010 NDAA Sec. 708 levied additional requirements that were not anticipated at the outset of the study which directly impacted the study design
Government partners keep us updated on NDAA implementation. We have modified our intervention so that it is complimentary, but not redundant with NDAA guidelines
13


Study Progress (cont)
Barriers and Contingencies
Data collection must be completed by Sep-11
Timing and location of PDHRA events for delivery of pilot intervention
Expenditures
Due to unexpected delays , funds have been conserved to make possible a one year no-cost extension
As of 31-DEC-10 project under-budget to allow for staff salary support during no-cost extension year
Next Steps
MRMC approval for revised study plan affecting SOW
Finalizing intervention and submitting IRB protocols
14


Study Progress (cont)
Current/Anticipated Challenges
Data collection must be completed by Sep 2011
Obtaining linking file from AFHSC for Purdue secondary analysis of VA data
New data request to AFHSC for study data
Efforts to Address Challenges
Simplified research design to reduce development time and # of providers
Coordinating discussion between VA and AFHSC representatives
Make the request as early as possible (pending IRB approval). University waiver of Information Dissemination Policy already in place
15

Appendix P: Purdue Literature Review

LITERATURE REVIEW UPDATE – *From 2007 to Present*

- **Post Traumatic Stress Disorder**
  - PTSD was first classified and identified as an anxiety disorder in the DSM-III in 1980 (Creamer, Wade, Fletcher, and Forbes 2011).
  - Diagnostic criteria suggest that in order for one to suffer from PTSD, they have to actually experience a traumatic situation (Creamer, Wade, Fletcher, and Forbes 2011). However, there are contrasting theories that propose even the fear of being involved in a traumatic episode may qualify as grounds for PTSD to develop (Creamer, Wade, Fletcher, and Forbes 2011). In fact, Creamer, Wade, Fletcher, and Forbes (2011) report that the United States military now takes into account the likelihood of PTSD having an influence not only on those serving in direct combat, but on those present in those zones who may never engage in fighting yet fear the possibility.

- **Post Traumatic Stress Disorder and the Military**
  - Knowledge about PTSD, including the causes, symptoms, and acquisition of treatment may be low among veterans and their families (Buchanan, Kemppainen, Smith, MacKain, and Wilson 2011). For example, in a recent study only a small minority of members could accurately point out the causes of PTSD and describe a few of the possible symptoms (Buchanan, Kemppainen, Smith, MacKain, and Wilson 2011).
  - There are perhaps many identified and unidentified factors that prevent military veterans from seeking treatment for PTSD. In recent surveys, veterans report the most likely conditions for not seeking treatment to include ignoring symptoms, fear or perceived stigma of PTSD, and possible repercussions on one's military career (Buchanan, Kemppainen, Smith, MacKain, and Wilson 2011).
  - Recent research reports that sleeping problems or insomnia is the most frequently reported symptom of PTSD in service members (primarily Navy and Marines) returning from Afghanistan or Iraq (McLay, Klam, and Volkert 2010). The study's authors propose that service members may be more likely to report these symptoms as there is less cultural stigma for insomnia when compared with other PTSD symptoms, or that it is an easier symptom for service members to track (McLay, Klam, and Volkert 2010).
  - **Military Branch**
    - **Air Force**
      - Some studies explore the relationship between military unit cohesion and PTSD (Dickstein, McLean, Mintz, Conoscenti, Steenkamp, Benson, Isler, Peterson, and Litz 2010). In a recent study on Air Force unit cohesion and PTSD, as cohesion strengthens, PTSD symptoms decrease (Dickstein, McLean, Mintz, Conoscenti, Steenkamp, Benson, Isler, Peterson, and Litz 2010).
      - According to prior scholarship, unit cohesion can vary by gender, with men reporting stronger cohesion than women (Dickstein, McLean, Mintz, Conoscenti, Steenkamp, Benson, Isler, Peterson, and Litz 2010).
    - **Army**

