Chapter 18

RESETTING THE FORCE: REENTRY AND REDEPLOYMENT

KRIS A. PETERSON, MD*; AND MICHAEL E. DOYLE, MD†

*Colonel, Medical Corps, US Army; Chief, Department of Psychiatry, Madigan Army Medical Center, Tacoma, Washington 98431; formerly, Child and Adolescent Psychiatry Consultant to The Surgeon General, US Army
†Lieutenant Colonel, Medical Corps, US Army; Deputy Commander for Clinical Services, USAMEDDAC West Point, 900 Washington Road, West Point, New York 10996

This chapter was previously published as: Doyle ME, Peterson KA. Re-entry and reintegration: returning home after combat. *Psychiatric Quarterly*. 2005;76:361–370. Adapted with permission of Springer.

The capacity of Soldiers for absorbing punishment and enduring privations is almost inexhaustible so long as they believe they are getting a square deal, that their commanders are looking out for them, and that their own accomplishments are understood and appreciated.

—General Dwight D Eisenhower, 1944

INTRODUCTION

Soldier life in the US Army is structured by the cycles of predeployment, deployment, and postdeployment. Management of behavioral health in each phase is a continuous process, with features unique to each phase. Soldiers redeploying from combat to their home units face a number of stressors that may affect postdeployment adjustment. Among the factors that influence stress levels are the nature of the conflict, level of national support, family support and family stability, and the soldier's component (regular Army, National Guard, or US Army Reserve).

"Resetting the force"—reentry, reintegration, recovery, and reconstitution—has become an essential operation of the postdeployment phase of the cycle. Resetting the force can be thought of as personal or soldier maintenance. Just as equipment needs to be repaired or refurbished after deployment, and maintained throughout its use to prevent breakdown, so, too, do soldiers need "maintenance" in the form of support before, during, and after deployment. This chapter will look at processes developed by the military over the course of the global war on terror (GWOT) to reset the force by assisting soldiers in reentry and reintegration.

Resetting the force includes many concepts; for example, implicit in maintaining a ready deployable force is making soldiers available for contingency operations while simultaneously sustaining garrison operations. Early inclusion of families and communities into the planning for reentry and reintegration, normalization (nonmedicalization of distress), destigmatization of behavioral health problems, and assistance for behavioral health needs, including easy access to a behavioral health professional and education of soldiers and families on resources and benefits, are other essential elements in this process.

The military recognizes resetting the force as a vital part of the return to readiness, as important as preparing soldiers for deployment. This concept acknowledges that recovery after a deployment maintains the soldier and is part of the preparation process for future deployments. Soldiers recover and return to combat readiness as the next round of deployments approaches. The effectiveness of the reintegration process strongly affects the state of individual and unit readiness. Thus, stakeholders include the soldier; the soldier's family, unit, and local community; the Army; and all of US society. These identified stakeholders provide context to resetting the force and shape its outcome.

Recognizing this, Army leadership (under G1), in concert with behavioral health professionals, developed an intensive program to reach all returning soldiers—active duty, reserve, and National Guard—who were mobilized and deployed to combat zones. The Deployment Cycle Support Program (DCSP) directs as much attention to the postdeployment phase as the Army historically has to the actual deployment and run-up to it. The DCSP brings balance to the varying soldier, unit, and family needs within the deployment cycles or continuum.

BACKGROUND

Accounts of wars throughout recorded history frequently include descriptions of the physical and emotional suffering of the combatants. The GWOT, Operation Iraqi Freedom (OIF), and Operation Enduring Freedom (OEF) will likely continue this trend. Scientific study of the emotional and psychiatric impact of combat operations is extensive up to and including the Persian Gulf War. Publications since then include numerous reports on peacekeeping operations[1,2] and a recent article on symptoms of posttraumatic stress disorder in OIF/OEF soldiers and marines.[3]

For OIF/OEF, reentry—or returning home after combat—and reintegration have received attention in the media, but rigorous scientific study has not yet occurred. Moreover, the media attention has been primarily negative: individual incidents of criminal behavior with deployment experience implicated as the cause, an anticipated epidemic of posttraumatic stress disorder as thousands of service members demobilize following the war, and problems with soldiers' follow-up medical care, infrastructure at major medical centers, and the physical disability system.

