Defense Health Agency

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Webinar Series

"Facilitating Help-Seeking Behavior for Psychological Health Concerns in Service Members"

May 26, 2016 1-2:30 p.m. (ET)

Operator: Thank you for standing by. At this time, all lines are in listen only mode. Today's call is being recorded. If you have any objections, you may disconnect at this time. I would now like to introduce your host for today's call, Dr. Vladimir Nacev. You may begin.

Dr. Nacev: Good afternoon and thank you for joining us today for the DCoE Psychological Health May Webinar. My name is Dr. Vladimir Nacev, and I'm a clinical psychologist and acting chief of the implementation division at the Deployment Health Clinical Center. I will be your moderator for today's webinar. Today's presentation and resource list are available for download from the files pod below.

Before we begin, let us review some webinar details. Live closed captioning is available through Federal Relay Conference. Captioning please see the pod beneath the presentation slides. Should you experience technical difficulties, please visit DCoE.mil/webinars and click on the troubleshooting link under the monthly webinars heading. There may be an audio delay as we advance the slides in this presentation. Please be patient as the connection catches up with the speaker's comments.

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I will now move on today's webinar, which is facilitating help seeking behavior for psychological health concerns in service members. Service members are often susceptible to increased rates of diagnosable

psychological health concerns. This is particularly true in service members who have experience multiple deployments and/or have served in combat roles.

Data suggests that relatively few service members with psychological health concerns seek help, which may increase the risk of ongoing symptoms, diminished readiness, and career implications. These barriers to care are present across all service branches, including the National Guard and Reserve components, who face additional challenges and potentially reduced access to psychological healthcare or resources.

Today's review presents research findings about the areas to care for service members, along with specific efforts to reduce stigma and facilitate help seeking behavior. Additionally, the presentation will discuss strategies that healthcare providers and line leaders can implement to reduce stigma and facilitate help seeking behavior.

At the conclusion of this webinar, participants will be able to identify the major barriers in seeking help for psychological health concerns for service members. Recognize systematic efforts to increase access to care. Reduce stigma and encourage help seeking behavior. Last, apply strategies to dispel stigma and facilitate help seeking for psychological health concerns in service members.

I would now like to introduce our presenter, Dr. Bradford Applegate. Dr. Applegate is a clinical health psychologist supporting [inaudible] contract. He provides subject matter expertise and [constant] oversight to the Real Warriors Campaign, which is a DoD funded public health campaign aimed at increasing psychological health literacy, help seeking behavior, and outreach to members of the military, veterans, their families, and healthcare providers.

Dr. Applegate is a licensed psychologist and earned his doctoral degree in clinical psychology from Louisiana State University in 2000. He also completed a postdoctoral fellowship in primary care health psychology at the department of family medicine at the University of Mississippi Medical Center. Dr. Applegate has worked in a wide range of settings, including academic medicine, private research, and clinical practice, and corporate contracting environments. Prior to joining the Real Warrior Campaign, he served as subject matter expert in psychological health for the Navy Bureau of Medicine and Surgery, Wounded Warrior [three], and injured program management office. I'm sorry that was Wounded Ill and Injured program management office. Welcome, Dr. Applegate.

Dr. Applegate: Dr. Nacev, thank you for the invitation, it's a pleasure to speak today. Before we begin, I'd like to first let the audience know that I have no financial relationships to disclose. My employer, [inaudible] and Hamilton, provided support for this activity, and the views expressed in this presentation are those of mine, are my views, and do not necessarily

reflect the official policy or position of the Department of Defense, or the U.S. Government.

As I stated a moment ago, it's a pleasure to speak to you today on the important topic of facilitating help seeking for those with psychological health concerns. I'd like to start today's talk by acknowledging first those in uniform who are protecting us from harm. I'd like to also give a thank you to those who support our service members by providing important healthcare services, including those who are in uniform, civilians, and contract positions. You play a critical role in keeping our nation's war fighters ready, and support them once they return from harm's way. Thank you for what you do.

Today's discussion is going to center around facilitating help seeking for service members with psychological health concerns. Today's audience is very diverse, ranging from those in the mental health field, to general healthcare practitioners, and some in research positions. Because of this, my talk will tend to touch on several areas without diving deeply into any. I also hope to provide actionable information to help providers to get help for service members who may need access to treatment.

I'm going to start today's discussion with a very brief overview of the problem of psychological health problems in military and non-military populations. I'll then spend some time discussing the role of stigma and how it relates to seeking care with those with psychological health concerns. I'll then discuss some systematic efforts designed to encourage help seeking, and facilitate access to care in those who may need it. I'll finish my talk with a presentation of some things that we as healthcare providers can do to get those in need of treatment access to care.

In looking for the mandatory comic relief slide that accompanies these types of presentations, I came across several potential candidates. I chose this one of a drowning man asking his dog for help only to find that his dog has sought the advice of a therapist as it his owner's command. It does a great job of highlighting how far off our service members are from getting to this point. If we ever get to this level of help seeking, we certainly won't need a presentation on the topic.

I feel its important to start any discussion about help seeking with at least a brief overview of the problem. As a psychologist and somebody in the helping profession, it still startles me to see just how high the prevalence of psychological health problems are. The field of psychiatric epidemiology has come a long way since my first exposure to it in graduate school in the mid-1990s. The field at that time was just organizing around a more reliable diagnostic criteria, as well as valid and reliable methods to ascertain symptoms and the disability associated with them. More than 20 years later, the improved ability to measure and classify disorders shows a startling picture in both military and non-military populations.

In any given year, approximately a quarter of the population experiences some type of diagnosable psychological disorder. Depression and anxiety are the main culprits. Military service, of course, comes with distinct risk factors of combat and exposure to both traumatic events and traumatic brain injury disproportionate to civilian populations. Within the military populations, we have generally seen that the risk of psychological distress and disorder increase with exposure to deployment and combat. Recent data, however, indicates that there are other factors, as well. Recent suicide data indicates that increasingly, those who have not deployed are at risk for suicide. Other data suggests that many have had psychological health problems before enrolling in the military. In non-military populations, a variety of environmental and social factors contribute to the development of psychological health problems. These problems may actually follow them into the military.