    - **Marines**
        - Research has found a relationship between PTSD and Marines serving in OIF and OEF to be dismissed for various types of misconduct, in many cases this misconduct was drug-related (Highfill-McRoy, Larson, Booth-Kewley, and Garland 2010).
        - Both experiencing trauma (i.e. being wounded), observing trauma (i.e. seeing someone else shot or killed), or fearing potential trauma significantly increases the likelihood of experiencing post-deployment PTSD (Phillips, LeardMann, Gumbs, and Smith 2010).
        - Prior to joining the Marines, male veterans who suffered or witnessed violence in their childhoods were more likely to report post-deployment PTSD (Phillips, LeardMann, Gumbs, and Smith 2010).
        - Several factors relate to developing post-deployment PTSD in male veterans, such as the number of close social ties (i.e. friends and/or family) and level of military pay (Phillips, LeardMann, Gumbs, and Smith 2010).
    - **Navy**
- **Frequency of Deployments**
    - **Number of deployments**
    - **Total time deployed**
        - A recent study found that serving a deployment longer than 180 days more than doubled the risk of PTSD (Shen, Arkes, Kwan, Tan, and Williams 2010).
    - **Time between deployments**
    - **Exposure to combat**
        - Both direct and indirect exposure to combat can lead to the development of PTSD (Feczer and Bjorklund 2009; Dickstein, McLean, Mintz, Conoscenti, Steenkamp, Benson, Isler, Peterson, and Litz 2010). For instance, observing traumatic fights or cleaning up the devastating aftermath can have lasting implications in the same ways as personally engaging in fights.
    - **Total OIF deployments**
    - **Total OEF deployments**
- **Iraq or Afghanistan**
    - A recent study examining the mental health trends of United States active duty military personnel identified those deployed to Iraq and Afghanistan had a greater need of PTSD diagnoses and care than those serving in noncombat areas (Bray, Pemberton, Lane, Hourani, Mattiko, and Babeu 2010).
    - Personnel serving in OIF and OEF indicated they had much more family stress than personnel engaged in other zones or those not currently serving at all (Bray, Pemberton, Lane, Hourani, Mattiko, and Babeu 2010).
    - **Iraq**

        - A regional study of Connecticut veterans found women who served in Iraq had less chance of being diagnosed with PTSD than men (Haskell, Gordon, Mattocks, Duggal, Erdos, Justice, and Brandt 2010).\
        - Service members serving in Iraq or Afghanistan have a much higher likelihood of developing PTSD, and this risk is especially high for those serving in the Navy (Shen, Arkes, Kwan, Tan, and Williams 2010).
    - **Afghanistan**
- **Women**
    - Increasingly, women are exposed to direct action in combat and certainly, those serving in medical roles experience the stress of treating the victims of war (Feczer and Bjorklund 2009).
    - The ways in which males and females are inflicted, suffer, and respond to treatment for PTSD is not well understood (Feczer and Bjorklund 2009).
- **Marital Status**
    - **Single**
    - **Married/Partnered**
        - There may be direct and indirect benefits to a veteran being in a married or partnered relationship when returning from combat zones. Spouses or partners, in a recent study, reported paying careful attention to developments in their partner's attitude or behaviors, as both a conscious and unconscious monitoring for symptoms of PTSD (Buchanan, Kemppainen, Smith, MacKain, and Wilson 2011). Not all of the respondents could identify symptoms of PTSD, but were mindful of their partner suffering from sleeping disturbances, jumping after loud noises, acts of anger or aggression, or not eating (Buchanan, Kemppainen, Smith, MacKain, and Wilson 2011, p. 747).
        - In terms of veterans seeking treatment for PTSD, many partners wait for the veteran to initiate, but many partners have reported they would be willing to issue ultimatums, make suggestions, provide examples as proof of PTSD, and show support if their veteran resisted getting help (Buchanan, Kemppainen, Smith, MacKain, and Wilson 2011).
        - National Guard members, who returned from Iraq and Afghanistan, were more likely to report PTSD symptoms if they were also have marital problems (Khaylis, Polusny, Erbes, Gewirtz, and Rath 2011). Moreover, these service members were more likely to seek counseling than individuals not partnered (Khaylis, Polusny, Erbes, Gewirtz, and Rath 2011).
            - Additionally in this study, increased parenting concerns after deployment also led Guard members to seek out family counseling (Khaylis, Polusny, Erbes, Gewirtz, and Rath 2011).
    - **Divorced/Separated**
    - **Widowed**
- **Race/Ethnicity**
    - **Asian**

