



## **Psychological Health External Advisory Subcommittee**

**Charles J. Fogelman, Ph.D.  
Chair**



## **Overview**

- **Subcommittee Membership**
- **May Subcommittee Meeting Summary**
- **Subgroup Teleconferences**
- **Future Meetings**
- **Current Questions Posed to Subcommittee**
- **Subcommittee Findings: Evidence-Based Metrics**



## Subcommittee Membership

### Pre-Clinical Subgroup

- Dr. Brett Litz
- Dr. Robert Anders
- Dr. Richardean Benjamin
- Dr. John Fairbank
- Dr. Shelley MacDermid Wadsworth
- Dr. James Campbell Quick
- Dr. Thomas Uhde

### Clinical Subgroup

- Dr. Kurt Kroenke
- Dr. Robert Certain
- Dr. Christopher Colenda
- RADM Peter Delany
- Dr. Thomas Detre
- Dr. Jesse Fann
- Dr. John Krystal
- Dr. David Kupfer
- Dr. Patricia Resick



## May 4-5, 2010 Meeting Agenda & Briefers

- **Assessment of Functional Impairment among Active Duty Service Members and Veterans**—Dr. Brian Marx
- **Department of Defense Mental Health Assessment**—CDR Meena Vythilingam
- **Subgroup Breakout Sessions**
- **Tour at Walter Reed Army Medical Center**
  - **Military Advanced Training Center**—COL (ret) Charles Scoville
  - **Army Center for Enhanced Performance**—Mr. Peter Lee and Ms. Holly Sisk



## Subgroup Teleconferences

- **Pre-Clinical Subgroup**
  - February 3, 2010
- **Clinical Subgroup**
  - January 26, 2010
  - February 8, 2010
  - March 22, 2010
  - April 23, 2010



## Future Meetings

- **Scheduled as follows:**
  - September 13-14, 2010—location to be determined
  - December 2-3—tentatively scheduled in the National Capital Region
- **Future meetings will follow agenda template**



## Previous Question Tasked to the Psychological Health Subcommittee

- **Request by Ms. Embrey, the DASD for Force Health Protection and Readiness Programs to review the Automated Neurocognitive Assessment Matrices (ANAM), which is a Pre-Deployment Neurocognitive Assessment Testing tool**
  - Provide recommendations on use
  - Determine added value of sections on language, memory, attention, executive function, and cognition
  - Examine inclusion of symptoms and patient history, mood, and sleepiness scales, as well as, measures of response inhibition and effort



## New Questions Posed to the Psychological Health Subcommittee

- **What evidence-based metrics should the DoD use to measure the effectiveness of our preclinical programs supporting resilience, education, and counseling?**
- **What evidence-based metrics should the DoD use to measure the outcomes of our clinical mental health programs?**



## Recommendations Pertaining to Pre-Clinical Program Effectiveness

57. In order to focus evaluation and program design efforts, the DoD must develop working operational definitions of: resilience in Service members and their families; pre-clinical; and programs supporting resilience, education, and counseling. Any measurement tool(s) which are employed or developed must be linked to these definitions.
58. Because there are so many programs, contexts, and Service branch-specific initiatives, planning for evaluations of programs and of specific metrics requires a full accounting and categorization of all existing programs. Any effort underway to do this should be expedited.
59. The major measures of the impact of resilience programs should be reduction in the incidence of pre-clinical distress and impairment and of mental health disorders among the military and family members.



## Recommendations Pertaining to Pre-Clinical Program Effectiveness (cont)

60. Any resilience program must demonstrate incremental validity. That is, measurement must be made of the impact of programs above and beyond the indigenous resources provided by military training, group and peer supports, family supports, and generic sources of wellness (for example, physical training). This requires equivalent measurement before and after the program's occurrence as well as, ideally, continuing across time.
61. Funding for resilience programs should be awarded contingent on the inclusion of an evaluation plan and a minimum of 10% of program resources should be allocated for evaluation.
62. Rigorous clinical trials are typically infeasible in the military and many programs that need to be evaluated have already been rolled out; therefore, a program evaluation framework to determine the viability and impact of resilience training efforts is the most appropriate and applicable.
63. In addition to program evaluations, quasi-experimental or experimental designs should be used, including use of randomization, where possible.



## Recommendations Pertaining to Pre-Clinical Program Effectiveness (cont)

64. Most of the prevention efforts in the military to date have focused on universal and selective strategies. Indicated prevention programs should be fostered and evaluated as well.
65. In order to develop a methodology for program evaluation and a plan to conduct an assessment of effectiveness, programs should articulate: a conceptual framework; a definition of resilience; the guiding assumptions of and the rationale for the approach taken; what is being targeted and why; the program content and the delivery process (for example, credibility and usefulness to Service members and leaders); the knowledge of behavioral repertoires intended to be retained and used by Service members and family units; and program deliberation and uniformity.