In spite of the high rates of diagnosable psychological conditions, studies indicate that relatively few with problems actually receive care. This is true for both military and non-military population. For example, a recent report published by Rand indicated that fewer of half of service members with PTSD actually receive treatment. Another study indicated that approximately one in five service members with a diagnosed psychological health condition were in treatment. Of course, the widely cited work by Hoge and others found that a sizable minority of their participants were unaware of the symptoms that they were experience, that less than half were actually interested in receiving treatment, and that very few were actually receiving mental health treatment.

Similarly, in non-military populations, data are pretty consistently showing that the majority of people with diagnosable psychological health conditions are seeking help. Taken together, we then see that the rates of psychological health disorder are high, but that few seek treatment. Given that psychological health problems are associated with significant disability, loss of productivity, and suffering, this is a significant problem. For the military, it's a huge problem given that deployments are risk factors in and of themselves for the development of psychological health problems. For now, we can safely say that we're pretty far off from the introductory comic strip coming to life.

That being said, data do indicate that things may be changing a bit. The Deployment Health Clinical Center recently published data on their website from a data poll of military data repository, which shows that the number of outpatient mental health visits increased by 263% from 2005 to 2015. Similar rises have been found for in patient bed stays, as well. The increase in mental health visits comes at a time when the military is decreasing in size. Even though we have a significant problem, I do think that with increases in access to care, and the systematic efforts that we'll describe later, that we're slowly but surely having an impact on seeking care.

Switching gears, we'll now start to examine why a service member with a psychological health concern may not seek help. We'll discuss each of the factors on this slide, noting that the bolded and at the top of the list is fear that seeking help will in some way harm the service member's career. The list is hardly exhaustive, but with only an hour to define, elaborate, and present methods to facilitate health seeking, I'm somewhat limited in what I can discuss in detail.

As just stated, the most consistently reported and significant factor in deciding not to seek help for psychological health concerns is fear of negative impact on one's career. The findings presented on this slide are representative of what service members think and feel about seeking care. We can see that service members fear that disclosing a psychological health problem can in fact impact things like their ability to deploy, their security clearance, possible discharge, or a scar that may follow them on their record, and even being disqualified from doing their current job. Even though the military has engaged in a lot of education to try to counteract these beliefs, they persist over time. In addition, it's the case that some psychological conditions or treatments can affect service member's ability to deploy. Even if disclosing a condition and receiving treatment for it may affect one's ability to deploy, disclosing can and does bring about more scrutiny prior to deployment.

The next important role associated with not seeking help concerns stigma. Stigma has long been associated with failing to seek help for psychological health conditions in both military and non-military populations. However, the concept of stigma itself is somewhat confusing and a bit controversial. First, we have multiple definitions encompassing what stigma is. In their recent literature review on this topic, Rand found 98 distinct different definitions of the term stigma. For purposes of this discussion, we'll use the general definition of stigma that was put forward in a recent Rand publication on the topic. It's a process by which a person perceives that one who seeks help for a psychological health condition is outside what is normal and acceptable. Rand has an excellent review on the topic of stigma, which is presented to you in the links section.

Within the vast literature on stigma for seeking help in the military, we will focus on three types of stigma that have been identified and briefly examine the roles that these stigma sub-types have on help seeking. Presented here, we have public stigma, anticipated and active stigma, and self-stigma. the first sub-type that we'll talk about is public stigma.

Public stigma refers to the attitudes and beliefs of the general public towards persons with psychological health problems. For example, the public may assume that people with psychiatric conditions are violent and dangerous. Research into public stigma in service members bears this out. Both [Vogt] and Kim found that service members report feelings of public stigma. [Batal] and others found that some of the stereotypes associated with a PTSD diagnosis include being dangerous, being violent, or being crazy. Interestingly enough, however, data are mixed

when it comes to public stigma being a barrier to access and care with equivocal results being shown in a meta analysis.

Anticipated and active stigma relates to a fear that those with a psychological health problem will be associated with the negative stereotypes should their problem become public. This is a classic perception that one cannot disclose a psychological health problem for fear of being seen as weak. It's been theorized as a driver for one to keep their disorder quiet and not seek help. Interestingly enough, similar to the data on public stigma, a recent meta analysis showed mixed results, with nine out of 20 studies showing no association between anticipated stigma and help seeking intentions, and four out of 20 studies showing that those who endorse anticipated stigma were still interested in receiving services anyway.

Self-stigma, on the other hand, refers to those private and negative thoughts about oneself about having a psychological health problem. For these people, it's unacceptable to receive help for psychological health problems. The data is more clear with regards to self-stigma and help seeking. Individuals with higher levels of self-stigma have a more negative view towards treatment and lower levels of treatment intention. Even those who do make it into treatment are more likely to drop out.

When we add it all up, stigma in all forms is potentially a barrier to seeking treatment. It is the service member who rejects the notion that he or she could have a psychological health problem, that it somehow makes him look weak to others, who is less likely to engage in treatment, and even drop out of treatment. This represents the crux of the problem. Anti-stigma programs may be able to cut through the negative perceptions that others may have for seeking help, but if they don't make it acceptable for an individual to have a problem or seek treatment for it, it's likely to continue as a significant reason that service members fail to seek help.

For clinicians, this represents both a pitfall and an opportunity. First, it's really important to recognize that the service member sitting on the exam table may be extremely reluctant to admit that he or she has a problem. This may be especially true for clinicians who have put together the dots. That is, identified a set of symptoms that may be more physical in nature, but could be very well likely signs of a psychological health condition. Your patient may be very unwilling to admit that he or she has a problem when confronted in this manner.

