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# Implementation Of A Community Psychological Treatment Program For Military Families: Project Homefront

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***ABSTRACT***

***Demand for psychological services by the U.S. military population has outpaced supply in recent years. Despite record growth within the government health care systems in this area, roughly half of veterans have sought any healthcare within the Veterans Health Administration system. Civilian health care systems are often filling the void, particularly for military family members. This study used an implementation science approach to describe a civilian psychological treatment program for active duty service members (primarily Army) and their family members. Project Homefront provided free, unlimited and confidential mental health care in 2008-2012 – a time of rising suicide rates throughout the U.S. military. The program was grant funded. A considerable amount of work went into educating grant agencies and the public, while maintaining good working relationships with leadership on Fort Hood, in Central Texas. Fear of stigma was reduced with the use of community-based psychological care that maintained confidential patient records within a private electronic health record. Programmatic offerings evolved to accommodate the needs of those walking through the door: initially, mostly spouses, then later, when deployed units returned, mostly soldiers. A number of recommendations for how to coordinate fundraising, manage administrative infrastructure and reach out to the military community as a private health care entity are discussed.***

***Keywords: counseling; mental health; military personnel; program development; qualitative research; social stigma***

## INTRODUCTION

The psychological impact of more than a decade of war is pervasive throughout U.S. military families [1]. With more than two million U.S. military deployments since September 11, 2001, one of the biggest challenges is meeting the volume of need for mental health services [2]. Successful examples of government programs include the Bureau of the Navy's Families Overcoming Under Stress and Department of Veterans Affairs' use of cognitive processing therapy, family therapy and prolonged exposure therapy[2-7]. Despite the relative increase in available services in recent years, these evidence-based therapies are not widely available nationally, especially outside federal systems. Little is known about how civilian health care systems can augment military mental health services during times of frequent deployments.

There are a number of challenges for military families pursuing mental health services when it is available, which civilian health care systems are in perhaps a better position to mitigate. One formidable barrier is the fear of a negative impact on the service member's military career [8,9]. For those who seek care, there is a shortage of mental health providers on military installations, and civilian providers are often not attuned to their special needs[6,10]. Moreover, receipt of evidenced-based treatments are especially a challenge in the community as community programs have limited access to military-specific resources for training [11]. Finally, cost may be a barrier. TRICARE is the military's health insurance entity, but TRICARE does not cover group psychotherapy in the civilian community [12]. Therefore, effective group treatments available to active duty service members and veterans are often unavailable to their families.

While funding for mental health services has increased for service members and veterans, the family is often left without adequate services [13,14]. Government-funded Vet Centers offer individual and family counseling services; however, evidence for their utilization of evidence-based treatment is scant [15]. Little research exists on how civilian-funded health systems can augment the military mental health effort during times of a high operational tempo of repeated deployments.

To address some of these issues, Project Homefront was established to provide free, unlimited, confidential psychological services to military members and their families in Central Texas from 2008-2012. Project Homefront involved a major civilian health care system in close proximity to the largest U.S. military installation that


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provided mental health care to active-duty personnel and their families. The most unique feature of this treatment was that service members and their families could receive treatment without fearing a detrimental impact on their military career or family finances. The program later changed its name to Scott & White Military Family Services, but will be referred to as Project Homefront for the purposes of this paper. Project Homefront provided traditional individual, marital, and family counseling, neurofeedback, hypnosis, cognitive behavioral therapy, eye movement desensitization reprocessing (EMDR), intensive military family therapy and family resilience rejuvenation retreats.

The program was successful with respect to rapid growth, high levels of community acceptability and patient satisfaction. This civilian mental health program served as an adjunct to a large military base, Fort Hood, and its example may help other health care systems deliver psychological treatment services for returning combat veterans and their families. As the program grew, various donors allowed for retrospective research data to be obtained from the adults in this patient population. This study describes the analysis of qualitative data on the programs implementation, while the quantitative outcome data is ongoing and will be forthcoming.

Implementation science is a growing field that seeks to decrease the time it takes for effective treatments to materialize into routine practice. The type of research in encompasses varies according to setting and sponsor. This study describes the lessons learned during the implementation process of Project Homefront in order to speed up the development of similar programs elsewhere.