## Recommendations Pertaining to Pre-Clinical Program Effectiveness (cont)

66. In terms of effectiveness, programs should demonstrate the following, that they:
  - a. Provide incremental validity, above indigenous training, leadership, other ongoing DoD programs, and peer (and family) support.
  - b. Prepare Service members and family members to manage the immediate aftermath of various stressors.
  - c. Improve wellness behaviors, such as self-care, driving habits, and so forth.
  - d. Motivate individuals to seek care if psychiatric illnesses develop.
  - e. Help the Service member to provide support to peers at times of trauma and loss.



## Recommendations Pertaining to Surveillance and Psychological Health Indicators

- 67. The Board recommends that the following measures be included or modified:**
- a. The compound self-report item currently used for assessing global psychological functioning should be modified to differentiate impairment in the three discrete domains: work, home activities, and social relations.
  - b. A structured assessment including several additional questions for individuals who endorse the screening questions on self-harm (suicidality) or harm to others should be added. The Subcommittee endorses the structured assessment for self-harm being considered by the ASD(HA). A single question about sexual assault should be added to the PDHA.
  - c. Additional screening questions regarding anxiety are not recommended.



## Recommendations Pertaining to Surveillance and Psychological Health Indicators (cont)

- 68. The inclusion of self-report questions about illicit or prescription drug misuse, including current use, is not recommended at this point. However, drug misuse should be considered as an area for future deliberation, as it may directly impact the preparedness, effectiveness and deployability of the Force.**
- 69. Assure that there are sufficient numbers of trained personnel to conduct the recently mandated pre- and post-deployment person-to-person mental health assessments, as well as adequate mental health clinical resources to handle referrals in a timely fashion, particularly in times of military surges.**



## Recommendations Pertaining to Surveillance and Psychological Health Indicators (cont)

- 70. A uniform, minimum set of measures and of screening frequency should be adopted across the different branches of the military.**
- 71. Develop a standard set of key psychological health indicators, in addition to, or adapted from, the ones derived from the ASD(HA) measures, which can be reported annually noting the state of behavioral health in the Armed Forces.**



## Recommendations Regarding Clinical Care

- 72. Incorporate routine measurement and documentation of depression (PHQ-9) and PTSD (PCL) into clinical practice to assess symptom severity and to monitor treatment outcomes.**
- 73. Incorporate routine measurement of global psychological functioning into clinical practice using both patient self-report and clinician-rated impairment. The question proposed for surveillance screening is also suitable for self-report in clinical settings, whereas the clinician rating should confirm actual impairment in the same three functional domains (work, home activities, and social relations).**
- 74. Measurement-based care should be the principal method for assessing treatment outcomes regarding mental disorders.**



## Recommendations Regarding Clinical Care (cont)

75. While evidence-based metrics for processes of mental health care were not the focus of this report, such processes should nonetheless be monitored, and measures developed, as secondary indicators of the quality of mental health care and the adequacy of clinical capacity/resources. Important processes that should also be evaluated include the following:
- a. Access to care (for example, days between referral and actual mental health appointment)
  - b. Clinical competence (training) in providing evidence-based treatments and in adherence to guideline-level care (fidelity) in their administration (for example, psychotherapy, medication management)
  - c. Patient adherence to treatment
  - d. Patient satisfaction
  - e. Effectiveness of programs that facilitate transition of care from Active Duty to VA or civilian mental health treatment providers and facilities (for example, for those from Reserve or Guard units)



## Recommendations Regarding Clinical Care (cont)

76. At a clinical and systems level, measures should be clearly tied to interventions to determine the effectiveness and performance of current programs.



**Questions?**

**Other Considerations?**

**Offers of Advice and Assistance?**



**Supplemental Slides**



## Documents Reviewed by the Subcommittee/Subgroup

- Draft DCoE In-Theater Psychological Health Protocol
- Resilience Training Programs in the DoD (provided by DCoE)
- Health Risk Assessment Questionnaire
- Functional Impairment Measures
- ABHC Mental Health Items
- Sleep Measures
- Deployment Risk and Resilience Inventory
- Inventory of Functional Impairment
- Pittsburgh Sleep Quality Index Addendum for PTSD
- ABHC Data Dictionary
- Medical Outcomes Study Sleep Measure
- DCoE PH/TBI Program Evaluation Guide



## Documents Reviewed by the Subcommittee/Subgroup

- Periodic Health Assessment
- Pre-Deployment Health Assessment
- Post-Deployment Health Assessment
- Post-Deployment Health Reassessment
- DoD Health Assessment Cycle
- DoD Instruction 6490.03
- Recommended Modifications to PDHA/PDHRA
- Global Assessment Tool
- Possible Metrics of Line of Action 2
- Force Health Protection and Readiness Line of Action 2 Projects Listing