How you speak to him or her in these moments can help facilitate or help prevent them from taking the next step. It's at this time that noting the sheer numbers, upwards of one in four service members having an issue in a given year, the toll of deployment and combat and injuries, and the stress of military service, makes these things more likely to happen. Telling the service member that these problems are common and treatable conditions are all things that can help normalize the experience for the service member. After that, communicating that you, as a

healthcare provider, see positive results when your patients seek care early, and that you have seen other service members get back on their feet and back with their unit can help facilitate the patient to seek care. On the other hand, not assessing for problems, being dismissive of them, and not understanding the impact that they have on service members can reinforce the notion that seeking treatment would be unacceptable.

Beyond career fears and stigma, several other factors are associated with a lack of seeking treatment from service members. Here we'll quickly go through a few that you should be aware of. First, active duty service members seek help at less than half the rates in the National Guard. Along with this, those on active duty demonstrate higher perceptions of stigma than those in the National Guards. Second, the younger and more junior enlisted service members are more likely to report psychological health problems, but less likely to seek help for them. Officers, on the other hand, report more embarrassment over disclosing psychological health concerns.

Of course, unit and leadership factors play a role in both the perception of stigma and the likelihood of seeking help. Units that are closer and more accepting of their members, and show less public stigma, help those with problems to speak up and get care. Leadership that discourages the disclosure of psychological health problems report higher levels of stigma and lower help seeking behaviors. For the clinician, there's a teachable moment when line leaders are in your office. Taking the time to ask them how they handle those with psychological health problems and providing information, resources, and education related to psychological health problems can help them think about it differently. Asking them how they go about helping the little guy, what pressure they face leading men, can also help set the stage for such a discussion.

Even beyond these factors, we need to look at other reasons why people might not seek help. Data from civilian populations demonstrate that Blacks, males, and other ethnic groups such as Hispanic and Asian, seek help at a lower rate than do Caucasians and women. We can assume this holds true in military populations, as well. A significant problem concerns those who don't recognize, or deny the presence of symptoms. Many of us just don't think about ourselves in a way that we can recognize that we're struggling with some that's a psychological health issue. If we can't recognize it, why would we get help for a problem.

Research has also demonstrated that certain types of problems are more associated with seeking care than others. With severe PTSD and depression being associated with higher rates of utilization for psychological health services. Of course, prior psychological health treatment is also associated with seeking help. Service members who report positive experiences in treatment are more likely to engage in treatment in the future. This is an important point that should not be underestimated, given the recurring nature of certain psychological health problems.

If these factors weren't enough, there's a number of other more logistical issues that pose barriers to treatment. Including distance. The distance that one must drive to get to your visit. Taking time off of work to attend weekly or sometimes more intense, more often sessions. Parking, especially when considering military treatment facilities in urban areas, can add another 15-30 minutes to your already long scheduled appointments. Navigating the mental health system in and of itself can be difficult to do, and can turn people off of treatment or drive them away. This list, not even comprehensive, demonstrates that there is much in the way of barriers to attending psychological healthcare appointments.

Okay, so enough about barriers for now. Let's start to turn the page to talk about what the DoD has done, and what you as individuals providing care can do to help service members seek care when they need to. On this slide, I present three types of systematic efforts that the military is engaged in to improve psychological healthcare in service members. Integrative primary care involves a multi year commitment to change healthcare delivery to reduce costs and increase access to behavior healthcare. Embedded behavior health acknowledges the inherent risks involved in deployment and combat, and goes even further to provide access to necessary behavior healthcare while on deployment and in combat zones.

Last, in response to access to care issues, transition issues, and stigma issues, the DoD has funded a number of public health awareness and anti-stigma campaigns, including the Real Warriors campaign, After Deployment, and Make the Connection. Mostly due to time constraints, I'm only going to talk about the Real Warriors campaign in detail. The roll out of integrative primary care across the military health system is near and dear to my heart, and I haven't even been a part of it. My training as a psychologist started out more than 20 years ago as a first year graduate student in a teaching hospital.

Our psychology clinic was housed in a Department of Family Medicine, and we as graduate students provided consultation to family medicine residents and faculty, oftentimes providing assessment and treatment on the fly in patient treatment rooms. My major professor was one of the few who consulted with the Air Force in their original pilot programs related to primary care. It's just amazing to see the growth in this movement since I started, back more than 20 years ago.

Integrative primary care is being rolled out across all three components that provide healthcare to service members. It started from the realization that a significant percentage of primary care visits were for conditions were behavior was either a main or the sole contributor to the patient visit. Additionally, those who present for care would present with more vegetative symptoms, not recognizing that feeling fatigued, tired, or out of whack related to a behavioral health issue, rather than a medical issue. [Thus] for a while, and currently still, the primary care system is actually the de factor behavior healthcare system.

Integrative primary care acknowledges this and accounts for it by placing a trained behavioral health consultant in the primary care home, where they provide consultation to providers and brief, problem focused treatments to those with problems with a behavior or psychological component. This means that the treatment can come to the patient rather than the patient feeling singled out and having to attend an appointment at the dreaded mental health clinic. It also changes the model of treatment from one that emphasizes the mental health diagnosis to a brief problem focused treatment that oftentimes does not involve mental health diagnoses. There's much potential for the system moving forward to facilitate care for service members without ever having to leave the primary care home. Furthermore, in the event that a service member does have a problem that warrants specialty mental health care, exposure to such a provider in the primary care home can help ease the transition to specialty mental health care.

On the ground consultation to educate service members, increase efficacy for change, and increase familiarity with psychological health problems, is a hallmark of embedded behavioral health. While integrative behavioral health has a done a fantastic job of meeting the service member in the healthcare setting, embedded health has taken a gigantic step farther, assessing and treating health concerns in deployed settings. This on the ground consultation service provides more access to behavior health without having to come to the clinic. The exposure to behavioral health in the deployed setting has the potential to increase psychological health literacy, intervene earlier, and perhaps preventatively, and reduce the stigma for seeking care, all because it is done in the theater.

