

Division Mental Health in the New Brigade Combat Team Structure: Part II. Redeployment and Postdeployment

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Objective: Recent Army transformation has led to significant changes in roles and demands for division mental health staff members. This article focuses on redeployment and postdeployment. **Methods:** The postdeployment health assessment behavioral health screening and referral process and redeployment plan are reviewed, and data on postdeployment rates of negative events are reported. **Results:** All soldiers and many of their families participated in an aggressive education program. Of the 19,500 soldiers screened, 2,170 (11.1%) were referred for behavioral health consultation; of those referred, 219 (10.1%) were found to be at moderate or high risk for mental health issues (1.1% of total screened). Of the moderate/high-risk soldiers, 146 (71.9%) accepted follow-up mental health treatment upon return to home station. Fewer cases of driving under the influence, positive drug screens, suicidal gestures/attempts, crimes, and acts of domestic violence were seen, in comparison with rates seen after an earlier deployment of this unit to Iraq. **Conclusions:** A formalized approach with command support and coordination can have a positive impact on successful referral and treatment and reduce negative postdeployment events.

Introduction

Behavioral health issues have been documented throughout the history of warfare.¹ Since World War I, the U.S. Army has been deploying behavioral health assets to the front line for treatment of combat operational stress.² Since World War II, division mental health (DMH) has existed both in garrison and during deployment.^{3,4} By doctrine (Field Manual 8-51), the mission of DMH is to assist command in controlling combat operational stress through training, consultation, and restoration.⁵

In the midst of the war on terror, however, the Army is undergoing its largest restructuring since World War II, changing the emphasis from the division to the brigade combat team (BCT).⁶ This restructuring effort is designed to make the Army a more modular force and to increase efficiency and combat power; it will increase the number of BCTs from 33 to 43.⁶ This

increase brings a host of explicit and implicit tasks and challenges that the behavioral health system must address.

In conjunction with the reorganization, there has been an increase in the behavioral health assets assigned to each division. Before the restructuring of the force, each division was staffed with a DMH unit consisting of three providers (a psychiatrist, a psychologist, and a social worker) and three to five enlisted mental health specialists. The new structure includes a division psychiatrist and a senior noncommissioned officer located with the division surgeon at the division headquarters unit and a behavioral health officer (a psychologist or social worker) and an enlisted mental health specialist assigned to each BCT. Multiple BCTs are under the control of the division, such that six to eight mental health providers (psychiatrists, psychologists, and social workers) can be assigned to a DMH activity. This new modular design yields more providers and allows for projection of resources to commanders at lower levels (i.e., battalion and company). During its second deployment to Iraq, the 3rd Infantry Division (3ID) was the first division to make the transition to the BCT structure and then deploy in that format.

The purpose of this second in a series of articles is to outline the role, approaches, and utilization of the 3ID DMH in preparation for and during return to home station (redeployment) and upon return to home station from deployment to Operation Iraqi Freedom during the period from January 2005 through January 2006. Results of postdeployment mental health screening, rates of negative postdeployment behaviors, and lessons learned from the redeployment and postdeployment phases are discussed.

Methods

Task Force Baghdad

The 3ID deployed to Iraq as part of Task Force Baghdad in support of Operation Iraqi Freedom 3 during the period from January 2005 to January 2006. Task Force Baghdad was commanded by the 3ID commander and included the units outlined in Table I. Two of the 3ID brigades (1st BCT and 3rd BCT) were assigned to a different area of operation under the command of the 42nd Infantry Division. Task Force Baghdad consisted of 25,000 soldiers, on average, and reached a maximum of 50,000 soldiers during the deployment. 3ID DMH in Task Force Baghdad consisted of one psychiatrist, two social workers, two psychologists, and six mental health specialists from 3ID and two social workers and three mental health specialists from the 101st Airborne Division and 10th Mountain Division. In the middle of the deployment, some of these nonorganic elements redeployed and were replaced with elements from National Guard, reserve component, or XVIII Airborne Corps elements.