In the 1995 textbook *War Psychiatry*,[4] Faris Kirkland discusses at length the impact on soldiers primarily, and on society to a lesser extent, of troops returning home after conflict. Kirkland divides US involvement

in numerous conflicts and armed interventions into three categories: major wars, limited actions, and rapid-deployment operations. Major wars are those defined by large-scale mobilizations against a defined, "evil" and dehumanized enemy, fought by "champions of the people" for the greater good, in which reentry of the combatant into civilian life is accomplished by demobilization. Demobilization places responsibility for reentry and reintegration squarely on society at large, making it "a societal, not military problem." In major wars the soldier and family impact involves less conflict. The societal embrace of soldiers doing their duty in the face of a dehumanized enemy, fighting for a greater good, validates the soldier's actions and modifies the negative psychological sequelae of combat. Resetting via acknowledgment of meaningful actions and sacrifices "not in vain" is more readily accomplished.[4]

Limited wars are those requiring only a fractional commitment of national resources; they are conducted in a different psychopolitical climate than major wars.[4] National interests frequently serve as the pretext for action, civilian inconvenience and involvement are modest, and ambivalence about the cause pervasive. Numerous factors complicate reentry of service members, significantly, the absence of national consensus, lack of validation of soldiers' efforts, and the return of soldiers individually from theater. "Soldiers were not able to process their experiences with the comrades with whom they had trained and fought."[4(p293)] Reentry management in modern limited wars has been shouldered by society. Following the Korean War, soldiers met indifference; following Vietnam, hostility.[4] Thus far public ambivalence has greeted returning OIF and OEF troops: praise for heroism, countered by belief in the moral injustice of the war, coupled with the portrayal of soldiers as pawns trapped in a commitment to serve.

In limited wars, wherein society does not identify with the soldier and is neutral or even negative toward a soldier's sacrifice, the psychological impacts land more heavily upon both soldier and society. "Psychiatric casualties increase greatly when the soldier feels isolated, and psychological and social isolation from home and society was one of the results of the growing antiwar sentiment in the United States," such as during the Vietnam War.[5] Furthermore, in Vietnam, one consequence of soldiers' alienation was an increase in "Dear John" letters.[5] OIF and OEF reflect similar dynamics; the divorce rate for soldiers, and the officer corps in particular, rose rapidly in the first 3 years of the conflict, leveled off, and then rose again.

Psychiatric casualty rates in Vietnam "were similar to home-front approval ratings for the war, and an argument can be made that psychiatric casualties can be impacted by public disapproval."[5(p278)] In multiple studies two factors show up again and again as critical to the magnitude of the posttraumatic response. First and most obvious is the intensity of the initial trauma. The second, and less obvious but absolutely vital, factor is the nature of the social support structure available to the traumatized individual.[5] Society accepting as necessary soldiers' behavior in combat—killing, managing violence—vitalizes resetting the force and mitigates the psychological impact of combat. In contrast, the decline in public support for the war in Iraq as well as negative media attention may contribute to difficulties in reentry and reintegration for redeploying and demobilizing service members. Leaders and citizens, locally and nationally, who comment that a war is unjust, based on a lie, or in vane, make the soldier's task to refit and reset more difficult. It is consequently important for leaders to speak up about the justness of the fight, identify what the country is fighting for, and outline the strategic successes. Reset must encompass not just an acceptance of but accolades for soldiers' accomplishments.

The third form of combat, the rapid-deployment operation, is enacted for national interest by a professional military cohort that has trained together but must rapidly transition from training to combat mode and back again to prepare for the next deployment scenario.[4] Soldiers involved in these actions seldom have time to consider or internalize virtues of the cause, but instead must rely on horizontal and vertical cohesion

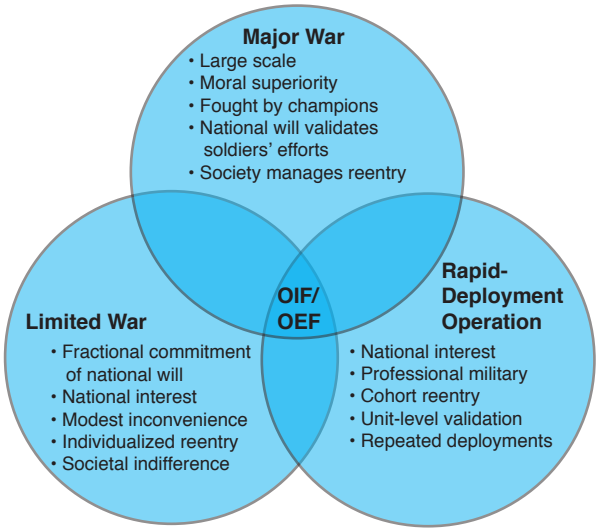

Figure 18-1. The characteristics of major wars, limited wars, and rapid deployment operations overlap in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