Beyond these relatively new and innovative methods of practice, there needs to be other systematic efforts that help increase psychological health literacy, reduce stigma, and facilitate help seeking. This is where public health programs and the Real Warrior campaign comes in.

I'd like to begin this part of the talk by polling the audience. Before today, had you ever heard of the Real Warriors campaign? Please indicate yes or no on your screen. Okay, interesting. It looks like a little less than half of you have heard of the Real Warriors Campaign. Now that we have that, let's move on to what the Real Warriors campaign is.

The Real Warriors campaign was launched by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, or DCoE, in May of 2009. The campaign is one initiative in a comprehensive set of DoD programs to address stigma in the military. DCoE partners with the DoD, the Department of Veteran Affairs, and a National Network of Federal, Military, not for profit and local organizations.

Currently in year seven, the Real Warriors campaign is a groundbreaking initiative promoting the processes of building resilience, facilitating recovery, and supporting reintegration for returning service members and their families. The target demographic for the Real Warriors campaign is

service members between the ages of 18 and 28, including members of the National Guard, Reservists, and line leaders. Military families and caregivers, veterans, healthcare providers, and military program managers. Within the Armed Forces, 75% of service members are between the ages of 18 and 34. This is our core audience.

The initial goals of the campaign were to create awareness of the resources available for psychological healthcare and to create an understanding regarding the challenges service members may feel that prevent them from seeking care or support for psychological health concerns. At last, to create awareness of resilience in early intervention, and the roles it plays in successful recovery and reintegration for service members, which directly impacts the overall force readiness.

The campaign was in part started because the pace and number of deployments in support of Operation Iraqi Freedom, Operation New Dawn, and Operation Enduring Freedom for service members was unprecedented. More than two million service members have been deployed since September 2001, and an estimated 30% have had a psychological health condition or traumatic brain injury. The Real Warriors campaign was developed in response to the 2007 DoD Mental Health Task Force recommendation 5.1.1.1, which states that the Department of Defense should implement an anti-stigma, public education program using evidence based techniques to provide factual information about mental disorders.

The campaign was designed to reduce stigma that service members face about seeking care for psychological health concerns, as well as addressing those barriers to seeking care. Prior to launching the campaign, we facilitated a series of focus groups, and conducted key informant interviews with a variety of stakeholders to gain a greater understanding of the complexities and individual experiences behind the kind of information gathered from surveys, articles, and studies. Key stakeholders and audiences who provide feedback included military mental health professionals who provided care in a post-deployment setting, previously deployed service members who sought treatment for post traumatic stress disorder and other psychological health conditions. Previously deployed service members who demonstrated a reluctance towards seeking help for their psychological health issues. Line leaders who deployed in OEF and OIF. Reservists and Guard members who deployed in OEF and OIF. Spouses and other family members of service members who've returned from deployment and exhibit PTSD.

Key findings from our research include those that are on the screen here. Mainly that service members want proof. They want examples of service members who've received psychological healthcare and are maintaining their career. They want success, either in their own military career, or post service. Words like, "I'm back with my unit and I'm still in command" were aplenty in these focus groups. Service members also want to see themselves. They want to see a variety of services and ranks and age, as

well as representation of both active duty and National Guardsmen and Reservists. Those were the foundations of what brought the campaign to light.

Due to time constraints, I'm going to jump in and discuss how healthcare providers can use the campaign to support help seeking. Here are five takeaways for you to use the Real Warriors campaign to promote help seeking in your patient population. First, direct individuals to the campaign website for resources for 24 hour, seven day a week access, through the realwarriors.net website. Through its partnership with the DCoE outreach center a masters level resource consultant is available via telephone or live chat.

Two, display and distribute tangible help seeking resources. These resources can make a difference in connecting with patient populations. The campaign website has over 130 articles on a variety of topics that increase literacy and promote help seeking. Three, recommend to your patients to use the Real Warriors app to support care and connect with peers. Digital resources like this offer real time, easy access to psychological health resources that can be used in remote locations or even downstream, down range.

Four, reach remote audiences by engaging with the campaign's social media. Sharing content on digital platforms such as social media channels can reach individuals and encourage help seeking. Five, use videos of real stories or testimonials to dispel myths, show success, and promote help seeking. As demonstrated in our formative research, service members want to see proof, they want to see success, and they want to see themselves, so show them real warriors to help them understand that reaching out is a sign of strength. The next few slides are going to illustrate these resources.

The campaign's website, realwarriors.net, serves as the central hub for resources to the campaign audience. The website contains over 130 articles related to psychological health, with content aimed at each of our core audiences. Service members, families, military families, veterans, and healthcare providers. Some categories in each section capture common themes to assist audiences finding articles that fit their needs. A unique feature of the website is the availability of live chat with a trained health resource consultant 24 hours a day, seven days a week. The consultant can answer questions related to psychological health issues, and serve as an overall resource to one considering seeking care. In addition, the military crisis hotline is displayed, as well. This allows audience members in a crisis a place to reach out for help. These features are prominently displayed on each page of the website.

The campaign has created a number of materials designed to increase health literacy, reduce stigma, and promote help seeking in its audience members. These materials include patient education materials, materials to facilitate communication between patient and provider, and

infographics that support help seeking. For example, our "Know the Facts" booklet, shown here on the left hand side of the screen, includes a self-assessment related to psychological health, and provides information about the benefits of seeking treatment for psychological health concerns. Our "Five Questions to Ask Your Psychological Healthcare Provider" informational tri-fold, which is shown on the right hand side of your screen, provides information that helps prepare for attending a first visit with a psychological healthcare provider, and facilitating communication at that visit.