  - **Black**
  - **Latino**
  - **White**
  - **Other**
- **Pre-existing medical conditions**
  - Prior research suggests the severity of PTSD increases for military members who have previously received inpatient mental health treatment (Elhai, Kashdan, Snyder, North, Heaney, and Frueh 2007).
  - Those with other health concerns were more likely to receive health treatment (Elhai, Kashdan, Snyder, North, Heaney, and Frueh 2007).
  - There is a relationship between predeployment anxiety levels and amount of postdeployment PTSD symptoms (McNally, Hatch, Cedillos, Luethcke, Baker, Peterson, and Litz 2011). Longitudinal analysis suggests that the greater one's anxiety level prior to deployment the more common PTSD symptoms will be after deployment (McNally, Hatch, Cedillos, Luethcke, Baker, Peterson, and Litz 2011).
- **Alcohol use**
  - Recent analyses of alcohol use among active duty military personnel suggest the use of alcohol is significantly higher than use in previous decades (Bray, Pemberton, Lane, Hourani, Mattiko, and Babeu 2010). In fact, in 2008, of those surveyed, around 20 percent engaged in heavy drinking that consisted of having more than five drinks in a given week (Bray, Pemberton, Lane, Hourani, Mattiko, and Babeu 2010, p. 394).
  - Those who are deployed to any operational zone have a higher risk to engage in heavy drinking than military personnel who are not deployed (Bray, Pemberton, Lane, Hourani, Mattiko, and Babeu 2010).
  - Previous studies suggest those with PTSD may be more apt to manage their condition with alcohol or participate in heavy/binge drinking (Bray, Pemberton, Lane, Hourani, Mattiko, and Babeu 2010).
- **Traumatic brain injury**
  - Studies have noted the challenges many healthcare professionals face when distinguishing the existence or prevalence of PTSD in veterans who suffer from other conditions, such as a traumatic brain injury (TBI) (Bahraini, Brenner, Harwood, Homaifar, Ladley-O'Brien, Filley, Kelly, and Adler 2009).
  - Veterans with a secondary traumatic brain injury, such as a concussion, seem to have more difficulty handing PTSD (Romesser, Shen, Reblin, Kircher, Allen, Roberts, and Marchand 2011).
- **Depression**
  - In a study with veteran representation from eight different wars or conflicts, those who had higher levels of depression, increased guilt, had more frequent participation in combat and found less meaning in life ranked highest for PTSD symptoms (Owens, Steger, Whitesell, and Herrara 2009).

- **Study limitations**

- Many studies are closely focused on a small regional area (i.e. the state of Connecticut), and therefore unable to have generalizable results (Haskell, Gordon, Mattocks, Duggal, Erdos, Justice, and Brandt 2010).
- How might the risk of PTSD vary within and between men and women, when the levels of combat exposure vary (Haskell, Gordon, Mattocks, Duggal, Erdos, Justice, and Brandt 2010)?
- One study examines the prevalence of PTSD and misconduct suggests that Marines who are combat deployed may be more likely to receive encouragement to get treatment for PTSD versus those who are non-combat deployed, but did not have a way to distinguish this in their data (Highfill-McRoy, Larson, Booth-Kewley, and Garland 2010).
- In an article that reviewed 29 other studies on PTSD found that studies with the least precise measures of PTSD reported the highest estimates (Ramchand, Schell, Karney, Chan Osilla, Burns, and Barnes Caldarone 2010). Additionally, other studies have suggested similar findings that prevalence rates of PTSD can be dramatically impacted by the measure used or by sampling strategies (Richardson, Frueh, and Acierno 2010).

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