within their units for validation.[4] Responsibility for reentry and reintegration rests primarily on the unit and military. The ability of these soldiers to rely on unit cohesiveness and esprit de corps significantly impacts deployment readiness.[4]

Special forces operations employed in GWOT as well as during the Cold War fall under this construct. The resetting of these combat teams is made easier through the unit cohesion and esprit de corps developed during their specialized training. Conversely, frequent deployments, toxic environments, and combat losses take a toll. The stigma of having a behavioral health problem is amplified because these soldiers may feel they cannot rely upon distressed members. Consequently, seeing behavioral health practitioners for assistance in a reset is made even more difficult in this group. Typically, special forces soldiers reach out to chaplains and leaders for these needs. Increasingly, however, regular forces follow the same behavior pattern, and the factors that mitigate distress in the special operations population may not exist as robustly in the regular forces community.

History may determine where GWOT, OIF, and OEF fall among the models discussed. These related conflicts have been framed as a major war against a great evil but executed as a limited war by an increasingly professional and full-time military that must prepare for return-to-combat while planning its return home. OIF and OEF also entail the largest call-up of reserve forces since World War II, with 18-month mobilization orders for the National Guard, and 2- to 3-year mobilizations for reservists. These groups also face the increasing pressures of the deployment cycle. Figure 18-1 depicts this overlap between major, limited, and rapid deployment operations, with elements of each apparent in OIF and OEF.

REENTRY CHALLENGES BY POPULATION

The unusual spectrum of the GWOT, OIF, and OEF conflicts presents multiple challenges to reentry and reintegration for the three separate populations of regular Army soldiers, National Guard and reserve soldiers, and family members.

Regular Army

The DCSP, resulting from the peacekeeping operations of the 1990s and the development of concepts based on expeditionary force practices among Army leadership, reflects recognition that in the post-Cold War era, soldiers are in predeployment, deployed, or postdeployment states at any given time. And so are family members. The DCSP plan, dated May 2, 2004, disseminated and operationalized Army-wide, includes a return-to-readiness—termed "recovery" or "reconstitution"—period (Figure 18-2). The plan is intended to assist soldiers in reentry and reintegration and restore them and their units to combat readiness:

> Reintegration training for both the Soldier and his/her family is an essential task for all units' return to readiness plans. It is as important as any other training or personnel action the Soldier undertakes. Reintegration entails three components; the single Soldier and his/her assimilation back into a garrison environment; the married Soldier and his/her assimilation with his family; and the family of the deployed Soldier.[6]

Reintegration training is not a single session but a continuous and, at times, parallel process:

- Reintegration training occurs in advance of soldiers' return to home station, often in-theater or at the location to which soldiers have been deployed.
- Rear detachment leaders coordinate with the installation to provide reintegration training to families of deployed soldiers as well. Although the training is voluntary for family members, units encourage participation. Units publicize training sessions and conduct them at times that allow maximum family member participation. The training also includes take-home information about what families might expect during the homecoming of their combat veteran.[6]
- The reconstitution phase starts upon a soldier's arrival at home station after deployment. Commanders establish a half-day schedule to "facilitate family reintegration and to commence administrative tasks required upon return."[6] Half-days occur through the first 10 days, and during this time the soldier's duties entail "administrative functions, Soldier and leader professional education, and family reintegration."[6]

Rear detachment commanders and personnel provide support and training resources for reintegration in advance of the unit's return. They ensure that "suitable time is allocated for family reintegration activities both for the married and single Soldier."[6] Leaders will "execute family reintegration counseling for all redeploying Soldiers. To the greatest extent