METHODS

This study was approved by the institutional review board at Scott & White (now Baylor Scott & White; IRB number 120502).

Guided by work in other qualitative studies, semi-structured interviews were developed by the study team within the Consolidated Framework for Implementation Research (CFIR) to elicit how Homefront developed, what factors were most important to its development, and why programmatic evolution occurred over the five years of its existence [16]. Education about implementation research was provided to the mentored investigator to ensure a systematic assessment of the data from the structured interviews. A list of survey questions was developed by the investigator with experience in veterans' health research and reviewed with a consultant familiar in VA qualitative data and then with the psychiatry resident physician mentee. The questions were crafted to assess formative data on the program's implementation and later programmatic changes. A set of questions was used to interview key informants instrumental in the creation, sustainability or delivery of Project Homefront. Key informants were contacted via email and telephone and invited to participate in the study. Informed consent and a standard explanation of the interview were also provided. A structured interview was conducted and audio-recorded, then transcribed (Table 1) [17-20].

**Table 1. Structured interview questions for Project Homefront developers, therapists and staff regarding the implementation of the program.**

Introduction: "Homefront was initiated in February 2008 and quickly exceeded its 2-year goal of 900 patient contacts in 7 months. Its initial vision was to provide free, unlimited, and anonymous mental health counseling to families of and service members deployed to Iraq and Afghanistan without hurting the career of the service member. Over the next 5 years, various programmatic approaches were explored. We would like your perspective of the programs offered and how they developed."

1. How did Homefront begin?
2. Who were Homefront's first clients in 2008?
3. When Homefront began to change, can you describe what changes were required and how the Homefront developers strategized the changes?

a. What were the major milestones and when did they occur?
b. Who was responsible for key changes?
c. What adaptations were made to administrative systems?
d. What was done to orient staff to the change?
e. What was done to spread the word to prospective clients?
f. Has the transition strategy evolved over time?

4. How was input solicited from clients to help shape Homefront programming?
5. How was input solicited from staff to help shape Homefront programming?
6. How was input solicited from military collaborators to help shape Homefront programming?
7. How did financial pressures contribute to Homefront programming changes?
8. When new programs were offered, what process determined whether it was a success or failure?
9. Looking back at the various programs Homefront offered, what programming do you think Homefront should have offered from the beginning?

Two team members listened to the recordings separately, read the transcripts and identified themes from the informants' narratives. A theme was defined as a topic


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mentioned by at least two informants or on two separate occasions by one person. If the informants mentioned a theme such as availability of grant funds, this was counted once. If this topic was mentioned again by the same person in response to a different question, it was counted a second time. Therefore, informants could endorse individual themes multiple times. Themes were counted to reflect the relative weight of importance of the material in the resulting implementation narrative. There were no pre-determined themes created by the investigators.

RESULTS

Six key informants were identified and invited to participate in this study. All but one were able to participate. Seventeen different topical themes were identified by the key informants. Themes were mentioned on an average of 8.3 times (Table 2).

**Table 2. Themes mentioned by interviewees at least twice or by at least two interviewees.**

| **Theme** | **Interviewee**[†] | | | | | **Total** |
|---|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** | |
| 1. Funding source | 4 | 10 | 2 | 2 | 2 | 17 |
| 2. Marketing/Outreach | 1 | 6 | 3 | 4 | 3 | 17 |
| 3. Treatment modalities | 6 | 2 | 3 | 5 | 1 | 11 |
| 4. Process feedback | 3 | 0 | 2 | 5 | 1 | 10 |
| 5. Children's needs | 3 | 1 | 2 | 2 | 2 | 9 |
| 6. Hiring/Staffing | 2 | 0 | 4 | 2 | 1 | 8 |
| 7. Confidentiality | 1 | 3 | 3 | 1 | 0 | 8 |
| 8. Leadership | 3 | 1 | 1 | 1 | 2 | 6 |
| 9. Complimenting post resources | 3 | 1 | 0 | 1 | 1 | 6 |
| 10. Training | 3 | 0 | 0 | 1 | 1 | 5 |
| 11. Initial idea | 1 | 1 | 1 | 1 | 1 | 5 |
| 12. Military mindset | 2 | 0 | 2 | 0 | 0 | 4 |
| 13. Flexibility | 0 | 0 | 0 | 0 | 4 | 4 |
| 14. Nov. 5, 2009 shooting | 1 | 0 | 1 | 1 | 0 | 3 |
| 15. Research | 0 | 2 | 0 | 0 | 1 | 3 |
| 16. Suicide prevention | 1 | 0 | 1 | 0 | 0 | 2 |
| 17. Compounded stress | 0 | 0 | 0 | 2 | 0 | 2 |
| | | | | | **Total:** | **123** |