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TABLE I

MAJOR UNITS ASSIGNED TO TASK FORCE BAGHDAD IN OPERATION IRAQI FREEDOM 3

Unit	Home Station
2nd BCT, 3ID	Fort Stewart, Georgia
4th BCT, 3ID	Fort Stewart, Georgia
3rd BCT, 1st Armored Division ^a	Fort Riley, Kansas
48th BCT ^a	Georgia National Guard
256th BCT ^a	Louisiana National Guard
1st BCT, 10th Mountain Division	Fort Drum, New York
2nd BCT, 101st Airborne Division	Fort Campbell, Kentucky
1st Battalion, 11th Armored Calvary Regiment ^a	Fort Irwin, California
42nd Military Police Brigade ^a	Fort Lewis, Georgia
36th Engineer Brigade ^a	Fort Benning, Georgia
Division Support Brigade, 3ID	Fort Stewart, Georgia
Combat Aviation Brigade, 3ID ^a	Hunter Army Airfield, Georgia; Fort Bragg, North Carolina; Fort Campbell, Kentucky

^a Did not have behavioral health resources within the unit.

Communication with non-3ID mental health providers was maintained to ensure adequate understanding of deployment expectations, adequate supervision for nonlicensed providers, and appropriate distribution and use of mental health assets. Multiple other corps-level behavioral health assets supported Task Force Baghdad, including elements from an area support medical company, the 55th Combat Stress Detachment, the 883rd Combat Stress Detachment, and the 528th Combat Stress Detachment.

Redeployment Mental Health Initiatives

In preparation for return to home stations, DMH was responsible for planning the Task Force Baghdad behavioral health redeployment plan. This plan included a three-tiered approach of education, early identification, and coordination of care for all soldiers assigned to Task Force Baghdad who were returning to nine military installations throughout the United States and to two reserve component and National Guard demobilization stations.

Education was directed at soldiers and their family members and primary care providers before departure from Iraq. Soldiers received postdeployment stress and suicide prevention briefings. At home stations, local advertising campaigns notified family members of available mental health and other support resources for their area. Both soldiers and family members received educational handouts for soldiers on common redeployment stressors. Additionally, primary care providers received blocks of instruction on key topics, including the recognition and management of postdeployment stress, depression, anxiety, and substance abuse disorders.

A key component of the redeployment education program was the postdeployment stress pamphlet. This trifold pamphlet provided educational material, in a question-and-answer format, on what to expect, what resources were available both locally and nationally, and how to access them. Pamphlets were tailored to each local home station's information. DMH coordinated with Military One Source (a Department of Defense-sponsored program of services for service members and their families) regarding preparation and distribution of the pam-

phlet. Military One Source produced the pamphlet and then stationed counseling teams at each unit's homecoming site, to distribute the pamphlets to each soldier and family member. Family readiness group leaders were informed of the program, and many of those groups requested that Military One Source teams attend one of their meetings to present the information.

Early identification was accomplished through the postdeployment health assessment (PDHA) screening process. The PDHA process begins with the completion of an 18-question survey of soldier exposures during deployment and current physical and mental health symptoms at the time of screening. After completion of the screening questions, soldiers receive a face-to-face evaluation with a medical provider to address physical and mental health conditions. The PDHA screening form incorporates questions from the Patient Health Questionnaire-2 and Primary Care Post-Traumatic Stress Disorder (PTSD) Screen to evaluate subjects for potential depression and PTSD.⁷⁻⁹ There are two questions related to depression (depressed mood and anhedonia), for which soldiers indicate whether each symptom has been present "none of the time," "some of the time," or "a lot of the time" during the past 2 weeks. There are four questions related to PTSD (nightmares or intrusive thoughts, avoidance of thoughts or situations, vigilance or startle, and numbness or detachment), for which soldiers indicate whether each symptom has been present or absent during the past month. In addition, the PDHA includes three questions pertaining to interpersonal relationships and interest in receiving care. Individuals are asked about the presence or absence of thoughts that they are (1) "interested in receiving help for a stress, emotional, alcohol, or family problem," (2) having thoughts or concerns about "having serious conflicts with their spouse, family members, or a close friend," or (3) having thoughts or concerns that they "might hurt or lose control with someone." Lastly, individuals are asked a modified question from the 9-item Patient Health Questionnaire to evaluate potential suicidal ideations. The soldiers are asked whether, in the past 2 weeks, they have thought that they "would be better off dead or hurting yourself in some way" (indicating "none," "some," or "a lot").¹⁰