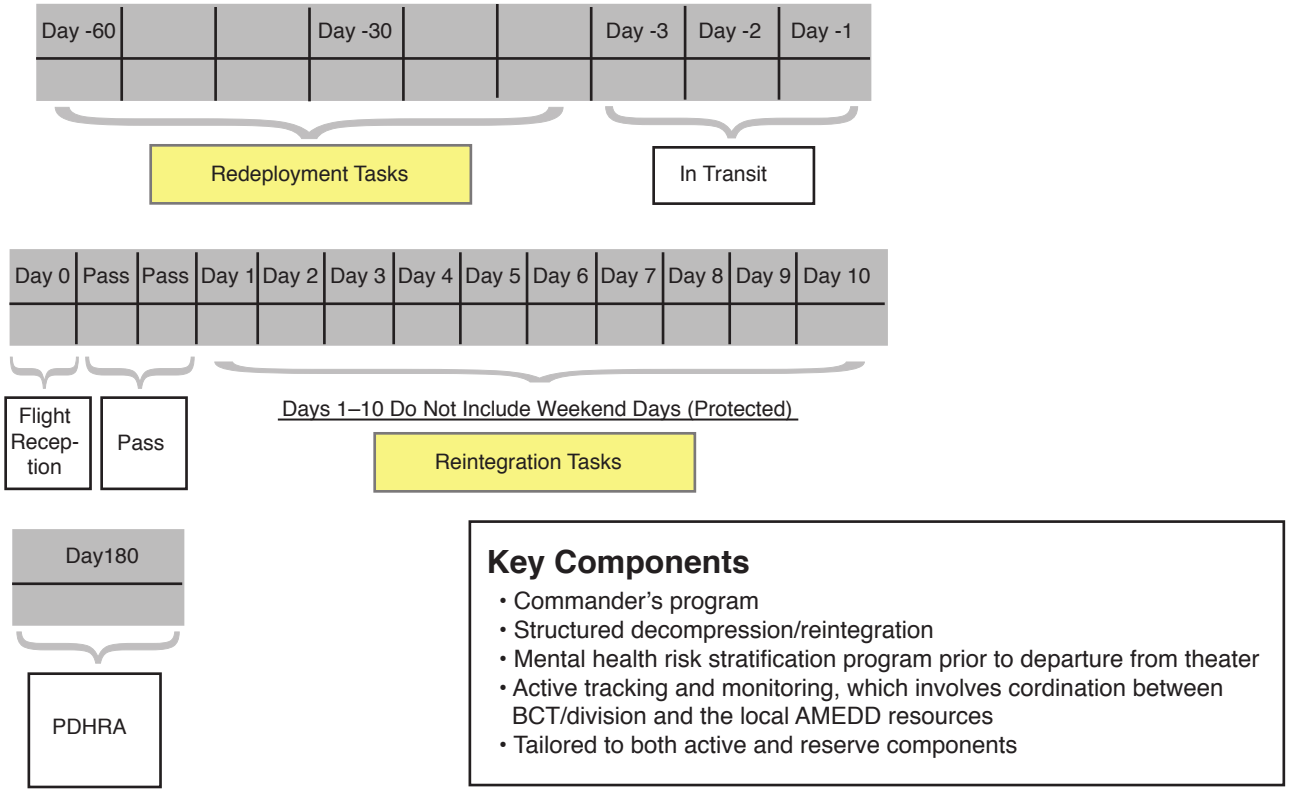

Figure 18-2. Key components in decompression and reintegration.
BCT: brigade combat team
AMEDD: Army Medical Department
PDHRA: Post-Deployment Health Re-Assessment

possible, this counseling will occur in theater, prior to the Soldiers redeploying."[6] Units are expected to sustain needed family reintegration training following soldiers' return, based on unit sensing sessions, command climate surveys, and feedback to the unit leadership from installation support agencies and healthcare providers.

At-risk soldiers are identified by commanders prior to returning home to "ensure that they receive tailored training and/or assistance based on their particular circumstances."[6] The Army identifies soldiers-at-risk by marital difficulties or difficulties with fiancés, financial difficulties, problems with alcohol or substance abuse, medical problems, and problems such as depression or anxiety reported by the soldier during pre- and postdeployment screening. This list is not all-inclusive and other issues might identify a soldier as at risk as well.[6]

Lastly, as directed March 26, 2007,[7] all redeploying soldiers undergo a health reassessment 3 to 6 months after redeployment. This reassessment includes general health questions, seeking to address medical issues not identified at the initial screening, but also presents soldiers with the opportunity to seek treatment for any behavioral health concerns that may have arisen since the initial screening.