Our [Take the First] infographic, presented in the middle of the screen here, presents information about common stressors that service members face, encouraging help seeking, and provides resources for service members and family members to reach out for help, if interested. These products are geared towards healthcare providers, line leaders, chaplains, and other individuals interested in facilitating help seeking. These resources and many others are available to download or ship for free anywhere in the world from our website, which is realwarriors.net/materials. For your convenience, we've placed the URL for the materials page of the Real Warriors campaign on the resources pod on your screen. Feel free to, at your leisure, scroll for our library of brochures and educational materials and incorporate them into your clinic. For those in primary care clinics, I recommend three resources presented on this slide, but feel free to find the resource that best fits your needs.

The Real Warriors app is an online photo sharing service that encourages the military community to support its peers. Available for iPhone, iPad, and iPod touch users, users can upload photos to the wall, salute others, share photos via social networks like Facebook, Twitter, and Flickr, and access 24/7 resources, such as the DCoE Outreach Center, the military crisis line, and Real Warriors social media channels. Check out the wall and salute photos from any device through the app's complementary website, realstrength.realwarriors.net. Download it and use it for free from the App Store.

As a psychologist who provides care, my read is limited to the person in front of me. I do my best to provide a state-of-the-art, empirically-based assessment of my patients' problems and do my best to improve and manage symptoms with evidence-based treatment principles. This is the essence of good clinical practice. However, my reach is a psychologist is limited to those I can provide care to. Most of the time, one person at a time. This is where working with the Real Warriors campaign has been a real treat for me. We have the ability to reach hundreds and sometimes thousands of audience members through our social media channels. This map represents a graphic of the reach of our social media, truly across the globe.

Our social media channels offer a wealth of information on resources, and encourage our audiences to connect with each other and share our

resources. The frequency of content that we hope that we post helps to increase psychological health literacy amongst our target audiences. Content sent out through our social media channels are regularly shared with and engaged by other audiences. Our content can range from heartwarming and whimsical, as noted by this Facebook post showing a service member reuniting with his infant son. Other content, such as this Facebook post, contains the military crisis line and DCoE Outreach Center during identified high stress or high risk periods. Examples include holidays, weekends, and others.

This content is not only available to our stakeholders at time when it's most needed, but it's also consistently one of our most share posts on social media, furthering our reach to audiences that can use resources to increase help seeking. It's difficult to measure, but qualitative feedback, such as the one denoted in this Twitter post, reveal that our impact is certainly greater than which one clinician can have at any given time. In the past year, interactions on our social media channels have increased by over 125%, an online audiences have engaged with a campaign on on average 890 times each day. We've just surpassed the 100,000 Facebook fan mark. The take away here is that audience attitudes are supportive of campaign messages, including the concepts of resilience and seeking care, and can be promoted by healthcare providers to support their patients in between deployments.

The campaign uses video profiles [that] seeking help for psychological health concerns can be effective, as well as beneficial to the service member's career. This brief video profiles shows a service member showing from mild traumatic brain injury and post traumatic stress disorder, and how he struggled until he made the decision to seek help. Please note that there may be a delay in the video to respond for some of our audience members with less than stellar Internet connections. In this case, we've also provided the URL for this video in the resources pod on your screen. In addition, we placed a link to our YouTube channel here that contains all of our video profiles. Feel free to use them in your clinical settings, as a demonstration that Real Warriors can help seek and preserve the career. I'm going to give about a 15 second gap after the video ends, just to allow people downstream with less than great Internet connections to see it as well.

[They're backwards, oy]. Switching gears now, I like to move back to what we, as healthcare providers and line leaders can do to facilitate help seeking in the service members we work with. I'm going to provide what I think are some tangible recommendations that each of us can implement to help reduce the barriers associated with help seeking.

I'm going to begin this section by speaking about facilitating help seeking in integrative primary care settings. To some degree, the primary care manager is at an advantage in the integrative settings. You have a trained consultants there, on-site, able to consult with and provide treatment to patients in the primary care home. However, just because the consultant

is there doesn't necessarily mean that things move smoothly. This is a relatively new concept in healthcare delivery, and both the primary care providers and the integrated behavioral healthcare consultant were likely trained in different models than they're currently working in. It's almost a forced marriage of sorts, when integration first happens. Neither the clinic staff nor the behavioral healthcare consultant may know how to act around each other. Here are some things that can help improve this and benefit patients you work with.

First, it's critical to establish relationships between the behavioral healthcare consultant in the rest of the clinic staff. The clinic staff need to know exactly what the mission of the behavioral healthcare consultant is, what he or she is capable of intervening with, and what limitations there are. Vice versa, the behavioral healthcare consultant needs to understand the needs of the clinic, come up to speed quickly on the types of problems seen in the setting, and be able to intervene quickly and effectively with their patients.

Second, primary care clinicians should learn how to utilize brief, effective screening measures to identify sources and symptoms of psychological distress is in their patients. Having a behavioral healthcare consultant available to you in the clinic is fantastic, but if you aren't identifying those who need care, they can't get the help that they need.

Third, as primary care clinicians, it's important to understand the broader context of your service member's visit. The average service member sees a healthcare provider three times in a given year. Understanding important things like where they are in the deployment cycle, what their symptoms are, what's happening at home, and others, to understand what's happening at home and with others, to understand whether or not a service member is more or likely to disclose a concern. Generally speaking, the closer one is to a deployment, the less likely he or she is going to voice something that could potentially prevent that from happening. Because of this, you may have to look deeper for signs of distress. This includes examining common vegetative and physical symptoms of distress, including problems sleeping, low energy, feelings of stress are feeling run down. The presence of these symptoms warrants further screening, and perhaps a consultation with a behavioral healthcare consultant.

Next, and very important, is learning how to communicate with your patients about the behavioral healthcare consultant. Learn what the consultant does, how he or she obtains information, and what his or her preferences are with regards to that warm handoff. For example, in the clinics I've worked with in graduate school, internship, and fellowship, I was introduced as a behavioral medicine consultant, rather than as a psychology trainee, a mental health intern, or anything related to the mental health field. That helped me to build rapport with my patients without them being suspicious that they were seeing a shrink.