[†] Interviewees included a lead family therapist and program manager, Vice President of Development, Baylor Scott & White Health and lead Homefront administrator, A retired General officer tasked with fund raising and coordination with Army commanders, and two Homefront therapists.

*Overview of Theme Analysis*

Thirteen (77%) of the 17 themes clearly fit within the Implementation Science Model Constructs outlined by Cook and colleagues [19], while 4 (24%) did not. The two most common themes were the impact of funding sources and the marketing / community outreach activities of the Homefront program. These two factors were intertwined.

The therapists initially hired to provide counseling services were also responsible for launching and maintaining the Homefront program. Thus, the staff of the Project Homefront was tasked with dual roles – delivering psychotherapy services and educating grant agencies, military leadership, and the public including prospective clients. The grant agencies' funds, when available, had stipulations that impacted the daily clinical routine. For example, reporting requirements changed over time and communication about these changes to the conservators was not always effective. At one point, the communication breakdown directly affected the funding stream. Communication improved as information about the treatment and unique needs of the military clients was provided to the grant agencies. The project was novel and considerable education was also offered through press releases and events in the military community to advertise Homefront's services and unique model of free, unlimited, confidential counseling. One-on-one meetings with military leaders were needed to assure ongoing access to the military base. This education cycle was continuous because of the turnover of military personnel and funding agencies. Skills such as public speaking, creating brochures and fostering community relationships were needed continually, a departure from the usual demands on the psychotherapists given their clinical background.


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The third most common theme involved the various treatment modalities that were utilized. Project Homefront began providing services at a time when most of the troops were deployed and with relatively little advance planning. Therefore, the program relied on the strengths of the psychotherapists who tailored treatments to the clients presenting at the Homefront clinic, mostly spouses and their children. Traditional cognitive processing therapy and prolonged exposure therapy were not provided initially. The spouses and children of deployed service-members were presented a menu of treatment option: intensive military family therapy, EMDR, family retreats, biofeedback, neurofeedback and psychoeducational classes. Clients chose treatment approaches by working with the therapists.

The additional themes are summarized below.

*Recognition and Definition of the Problem.*
The initial idea for this community-based mental health initiative came from psychiatrist and then-commander of the Carl R. Darnall Army Medical Center at Fort Hood, TX. The commander noted that the 4th Infantry Division and 1st Cavalry Division were on deployment and anticipated that the base would not be able to accommodate the troops' mental health needs when they returned. Simultaneously, pediatricians at Scott & White, with offices in Killeen, TX outside Fort Hood, were diagnosing an increasing number of anxiety and somatic complaints from children whose parents had deployed multiple times.

*Program Implementation Narrative.*
The program was initiated as a cooperative effort among the hospital commander at Fort Hood, Texas, a retired U.S. Army General officer advocate, the military family support center on base, executives at Scott & White, psychiatrists and residents from the Department of Psychiatry, and therapists with military family experience. Key elements of program acceptability included the use of grant funds to keep services confidential and free, the collaborative relationship between Army commanders and community leaders, civilian financial donors, and a clinic organizational structure that relied upon the passion of the therapists to deliver care to this patient population. Psychology interns were integrated in the process and provided a substantial amount of the psychological services.