National Guard and Army Reserve

As advocated by the "One Army" concept of seamlessness among components, requirements of the DCSP apply equally across active duty, National Guard, and reserve units. Reserve and National Guard soldiers are demobilized, like soldiers from World War II or Korea; their reentry and reintegration is largely shouldered by their communities; and medical care is provided by the Department of Veterans Affairs (VA) hospital nearest their home.

Reentry anxieties abound among these soldiers. Many have lost their jobs or fear the possibility of job loss, despite legislative protections. Sole proprietors and small-business owners are particularly at risk. A frequently noted concern is that soldiers feel different than they did before deployment. Other issues faced by

demobilizing reservists and Guard members include a sense of isolation from peers, estrangement from family and friends, and a loss of common purpose. The bonds forged in combat and other operations may remain if the Guard unit has a localized base; however, this is often not the case.

Case Study 18-1: Specialist A presented for care shortly after being notified of his imminent release from active duty. The soldier expressed fears that he would respond negatively or even violently in his work environment when confronted with inevitable conflicts. "I'm not ready to go home. Most of the guys where I work are Middle Eastern; I'm afraid I will go off on them."

Demobilizing reservists and National Guard personnel often return to their home unit stations as soon as 4 days after arriving at the demobilization site. This facilitates a quick reunion for them and their families; however, follow-up care and monitoring may be scarce in the home communities. Thus, these soldiers may find themselves in a difficult situation: either remain on active duty, separated from family and loved ones, to address medical questions, or ignore the medical issues and return home. Washington state sought to redress these issues in November 2004 when it established a memorandum of agreement with multiple federal agencies to

> augment the ongoing, comprehensive effort to ensure military service members and their families are honored for their valuable and honorable service to our country. It is recognized that the Department of Defense and the U.S. Department of Veterans Affairs are providing world-class transition service . . . to deal with the multitude of medical and mental conditions associated with war. This agreement will focus primarily on "after active-duty" and deal with problems and issues military members often face several months or years following military service.[8]

This agreement and its accompanying programs aim to shore up local reintegration and reentry of returning service members. Features include

- ensuring that each returning veteran receives a letter from the governor, the adjutant general, and the director of the Washington State Department of Veterans Affairs thanking them for their service and encouraging them to seek their various veteran benefits and entitlements;
- follow-up letters at 3 and 6 months;
- a family activity day, held within 3 to 6 months following return, conducted by teams consisting of representatives from the VA, Veterans Benefits Administration, Veterans Health Administration, and Washington Employment Security Department; accredited veteran services officers; and mental health professionals for the purpose of providing information to assist veterans and their family members with reintegration; and
- a family support program providing education about VA services and benefits in classes for family members of deployed service members, conducted by accredited veteran services officers at local armories and sponsored by the command.[8]

Like those on active duty, reserve component soldiers receive the health reassessment screening at 3 to 6 months postdeployment. Specific questions on the screening aim to measure the presence and impact of posttraumatic stress disorder. If the reassessment identifies healthcare needs, soldiers are offered care through military medical treatment facilities, VA medical centers or veterans' centers, TRICARE providers, or community-based healthcare organizations established by the Army. Part of this intervention plan are behavioral healthcare providers, who further assess soldiers' needs and ensure that care is offered.

Family Members of Regular Army, Reservists, and National Guard Members

The Deployment Health Clinic at Madigan Army Medical Center, Tacoma, Washington, like similar clinics at other military treatment facilities, recognizes that family preparedness for deployment is essential to ensuring soldier readiness for deployment. With this in mind, the Deployment Health Clinic developed the Army Family Readiness Course, which is an online resource for soldiers and family members. This has evolved over time into additional resources for soldiers and family members now embodied in the efforts of the Technology and Telehealth Initiative from the Department of Defense.

Case Study 18-2: Ms B is a 32-year-old spouse of an infantryman. The couple arrived at Fort Lewis, Washington, 3 months prior to his deployment to Iraq. His previous assignment was in Korea, where his 12-month tour had been extended to 15 months. Ms B presented feeling overwhelmed at being separated from her spouse so soon and for yet another year. The couple had four children, ages 3 to 13. Ms B had significant back pain, anxiety, and a history of depression. Following her spouse's return from Iraq, where he had served as a squad leader for an infantry squad with numerous combat encounters, she reported, "He tells me everything. I thought he'd keep it inside. I thought I'd be better when he came home, but I still can't sleep."