Solid, patient centered listening is at the core of the physician-patient relationship, and shouldn't be underestimated. Your patients will give you more if they perceive your listening to them, as opposed to typing notes into your electronic health record. You'd be surprised at how much you can get from your patients just by being a good listener and asking good questions. To that end, it's also important to accept and normalize symptoms.

Let's face it, some service members are exposed to unthinkable actions. Humans aren't supposed to see each other die in traumatic ways. The experience can be distressing to anyone who goes through it. It's a normal part of the deployment cycle for a service member to experience some level of distress and normalizing this as a healthcare provider can have an important effect. As much as we want to push them into care right that moment, sometimes the more powerful intervention is to acknowledge their symptoms, normalize them, and then to follow them closely for signs of distress or impairment on an ongoing basis. Doing this can help the person recognize that they're not the only ones going through their symptoms, and to help relieve the pressure of having them.

For those providers in more traditional primary care, or even tertiary care settings, there are also things that you can do to facilitate care. First, it's extremely important to establish relationships with the behavioral healthcare providers that your MTF or clinic setting. I know everyone is busy, but getting to know who they are, what they treat, how they're staffed, and how to refer patients to the clinic, can go a long way to help. The reason that this is important is that it can help you to communicate with your patients who may be extremely reticent to venture out of the primary care setting into the behavioral healthcare setting for treatment. A reassuring word from your provider that you've met them, that you know what they treat, how they treat, and that they are competent professionals, can help alleviate fears. Knowing exactly how the referral process works and what to expect can also go a long way to relieve anxiety about the behavioral healthcare setting or appointments.

Beyond that, similar to the integrated care environments, learning how to utilize effective screening materials to pick up on signs of distress or impairment are probably more important in your setting, as you have less access to care, and a higher burden to detect symptoms. Similar to that, using effective patient education materials can help raise psychological health literacy, reduce anxiety, and facilitate care. This is where the Real Warriors campaign materials can come in handy. Having access to psychological health brochures, or a trifold that helps patients ask the right questions to their providers, and access to the website articles on psychological health can have the effect of raising literacy in facilitating care.

Recommending our social media channels and mobile app can help support service members between appointments connect with others and facilitate help seeking. Importantly, providing examples of success, how

you've seen others with similar problems overcome them, helps to set a good model, and helps to build faith that the military health system can help them, as well. Really emphasizing that you've seen the problem, you seen it treated, and you've seen the service member back with their command can help facilitate that care.

For those of you in the behavioral health field, there are things that you can do to help facilitate help seeking, as well. First, be sure to reach out and establish relationship with your referral sources. Too often, we as behavioral healthcare providers serve on an island and insulate ourselves from the rest of the medical health system. We need to seek out our colleague to medicine and find out what types of problems their patients are encountering, and let them know what you personally and what others in your clinic setting are competent at treating. Putting a name to the face can go a long way to alleviating concerns about who to send their patients to.

Second, ensure that the referral an appointment setting process is as smooth as it can possibly be. Patients generally do not need any excuses to fail to show up or schedule appointments. Having simple referral processes in place that are well communicated to your referral sources can help this. Third, be sure you have appropriate crisis management plans in place, so that providers and patients know what to do when there's a crisis. Real Warriors campaign resources can benefit your patients, as well. Patient education materials, video profiles, and the use of social media channels can help support your efforts to ensure behavior change.

Last, but certainly not least, like it or not, our reputation as providers plays an important role in perception of our ability to help those a psychological health problems. It's incumbent upon us as providers to ensure our patients get high quality assessment and evidence-based practice. As a practitioner, we stopped taking new patients almost two years ago, and with little or no advertising presence, I find that my phone still rings more than, on a monthly basis from people interested in starting to work with me. When I asked, almost all the time it's because I was recommended by a former patient or family member that I'd helped. There's no substitute for a good outcome, and the members we treat successfully will tell others when the outcome is good. Which is the best way to facilitate help seeking by others.

To finish off this discussion, for those attending who may be working in the line settings, as stated earlier, leadership style and unit cohesion play important roles in the presence of stigma, and whether or not help seeking happens or not. It's critical to recognize that you, as line leaders, set the tone for your unit. Here are some practical things that you can do to ensure that those you lead are in good psychological health. First, attend to all your members, even those on the periphery. Some people are slower to warm than others. Some may need more coaching and coaxing to come out of the shell. Some may not ask, and that's okay.

If you see a change in behavior from one of your unit members, such as decreasing participation in unit activities, withdrawing from social activities, or anything like that, where there's a change from where they were to where they are, take some time and spend time with them, or him or her. Assess them for their struggles. Find out what's going on. If they're struggling, encourage them to get help. Second, educate yourself. There are a wealth of trainings available in the military to help your leadership style and to understand the role of psychological health issues in your units. Any time you can improve your skills in this area, you should.

Next, look out for stigma. Quash it when you see it. As a leader you set the tone for what is allowable and what is not allowable for your unit. Allowing expressions of stigma in your presence means that it will continue behind your back, and to a more extensive amount. Set the tone by not allowing such expressions in your presence. Your unit will follow. Last, consider using Real Warriors campaign materials, as well. There are materials that can help you understand what service members may be going through, and video profiles that demonstrate how service members who sought help preserve to their careers.

This concludes the webinar for today. It's been a pleasure to speak to you. I hope you found some value in the suggestions related to your line of work.

Dr. Nacev: Dr. Applegate, thank you very much for your presentation. It is now time to answer questions from the audience. If you have not done so. Please submit questions via the question pod located on the screen. We will respond to as many questions as time permits. To start us off, a couple questions that we have, and one is, "Is there any research or [inaudible] or known, that addresses the National Guard members having higher rate of help seeking behavior?"

Dr. Applegate: I'm sorry, could you read that to me one more time? I wasn't ...

Dr. Nacev: Sure. "Is there any research that addresses the National Guard members having a higher rate of help seeking behavior?"