*Organizing the Team.*
The unique combination of base leadership and mental health expertise contributed to the initiation of Homefront. The base commander (a psychiatrist and General officer) approached a retired General officer, a previous base commander who also had experience with reducing stigma by embedding mental health workers in primary care clinics, and leveraging contacts at Scott & White to help raise funds. At Scott & White, two psychotherapists offered to help by downsizing their existing practices; they began working part-time on the new project. The decision was made to keep the program under the Scott & White Department of Psychiatry and Behavioral Science, but to collocate it with Family Medicine in Killeen, TX. This later grew to 10 providers in two locations as funding increased.

*Developing the Intervention: Infrastructure and Programming.*
From the beginning, there was a commitment to make sure that the military service members would have free, anonymous, and unlimited mental health visits that would facilitate their success in their military service. The initial clientele were mainly spouses and children coping with the compounded stress of repeated deployments and the associated loss of family relationships. As troops returned from deployment, the predominant clientele shifted to active-duty personnel struggling with family problems and deployment-related adjustment issues. As service members began to seek Homefront services, their medical records were encrypted and thereby only visible to the psychotherapists taking direct care of them. The goal of treatment was to help the service member stay in the military and continue their war-fighting mission, not to serve as an adjunct to the retirement and pension process.

The Family Program Director from a large VA medical center was consulted to discuss use of evidence-based therapies and program development. Initial therapy modalities were the intersection of evidence-based care with the therapists' skill set. This included family systems therapy, cognitive behavioral therapy, cognitive processing therapy and EMDR.

*Adapting the Process.*
This civilian treatment program adjunct to military mental health services was very much a collaborative effort with the clientele and featured a fluid, proactive style to deciding which therapies to offer. Clients were invited to suggest additional treatment options, and many were implemented. At the same time, the director of Homefront maintained relationships with military commanders and on-base mental health services. Soon after the Homefront program was funded, the psychiatrist General officer was transferred and a cyclic, educational outreach process began for incoming commanders on post as described above. Each new, incoming commander received briefings on the program's benefits to ensure buy-in.

The community engagement effort included: targeted town hall meetings in the greater Temple and Killeen, TX region, a newly created annual conference, Survivor Outreach


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Services, the Fort Hood Resilience and Restoration Center, Traumatic Brain Injury clinic, Warrior Transition Brigade, high school retreats, outpatient behavioral health clinic, the Department of Defense (DoD)-funded STRONG Star project, a grassroots support organization TexVet, and the Tragedy Assistance Program for Survivors offered by the DoD.

Multimedia announcements included national and local television networks, The Catalyst Magazine from Scott & White, local newspapers, creation of a promotional video, and a website link from Darnall Army Medical Center at Fort Hood.

Early milestones as identified by the key participants included a rapidly expanding clientele base and substantial grant awards. The program exceeded its two-year, 900-patient contact goal in only seven months, providing a total of over 16,000 visits with outstanding patient satisfaction scores. It was awarded the largest of the Texas Resources for Iraq and Afghanistan Deployments (TRIAD) awards issued through the Dallas Foundation and San Antonio Area Foundation. In 2012, Project Homefront received one of the first Texas Veteran's Commission grants [21].

All key informants discussed an historical event that impacted Homefront. On November 5, 2009, Project Homefront was unexpectedly called to provide mass casualty support to survivors of the shooting at Fort Hood. Scott & White Memorial Hospital in Temple, Texas was the designated receiving trauma center, some 40 miles from the incident site. In spite of agreements to provide care only to military personnel and their families, Project Homefront extended its services to DoD civilians and their families on the spot, in the wake of the shooting [22]. This type of flexibility and mission-focused passion was characteristic of the providers and managers of the Homefront program throughout its 5-year life cycle.

Community engagement and patient assessment resulted in a number of programmatic changes. The primary theme of these changes was a civilian mental health system that was receptive to a dynamic military culture. For example, the patients seemed to have an elevated level of suspiciousness that the therapists may not be able to help. Key informants reported that clients were deciding whether the clinicians could be trusted starting with their first phone call to the receptionist and within the first few moments of the initial clinical interview. Therefore, the process for hiring new therapists included assessing whether the therapist had been in the military or grown up in/married into a military family as well as high levels of compassion for military personnel. Some applicants were turned away. Project Homefront also utilized Scott & White staff psychiatrists, psychiatry residents, and licensed counseling and clinical social work interns. In addition, the clinic relied on a single receptionist handling all of the initial and subsequent calls with warmth, compassion and charisma throughout the five years of Homefront's operation.