During deployment, family members of regular Army soldiers usually have the benefit of support from the on-post community, support that is often not available for National Guard members or reservists. However, family members of National Guard and reserve soldiers may have greater access to family and long-standing community relationships that regular Army families do not. Regardless of component, home-front stability is key to soldier readiness. Family instability, which generally increases at deployment, distracts the service member, and absence of a family care plan often results in administrative separation of deploying soldiers.

Often, however, the greatest challenge to families is the return of the deployed soldier. When the returning soldier reclaims prior responsibilities, the spouse may be left feeling that his or her efforts during deployment are invalidated. Months of adaptation and coping are upended, giving rise to such questions as:

- Who now pays the bills, takes out the trash, mows the lawn?
- Who disciplines the children? How?
- Who gets the remote?
- Are there problems with intimacy?[9]

REDEPLOYMENT PROGRAMS

Commanders' plans for resetting the force have varied, but they generally intend to provide a broad-based and inclusive assessment of the mental well-being of soldiers deploying to and returning from combat. In the Army's first resetting iteration, the Walter Reed Army Institute of Research developed a postdeployment questionnaire that was filled out by soldiers upon or near redeployment and often in theater. This questionnaire became known as the Health Risk Appraisal questionnaire (HRA I). Subsequently, many local institutions and commands broadened the questionnaire and, through consensus, standardized its contents to create the HRA II. Soldiers completed the HRA II prior to deployment and upon return from a combat theater. Based on these assessments, interventions could be carried out to assist resetting soldiers in need. For example, a soldier who started smoking in the combat theater might express interest in smoking cessation. The request would be identified on the HRA II, and follow-up contact and treatment interventions arranged.

Further evolution of the resetting efforts occurred over time, with different programs being implemented on different military posts. Ultimately, Army leadership adopted a standardized schedule and format for the predeployment and postdeployment assessments and the postdeployment health reassessment (see Attachment). In addition to the health assessments administered upon deployment, redeployment, and 3 to 6 months postdeployment, the DCSP supports behavioral health by surveillance for trends and compliance, treatment referrals when indicated, and, most importantly, making it mandatory that soldiers have the opportunity to complete all assessments (although completion is voluntary).

The Army initially delegated treatment decisions to local medical treatment facilities. Arguably the most comprehensive of these efforts is a program called the Soldier Wellness Assessment Pilot Program (SWAPP), deployed initially at Fort Lewis, Washington (Exhibit 18-1).

In general, military treatment facility reintegration programs operate as follows: Returning soldiers are assigned a care manager (usually a social worker) if medical or behavioral health issues are identified on the postdeployment health screening. The care manager assists the soldier in scheduling needed follow-up and then in keeping those appointments. This often requires coordination with the soldier's command to ensure that the needed time is given. Those who need ongoing care are assigned case managers, who monitor the progress of the soldier's therapy with a goal of full return to duty. Soldiers with identified behavioral health concerns that may limit duty are assisted by case managers in concert with behavioral health professionals.

However, soldiers may also present with behavioral health concerns to the local behavioral health clinic, where those recently deployed are offered a wide variety of therapeutic modalities. These may include one-to-one supportive, insight-oriented, or cognitive/behavioral therapy, as well as group therapies such as postdeployment adjustment groups, interpersonal process groups, depression groups, groups focused on adjustment to military life, or groups focused on life skills or anger management. Marital and family therapies are also offered in a variety of modalities. Medication management is also available when appropriate. Treatment for posttraumatic stress disorder, consistent with treatment guidelines based on the literature, is also offered.[10]

The expectation of wellness and recovery remains an integral part of any treatment program. For many, use of reassurance is efficacious. Practitioners should use language such as: "What you are experiencing now is an expected consequence of your combat tour. It will get better with time. However, the following may be helpful in this process. . . ."