All Task Force Baghdad soldiers completed their PDHA before departing from theater. PDHA evaluations were conducted by physicians and physician assistants assigned to their units. Positive mental health screening criteria for providers were depressed mood or anhedonia at the level of "a lot," thoughts of death or self-harm some or a lot of the time, presence of any two symptoms of PTSD during the past month, or a yes response to any of the questions pertaining to interest in receiving care and interpersonal relationships.¹¹ During the face-to-face PDHA evaluation, all soldiers who required a behavioral health consultation were directed to the on-site behavioral health provider (psychiatrist, psychologist, or social worker). Furthermore, any soldier identified as needing additional immediate intervention was referred to the DMH clinic in Iraq. Of note, all PDHA behavioral health referrals were completed before redeployment to the United States.

During the course of the evaluation, all soldiers who screened positive for behavioral health evaluation were offered treatment in theater before redeployment and were assigned to a risk category, to assist in matching behavioral health resources to

TABLE II
RISK STRATIFICATION CATEGORIES OF BEHAVIORAL HEALTH CONSULTATIONS

Category	Definition	Action Taken
Green (low risk)	Having normal reactions to abnormal stressors	Provided education on mental health and support resources available both from the military and in the local community; battalion chaplains were notified so that they could continue to check on soldiers as they returned home.
Yellow (moderate risk)	Requiring further ongoing behavioral health treatment but not of concern for potential harm to self or others	Provided education on mental health and support resources available both from the military and in the local community; soldiers were identified to their local mental health support unit, which contacted them within 14 days after return to offer mental health and support services.
Red (high risk)	Presenting acute risk to self or others at the time of evaluation or, because of circumstances, was at high risk for harm to self or others upon return home	Immediate intervention was undertaken if required; soldiers were provided education on mental health and support resources available both from the military and in the local community; a command-directed evaluation packet was given to the soldier's commander and the soldier was evaluated for safety and offered services immediately upon return home, before being released by the military.

soldier needs in an optimal setting. Table II outlines the risk categories, definitions, and actions taken.

Postdeployment Decompression

Upon return to their respective home stations, all soldiers participated in a 10-day decompression process before entering their postdeployment leave period. The process began with their initial return to the home station. On the first day, the soldiers turned in their sensitive items, participated in a "welcome home" ceremony, and were thanked by the garrison commander for their service. High-risk soldiers (risk category red) received a command-directed safety evaluation during this time. All soldiers were then released for a 48-hour pass. Upon return from the pass, they spent the following 10 business days participating in half-day operations that included physical fitness training. Multiple postdeployment briefings during this period included suicide prevention, postdeployment stress, safety, and marital enrichment. During this period, a PDHA reassessment was conducted, in which soldiers had another face-to-face encounter with a medical provider and were asked whether they desired to change any of their responses from the PDHA they had completed in Iraq. Upon completion of the decompression, soldiers were released to a 1-month block of postdeployment leave.

During the next 3 months, unit commanders monitored adverse postdeployment events. Monitored events (reported by civilian and military law enforcement agencies and the Family Advocacy Program) included driving under the influence, positive drug test, behavioral health inpatient admission, suicidal acts, completed suicide, completed homicide, crimes against persons, property crimes, domestic violence against adults, and domestic violence against children. Similar adverse postdeployment event data were collected from the previous 3ID deployment in 2003. A χ^2 analysis was conducted to compare the rates of each event following the 2003 deployment and following the 2005 deployment.

Results

At the time of redeployment, Task Force Baghdad had ~19,500 soldiers returning home. During the PDHA process,

2,170 redeploying Task Force Baghdad soldiers (11.1%) were referred for a behavioral health evaluation. One hundred percent of these evaluations were completed in theater. The results of the PDHA risk stratification are outlined in Figure 1. Of these 2,170 referrals, 1,967 (89.9%) were for soldiers deemed to be experiencing expected stress symptoms from the deployment. However, 9.4% of referred soldiers (203 soldiers; 1.0% of the overall Task Force Baghdad population) were deemed to be at moderate risk for future problems and 0.7% (16 soldiers; 0.1% of the overall Task Force Baghdad population) were deemed to be at high risk for future problems.