Dr. Applegate: There is a bit of research suggesting that National Guard and Reserve members seeking care at a higher rate then service members, and I think I can dig up the actual reference, here. Just give me one second. That would be the [Chem] et al study, 2011, and it should be in the references section.

Dr. Nacev: Okay, can you just briefly summarize the response to that?

Dr. Applegate: National Guard members with psychological health problems, they use services more than twice the rate of [crosstalk] of the active component.

Dr. Nacev: Very well. How do we overcome the stigma when someone is denied joining the military based on certain needs for psychological health or mental health?

Dr. Applegate: That's a very tricky question.

Dr. Nacev: Specifically certain meds.

Dr. Applegate: Certain meds.

Dr. Nacev: For mental health or psychological.

Dr. Applegate: Yeah, so I profess that I am not an expert in this area. What I have heard is that in order for someone to be deployed, they have to be stable for a period of time. I think it's 90 days before they can be deployed. That is inherent in the risk model that the military has adopted. I can't comment as to why it's 90 days or 180 days or 30 days, but I think that the general gist of a hold like that would be to prevent somebody from having an adverse reaction. They need to be stable before they can go out into [inaudible].

Dr. Nacev: A part that I would add to that, which is very true, in terms of being stable, is just that when someone is on medications and they're deployed, and suddenly they run out of medications, then it becomes a risk factor. Being deployed in a remote area and not having access ... or the availability of medications. That's another added component. Next question, "How is the Real Warriors campaign integrated or present at pre- and post-deployment events?"

Dr. Applegate: That's a great question, and the Real Warriors campaign has a very robust outreach program that attempts to hit service members at different points in time, both pre- and post-deployment. Most notably, we hit most of the Yellow Ribbon Reintegration programs put on by the National Guard, as well as some USARC events, as well. It's an area where it gets us a lot of exposure to people who are either getting ready to deploy, or family members who are in deployment process or even post-deployment, as well.

Dr. Nacev: Another question from the audience is, "Please discuss some of the gaps that you identified in your research regarding reducing the stigma of behavioral healthcare. In other words, recommendations in policy or developing programs to overcome stigma."

Dr. Applegate: The gaps that I see ... is really time. We're trying to turn the Titanic in the ocean, and it does not turn on a dime. It takes time for anti-stigma campaigns and changes in healthcare delivery, and just the overall Zeitgeist of how people treat each other in the military to really take root. It's not probably going to be for another generation or so before psychological health treatment acceptance go significantly higher, in my view. I think that overall, we're doing a pretty decent job. I think if we can

continue to increase access to care, continue these evidence-based programs, and put the word out that there is help available, that early intervention can preserve one's career, can go a long way in terms of helping to reduce the stigma. Our biggest enemy here is probably time.

Dr. Nacev: [inaudible] "Are there cultural or age-related factors that play a role in help seeking behavior?"

Dr. Applegate: That's a good question, and I think the answer to that is, the military in some respects is going to be no different than civilian populations that show that males [are less] likely to seek care, and more likely to enact stigma, have feelings of stigma, than females are. That whites tend to seek care at a higher rate than some other racial and ethnic groups. I'm quite confident that that micro-cultural display happens in the military, as well as in nonmilitary populations.

Dr. Nacev: You may have addressed this in your presentation, I don't recall. One other question is, "What is the prevalence of mental health stigma in the military?"

Dr. Applegate: That's a good question, and I did not address it, and I probably can't give you an answer right off the top of my head. It's something that I would, however, recommend the RAND report, which is in our links section, has probably more information about stigma than you ever would want to know. It's very well done.

Dr. Nacev: Here's an interesting question for you. A listener asks, "When will Real Warriors have some of U.S. Coast Guard folks?"

Dr. Applegate: That's a great question. The answer is that they haven't ... we may have had some early interaction with the Coast Guard, but they haven't been a formal priority for us. I think it's probably time that we actually get some involvement in it. One of the things that I'll do after this conversation is I'll bring this to the people I work with, to see what they have to say about it.

Dr. Nacev: It is an entity we have not focused very much on, that's true.

Dr. Applegate: I completely agree. I have several friends in the Coast Guard, and I think they often get the short [inaudible] of the military service.

Dr. Nacev: It's worth saying that in many respects, the Coast Guard is much involved in ... gets in a harmful ways as the active duty military does.

Dr. Applegate: Absolutely.

Dr. Nacev: Another question is, "Looking for recommendations for further training in working with military personnel." It's from a provider, so what can a provider do in [crosstalk] for the training recommendations?

Dr. Applegate: The one that comes to mind, that I have at least a modicum of familiarity with is the Battle Mind program put forth by the Army. I think that probably the thing to do, actually, is to look for it. There are some trainings, and you kind of have to dig around for it, but if you go into the military education system there, there's a series of links and a series of courses ... keeping an eye out for it, I think, is probably the most important thing to do.

Dr. Nacev: A question, "Both the Army and the Marine Corps data suggested differences between branches of service and decrease in [inaudible]. How can we assume there is a significant problem that impacts seeking care in 2016, with all this data?"

Dr. Applegate: I think the best way to answer this question is to look at suicide data, which remains consistent. To look at overall prevalence of disorders, which remain high. I haven't seen very much in the way of updates on this data, and I would argue that the question is something that needs to be addressed. I'm not sure if it's being addressed right now. I'm not quite privy to the research that's going on, but I do know the Army [Stars], the research team, tries to answer a number of these questions. It's kind of partly up to them, they have a very robust research network, and hopefully they're addressing it.

Dr. Nacev: Another question from the audience is, "You mentioned that the benefit of using problem-based approach, and the de-stigmatizing interaction between the practitioner and client. Is there any research supporting this?"