Some donors disallowed the use of their funds for research, but collection of clinical data to assess treatment goals and help direct programmatic changes became the norm. Pre- and post-intervention mental health assessments were administered for weekend family and single-day high school retreats. Eventually, the entire clinic utilized well-studied assessment tools upon initial evaluation and subsequently every 90 days. These assessments included the Beck Depression Inventory, Beck Anxiety Inventory, Pittsburgh Sleep Quality Index and its addendum, Patient Health Questionnaire 9, Generalized Anxiety Disorder 7, CAPS and the PCL-M for military Post-Traumatic Stress Disorder [23-28].

Programmatic changes also occurred as a result of weekly team meetings among the therapists based on direct client feedback, requests for new services by clients and the community, and what the therapists agreed was the most helpful. This process allowed for regular input from the front-line therapists, solution-oriented discussion and timely dissemination of information about program changes. Program acceptability was solicited using Press Ganey patient satisfaction scores benchmarked against other departments.

A substantial change in the program occurred with the growing demand for the treatment of combat stress as soldiers returned from deployment. Many of their families had already established care with Project Homefront, but a large number did not recognize problems such as domestic conflicts and issues of neglect in the home immediately post-deployment. Some patients were followed for years and many experienced redeployment – sometimes repeatedly. Project Homefront's client needs became heterogeneous, representing all of the five phases of deployment (pre-deployment, deployment, sustainment, re-deployment, and post-deployment) with their attendant emotional challenges [1].

A disturbing finding in the analysis of these interviews was the apparent tendency of military families toward exposing very young children to the details of combat and their incumbent life expectancies. One interviewee recalled a therapy session in which children ages three to five would act out combat action during play therapy in chilling detail. Young military families did not seem to provide age-appropriate information to their children.


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"Homefront U." was developed and a collection of classes included Family of Origin, Basic Balance, and Attachment Parenting. Intensive Military Family Therapy, retreats, individual and marital psychotherapy, EMDR, cognitive processing therapy and neurofeedback / biofeedback were also routinely provided. After the clients completed the initial assessment, these classes and therapy modalities were presented as a menu of options for an individualized treatment plan. The client was empowered to choose only those options that they felt were a good fit for them and those with which they would actually follow through. Subjectively, this adaptive approach helped decrease the "sick role" mentality, normalize the process of getting help, and provide hope [29]. Notably, there were no known suicides among the participants of Project Homefront at a time when the military suicide was rising [30]. In addition, the approach used, while developed independently through observation and attention to client needs, resembled the toolkit approach to practice change espoused in other studies[31].

Other programmatic changes included infrastructure growth. Initially, the program had two, part-time therapists without a dedicated phone line or basic office equipment. As demand grew and funding was available, staff increased. Often there were same-day referrals from their counterparts in the primary care clinics, so the therapists' schedules were structured with an urgent walk-in slot for emergencies every day.

Administratively, grant auditors required that manuals be written for the retreats and Intensive Military Family Therapy. Service members were required to prove their service in Operation Enduring Freedom or Operation Iraqi Freedom. The donors emphasized counting the number of new patients instead of patient contacts underestimated the amount of care delivered.

DISCUSSION

The stress that today's military family endures is one of unique proportion. Gone are the days when military families could expect no more than three hardship deployments during an entire career. At the time of this writing, the 1st Cavalry Division had announced the first deployment of its kind to South Korea. As the operational tempo of many military units begins to slow, however, the psychological impact on the family is in many ways only beginning. The ripple effect of these recent conflicts will affect these families for decades to come.