Following the established redeployment plan, 100% of returning soldiers classified as being at moderate risk were contacted within the recommended 14 days after return, and 146 (71.9%) chose to participate in follow-up evaluations and/or treatment. All individuals deemed to be at high risk were evaluated by a behavioral health provider in the 2- to 3-hour "holding" period between the time their air transportation landed in the United States and the time their bus transportation took them to their home station. Because of the potential risk, the evaluations occurred through the emergency command referral process, as outlined in Department of Defense Directive 6490.1, but they were conducted as inconspicuously as possible (i.e., soldiers were removed from holding areas for a variety of reasons, in-

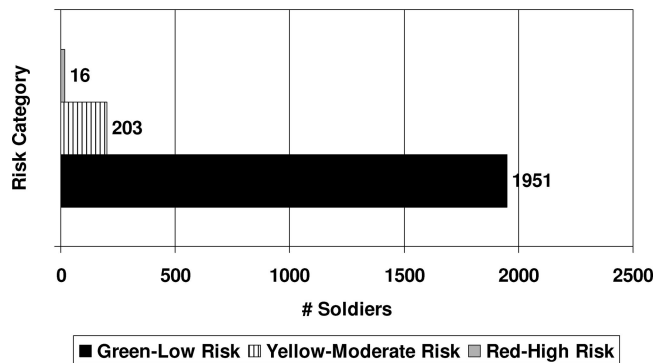


Fig. 1. PDHA behavioral health risk stratification. Table II presents the actions taken for each risk category.

TABLE III
POSTDEPLOYMENT NEGATIVE EVENTS WITHIN 90 DAYS AFTER REDEPLOYMENT FOR 3ID, IN 2003 (UNSTRUCTURED REDEPLOYMENT)
VERSUS 2005 (STRUCTURED REDEPLOYMENT)

	No. (%)		Change in Rates		
	OIF 1 (2003) (N = 17,600)	OIF 3 (2005) (N = 19,500)	Percentage Points	Percentage	χ^2 (df = 1)
Driving under the influence	116 (0.66)	92 (0.47)	-0.19	28.8	5.82 ^a
Positive urine drug screens	90 (0.51)	41 (0.21)	-0.30	58.8	23.83 ^b
Behavioral health admissions	63 (0.36)	54 (0.28)	-0.08	22.2	1.93
Suicidal ideations/attempts/gestures	37 (0.21)	19 (0.10)	-0.11	52.4	7.81 ^b
Completed suicides	0 (0)	0 (0)	0.00	NA	NA
Completed homicides	2 (0.01)	0 (0)	-0.01	100	NA
Crimes against persons	391 (2.22)	212 (1.09)	-1.13	50.9	74.45 ^b
Property crimes	198 (1.13)	35 (0.18)	-0.95	84.1	132.5 ^b
Domestic violence (confirmed cases), adult	48 (0.27)	26 (0.13)	-0.14	51.9	9.03 ^b
Domestic violence (confirmed cases), child	58 (0.33)	18 (0.09)	-0.24	72.7	25.47 ^b

The postdeployment period was defined as the first 90 days after return to home station. OIF, Operation Iraqi Freedom; NA, not applicable.

^a $p \leq 0.05$.

^b $p \leq 0.01$.

cluding turning in weapons), to reduce the likelihood of stigma. No soldiers in the red risk category required hospitalization or other immediate interventions upon returning to home station, and all received follow-up care through DMH.

All soldiers participated in the 10-day decompression process. Table III shows a comparison of rates of driving under the influence, positive urine drug screens, behavioral health admissions, suicidal ideations/attempts/gestures, completed suicides, completed homicides, and cases of crime and domestic violence during the first 3 months after the 3ID deployment in 2003 and during the first 3 months after the 3ID deployment to Iraq in 2005. There were statistically and clinically significant reductions in nearly all of the most commonly reported problem behaviors.

After the first Iraq deployment, all 3ID soldiers attended several mandated briefings, but implementation varied significantly between units and there was no structured period of decompression. Anecdotally, many soldiers from the second deployment reported that they thought the decompression phase was too long, they found the briefings to be "boring," and they "rarely paid attention." Most stated that, by day 6, they had little to do while waiting to be released to postdeployment leave.

The number of admissions to behavioral health wards within the first 90 days after deployment did not decrease. Further investigation revealed that >95% of those admitted to behavioral health units were not identified by the PDHA process. Either the soldiers had not reported their symptoms on the PDHA (18% of cases) or, more commonly, the problems did not exist until the soldiers returned home and faced home-front issues (82% of cases). Additionally, during the PDHA reassessment conducted during the 10-day decompression period, only 10 soldiers changed their responses to the behavioral health questions.