Dr. Applegate: That's an excellent question. I think from a pragmatic standpoint, the answer is yes, but from a research standpoint, I don't know if I can go out on a limb and say, "Yes, there is X study that shows if you use a simple problem-based approach ..." I know that much of the research has been related to more civilian populations, where we have seen decreases in healthcare utilization and increases in functionality on the basis of these types of interventions. The roll out in the military is so relatively new, it's a big machine that they're trying to roll these providers out, and I think it's going to take quite a bit of time really to get the machinery completed before we can get the level of outcome studies.

Dr. Nacev: Another question, a little bit more generic, and that is a participant asking, "Can you speak more specifically to how communications between providers can improve the treatment they provide?"

Dr. Applegate: Yes, I'm going to go back to what I mentioned earlier with patient centered listening. There is a literature base out there that has examined how physicians and patients interact with each other. There is definitely a literature base that suggests that when physicians use patient centered listening approaches, that is having their attention focused on their patient, actually asking them a few important questions, and truly listening to what the patient says, reflecting back what they say, and addressing

the concerns that the patient brings forward, helps to bring the patient and provider closer together. One of the things that we definitely know is that the more a patient thinks that their healthcare provider actually has concerns about their health, and is there to help them, the more likely the patient is going to feel some degree of help from that provider. It is just downright good clinical practice at this point in time.

Dr. Nacev: Very good. Another question, "Is there any data available on the number of active duty service members who have undergone mental health treatment, and remained with their unit?"

Dr. Applegate: Not to my awareness. That's a good question. I think that's a very complicated question that is at least partly ... first off, it's very difficult to answer the question, because we have issues like, at what point does the service member try to intervene and get care? Are they waiting to the point where their behavior and their distress is at a point where it's going to require them to be separated from their unit for a period of time? Even worse, if their behavior, they do something, they engage in substance abuse, or get in fights with people, or behave in ways that are so grossly out of character that it gets them into trouble. Well, if we start intervening at that level, unfortunately the person may have engaged in a level of behavior that is beyond which they can easily come back to their unit. The question is extremely difficult because you do have to really answer at what point you're catching that person, with regards to assessment and treatment. One of the things that we try to do in the Real Warriors campaign is put it out there, seeking help early is better than waiting.

Dr. Nacev: Yeah, right. If you wait, you may end up with more problems, in which case, it'll make it ... the consequences are not necessarily related to [having it]. [crosstalk] issue, but more related to the behavior that got you into trouble.

Dr. Applegate: Correct, and it tends to be a positive feedback loop where that behavior that's gotten you into trouble leads to more distress, more suspicion over a possible separation from the military, and sometimes a difficulty in ... getting along with your healthcare providers or unit leaders or whatever the case is.

Dr. Nacev: Right yeah. Very good. Another question, "Oftentimes, transitioning military end up at colleges and universities. What guidance can you provide to encourage help seeking behaviors with our veteran students?"

Dr. Applegate: That's a great question. One of the things that the Real Warriors campaign actually tries to do is provide a series of resources and articles related to issues that are less psychological health in nature and more pragmatic in nature for the transitioning service member. We actually have some articles related to how to use your GI benefits, how to enroll in VA care, or if you're in the Reserves, how to make sure you're enrolled in a TRICARE insurance program. Similar to that, some of the other campaigns, such as the VA's Make the Connection program, and After

Deployment, also try to get the word about what resources are available to those who are transitioning into more of a veteran status.

Dr. Nacev: Continuing on with a similar theme, "Does the research suggest that some kinds of behavior health intervention are more or less acceptable to service members?" You know, in other words, is there preference or focus by service members leaning toward one type of treatment versus another?

Dr. Applegate: Correct. I have to profess that I don't know the answer to that question, or if it exists. It's a good question, but it's not something that I came prepared to answer today.

Dr. Nacev: Let's try one more last question. "Are the Real Warrior campaign and other resources integrated in command briefings in order to all in layman's terms an appropriate clinical knowledge?"

Dr. Applegate: I don't believe it's formal. I would like to see it be, and I think that is probably up to the unit command at this point in time. I know that we try to have as much exposure as we can, but I cannot say to you that it is a service wide implementation.

Dr. Nacev: There's no formal requirement or policy to implement it.

Dr. Applegate: No, and the only think I know is that at the Yellow Ribbon Reintegration Programs, that the folks who go through that have a requirement to hit each station along the way, and when we are at those reintegration programs, all of them come through our-

Dr. Nacev: Station.

Dr. Applegate: -station yeah right.

Dr. Nacev: Okay, very well. That concludes our Q&A portion of the webinar for today. After the webinar, please visit DCoE.cds.pesgce.com to complete the online CE evaluation and download or print your CE certificate, or certificate of attendance. The online CE evaluation will be open through Thursday, June 9, 2016. Thanks again to our presenter, Dr. Applegate. Today's presentation will be archived in the monthly webinar section of the DCoE website.

To help us improve future webinars, we encourage you to complete the feedback tool that will open in separate browser on your computer. To access the presentation and resource list for this webinar, visit the DCoE website at DCoE.mil/webinars. A downloadable audio podcast and edited transcript of the closed captioned text will be posted to that link. The chat function will remain open for an additional 10 minutes after the conclusion of the webinar, to permit attendees to continue to network with each other.

The next DCoE TBI webinar is Clinician's Guide to Cognitive Rehabilitation and Mild TBI Application to Military Service Members and Veterans. It's scheduled for June 9, 2016 from 1:00-2:30pm Eastern Time. The next DCoE Psychological Health Webinar will deal ... will address obesity, eating behaviors, and stigma amongst service members and dependents, and is scheduled for June 23, 2016, also from 1:00-2:30 Eastern Daylight Time. That's in the afternoon, 1:00-2:30pm.

The 2016 DCoE Summit, State of the Science: Advances in Diagnostics and Treatments of Psychological Health and Traumatic Brain Injury in Military Healthcare is scheduled for September 13 through 15, 2016. Summit registration and continuing education information will be available soon. Thank you again for attending, and have a great day.

Operator: This concludes today's call, you may disconnect at this time.