Leaders of Project Homefront found that a collaborative approach (working with clients, expert consultants, and DoD partners) in creating individualized treatment plans worked best. This adaptive leadership approach to healthcare delivery helps build trust and validates patient's pre-existing self-reliance by respecting their relative readiness to change [29,32,33]. Namely, there was no "one size fits all" approach to psychotherapy recommendations. Cognitive Behavioral Therapy was not prescribed to all comers. In addition, it was evident from clients' remarks that personal characteristics of therapists and staff were critically important to the success of the program. Homefront staff needed to understand the military lexicon to establish quick rapport, have a passion to help their clients, and have the energy to be flexible and untiring in forging and maintaining ties with continually changing military leadership. These characteristics make reproducing this type of program challenging.

There was a tacit understanding that among staff and clients alike that military service members possess an adaptive narcissism. After all, their country asks them to deploy to foreign lands and make life and death decisions on a daily basis. This experience fosters a natural suspiciousness and strengthens one's sense of agency – by design. Future mental health programs could educate families, allow patients to choose from a menu of treatment of options, and minimize stigma.

Lack of facilities and staffing are a significant barrier for civilian healthcare systems to be able to assist the military community during these times. Future programs based on this model should acknowledge the funder annually, at a minimum, to show appreciation for providing these precious commodities. For example, program metrics and plaques on the clinic walls could help express gratitude for making mental health services available to military families. The many stakeholders – funders, military partners, healthcare system partners, community and clients – must be kept engaged in order for the program to maintain sustainability [34].

This qualitative study supports the hypothesis that a civilian health care system can assist with mental health services during times of high demand by military personnel and their families. It requires a receptive organization, understanding funders, and a handful of talented, even heroic therapists. Using Project Homefront as an example, planning for post-deployment mental health care should start before or in the early phases of a unit's deployment, because it takes time to ramp up civilian healthcare systems that otherwise depend on a fee-for-service or other strict reimbursement model. Identifying and organizing resources across the domains of administration, services, outreach, and support is needed (see Table 3).

**Table 3. Steps in initiating a civilian psychological services program to augment military mental health services.**


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| Administration | Services |
|---|---|
| Hire program director with credentials for research | Integrate research prospectively |
| Keep team leader doing the clinical work | Identify and Use Staff Strengths |
| Salary compassionate, military-experienced clinicians and train them well | • Combat stress therapy<br>• Biofeedback / neurofeedback<br>• Eye Movement Rapid Dissociation<br>• Individual and family psychotherapy<br>• Cognitive Processing Therapy<br>• Cognitive Behavioral Therapy |
| Separate funding from clinical care | Use a patient-centered, adaptive approach to treatment planning |
| Lead from the front | Encourage service dogs and equine-assisted learning for interested clients |
| Have focused, face-to-face meetings with therapists | |
| Use multi-disciplinary treatment team | |
| Know and love the clinical population | |
| Hire and develop good people | **Outreach** |
| Refer patients seeking disability to appropriate resources | Start with influential project champions |
| Integrate volunteers and interns in treatment | Use a broad multi-media campaign |
| | Prepare cyclic re-education process for incoming commanders |
| **Support** | Approach the military from the "we're already seeing your service members in our clinics" mindset |
| Establish clerk and office equipment | Raise cause awareness with community-based marketing |
| Maintain program in a stable location | Don't fear a waiting list |

Successful implementation of a new process or program often requires cultural change for which creative engagement among champions of the change is essential, which in Homefront's case included DoD partners and Scott & White leadership [18].

Flexible deviation from the standard model of care was critical to the Homefront program. Traditional models of patient care using a fee-for-service model would have drastically handicapped this program. Letting the therapists schedule have flexibly to accommodate client needs was key to giving Homefront credibility and utility in the eyes of its clients. A significant amount of administrative ground-laying occurred to facilitate this approach to care provision, use of donor funds and clinical reporting/billing requirements. It was estimated by one collaborator that 75% of the formula for success for this program was maintaining the delicate balance between handling administrative funding and exercising the clinical freedom to offer whatever evidence-based therapies were needed at the time. Future programs will need to find a way to put compassionate, military-savvy clinicians on a salary, offer their program to the military community with command and leadership buy-in, and tell their clinicians to "make it happen" (Table 3).

As long as novel solutions are called for to address the complex problems of today's returning warriors, learning health care systems will be needed to develop and accommodate treatment delivery models that work.

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