Discussion

Before and during the return home of soldiers (redeployment), DMH shifted the focus to soldier and family reintegration and care. The plan involved an approach of education, early identi-

fication, and treatment, with a focus on decompression. Significant coordination with each BCT home station or demobilization site (total of 11 sites) was required to ensure a smooth transition.

It was our experience during the redeployment that many organizations, both military and civilian, want to provide assistance and services to the soldiers. By developing an information pipeline through the development and distribution of an informational trifold pamphlet, we ensured that everyone was provided with education concerning available resources and clear guidance on when and how to access those resources. Use of Military One Source resources minimized unit costs and ensured that the same briefing/information distribution services were provided at each unit's home station. This approach also ensured that no additional demands were placed on returning mental health providers, who also needed to decompress and to recover from their deployment.

The early identification of behavioral health issues came directly from the health assessment program (PDHA). The risk stratification of soldiers meeting screening criteria for a potential behavioral health problem allowed for optimal matching of behavioral health needs with behavioral health assets in Iraq or in the United States. Providing the home station with the names of soldiers at moderate or high risk of postdeployment problems minimized the potential for soldiers experiencing difficulties to "fall through the cracks" and not seek needed care. The use of simple outreach methods for those in need, such as local mental health services calling and offering appointments to those with moderate risk of problems, led to a large number of soldiers seeking assistance shortly after returning home. This approach likely helped to reduce suicidal/homicidal ideations, completed suicides, and other negative postdeployment events.

The 11.1% rate for PDHA positive screening is lower than the 17.1% prevalence rate of soldiers with probable mental health problems during the 90- to 180-day postdeployment period (based on anonymous surveys) and less than the 19.1% PDHA positive screening rate reported in 2006 based on a review of all PDHA responses from 2004.^{7,11} In those studies, mental health

problems were most commonly associated with combat experiences and mental health care referral and utilization and were also associated with attrition from military service.^{7,11} It is unclear whether this lower rate represents greater resiliency resulting from the concerted efforts by command in combat operational stress control and the presence of a structured, organized, behavioral health plan or whether it is a consequence of demographic differences, effects of multiple deployments, differences in combat exposure, or soldiers under-reporting their symptoms. Furthermore, in this sample the PDHA was completed while soldiers were still in Iraq, whereas the previous anonymous surveys and PDHA screenings were completed in the postdeployment period. Experiences from other samples of returning soldiers indicate that rates of reported deployment-related symptoms can increase with time after return from deployment.^{12,13} The recent introduction of the postdeployment health reassessment (to be completed 90–180 days after deployment) will provide data on whether reported symptoms increase with time and on the characteristics of soldiers who report such increases.

The rate of admissions to behavioral health wards within the first 90 days after deployment did not significantly decrease, in comparison with those seen previously. In most cases, soldiers did not recognize the level of their problems until they returned home. Unanticipated failed relationships or marital problems were often at the root of the problems.

The provision of comprehensive treatment in the postdeployment period was a challenge. It was important to allow all redeploying providers to be able to have time off and be with their own families, because they also were returning from a year-long deployment. Coordination with the home station behavioral health assets allowed for this transition. At Fort Stewart, the military treatment facility maintained the DMH clinic throughout the deployment and continued to operate the clinic while all of the division providers took their time off with their families. As a result, the clinic remained fully operational throughout the redeployment process, providing soldiers with a consistent facility at which to seek care immediately upon their return. The providers who had just returned from a year-long deployment were therefore functioning at an optimal level when they assumed responsibility of clinic management after their leave period.

The concept of a formal decompression program was begun in U.S. Army Europe in 2004 and was further used by units from the 25th Infantry Division and 1st Cavalry Division upon their return from deployment to Iraq and Afghanistan. The benefit of such programs has never been proved. The 3ID 10-day restoration period appears to have had some benefit for the soldiers. Although anecdotally soldiers were frustrated by the activities, the substantial decreases in major events such as crime, family violence, driving under the influence, and suicidal gestures/attempts suggest that some form of the process is effective. These decreased rates cannot be directly attributed to this process or to any of the other redeployment behavioral health initiatives; however, there are no other clear explanations for the comparative differences between the postdeployment behaviors of 3ID soldiers with their first and second Iraq deployments. One other possible factor is that the return from the recent deployment maintained a relatively stable date, whereas the return

from the first deployment changed significantly, likely contributing to the stress felt by both the soldiers and their families. Similarly, the senior leadership within the unit (battalion level and above) remained constant throughout the second deployment but was less constant during the first deployment. Also, many soldiers and families might have been “seasoned” to deployment and aspects of redeployment stress from previous deployments during this war.

The decompression process needs to be studied further, including a review of what is being accomplished during the decompression program and the optimal length, content, and activities. Many of the soldiers completed all of the formal activities by day 5 and spent the next 5 days with minimal activities. Although many of the soldiers stated that they paid little attention to or “got little out of” the briefings completed during the decompression process, such subjective reports may not reflect the messages they received and incorporated into their decisions and attitudes regarding postdeployment behaviors. Some consideration should also be given to the value of a period of “slow pace” and a “sense of safety,” to allow for adjustment from a year-long period of high-tempo operations and constant life threats.

A reduction in formal activities and briefings in favor of more unit team-building and unit/family activities during this time frame should be considered. The confidence obstacle courses, unit field trips or picnics, and leadership reaction courses could allow for family reintegration while maintaining unit cohesion during the decompression phase. Future studies should assess the impact of a formal plan and decompression process on long-term mental health disorders and other long-term outcomes, such as retention, family interactions, and marital stability.

Conclusions

With the recent transition of the U.S. Army toward a more brigade-centered structure, DMH has undergone a significant expansion and change in mission. 3ID was the first division to deploy in this new format. Extensive predeployment preparation, flexible but coordinated distribution of personnel during deployment, active support from and open communication with commanders during deployment, and a well-organized, multifaceted, redeployment and decompression plan seem to have resulted in decreased negative postdeployment behaviors. With evolving missions and force structure, each of these areas of mental health interventions should be carefully examined and adjusted as needed to ensure optimal soldier care and readiness. Despite previous questions about the effectiveness of the PDHA program, a systematic plan of risk assignment and coordinated follow-up care proved an effective tool in reducing losses to follow-up monitoring, negative postdeployment behaviors, and mental health problems.

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References

1. Jones E: Historical approaches to post-combat disorders. *Philos Trans R Soc Lond B Biol Soc* 2006; 361: 533–42.
2. Strecker EA: Experiences in the immediate treatment of war neuroses. *Am J Insanity* 1919; 76: 45–69.
3. Rock NL, Stokes JW, Koshes RJ, Fagan J, Cline WR, Jones FD: U.S. Army combat psychiatry. In: *War Psychiatry*, Chap 7, pp 149–75. Washington, DC, Office of the Surgeon General, Borden Institute, 1995.
4. Jones E, Wessely E: “Forward psychiatry” in the military: its origin and effectiveness. *J Trauma Stress* 2003; 16: 411–9.
5. U.S. Department of the Army: Field Manual 8-51: Change 1 Combat Stress Control in a Theater of Operations: Tactics, Techniques, and Procedures. Washington, DC, Department of the Army, 1998.
6. U.S. Department of the Army: 2004 Army Transformation Roadmap. Washington, DC, Department of the Army, 2004.
7. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL: Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N Engl J Med* 2004; 351: 13–22.
8. Prins A, Ouimette P, Kimerling R, et al: The Primary Care PTSD Screen (PC-PTSD): development and operating characteristics. *Primary Care Psychiatry* 2004; 9: 9–14.
9. Kroenke K, Spitzer RL, Williams JB: The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care* 2003; 41: 1284–92.
10. Kroenke K, Spitzer RL, Williams JB: The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med* 2001; 16: 606–13.
11. Hoge CW, Auchterlonie JL, Milliken CS: Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *JAMA* 2006; 295: 1023–32.
12. Southwick SM, Morgan CA, Darnell A, et al: Trauma-related symptoms in veterans of Operation Desert Storm: a 2-year follow-up. *Am J Psychiatry* 1995; 152: 1150–5.
13. Grieger TA, Cozza SJ, Ursano RJ, et al: Posttraumatic stress disorder and depression in battle-injured soldiers. *Am J Psychiatry* 2006; 163: 1777–83.



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