EXHIBIT 18-1

SOLDIER WELLNESS ASSESSMENT PILOT PROGRAM

Interventions to reset the force have been in development since soldiers began redeploying to combat operations in Afghanistan and Iraq. A program that has gained significant acceptance and captured the commander's intent is the Soldier Wellness and Assessment Pilot Program (SWAPP) at Fort Lewis, Washington. SWAPP is a useful model built on the Deployment Cycle Support Program's intents to

- standardize predeployment and postdeployment health risk assessments, with an identical process before and after deployment;
- encompass a broad definition of health and wellness, including physical, emotional, spiritual, financial, and legal needs;
- make data transparent to commanders and medical staff; and
- ensure a face-to-face encounter with a licensed provider for each soldier assessed.

Participation in SWAPP is voluntary. Many commanders and soldiers view the program as an opportunity to establish a broad-based overview of physical, emotional, and spiritual wellness. The assessment is scheduled for completion between 90 and 180 days after return, and 45 to 125 days prior to departure. As seen in Figure 18-3, soldiers check in and begin with a face-to-face encounter that introduces aspects of the program and attempts to destigmatize the resetting process. It is made clear that the process is voluntary.

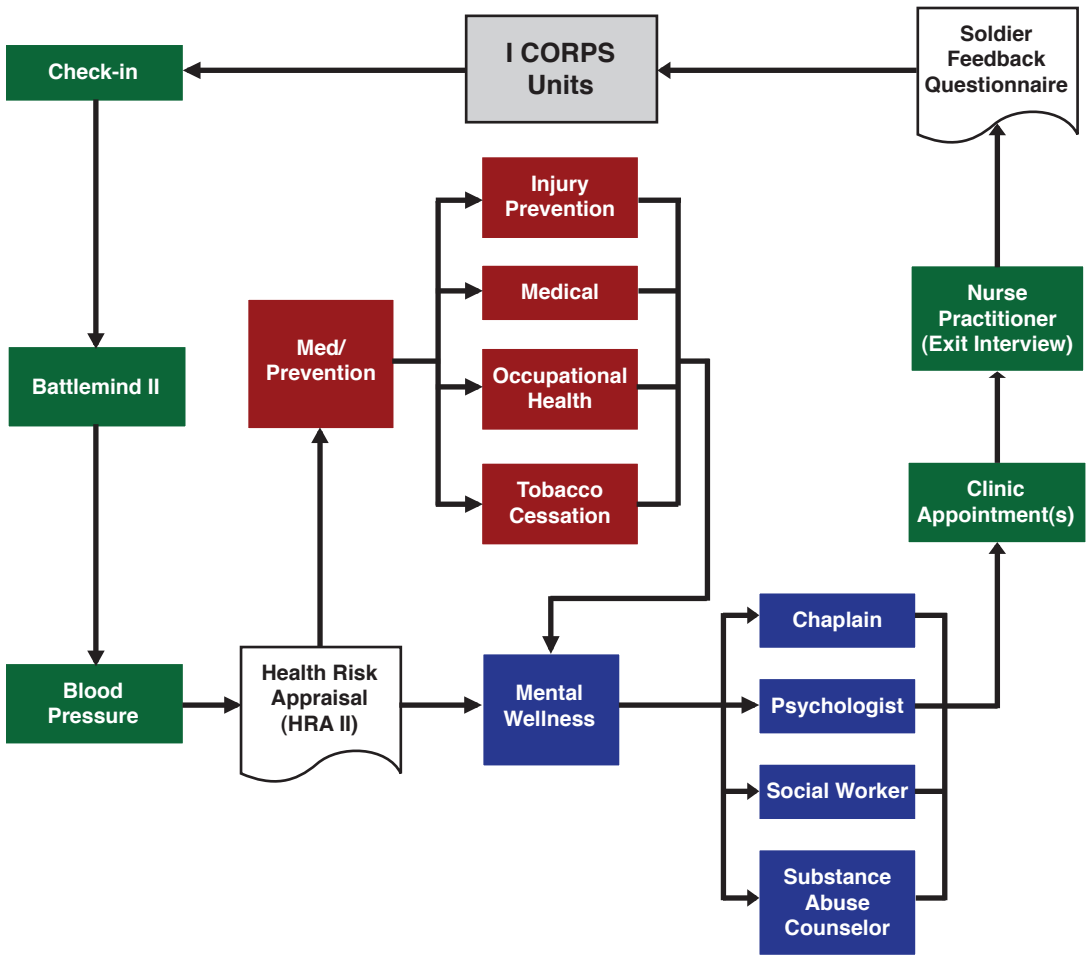

Figure 18-3. Soldier Wellness and Assessment Pilot Program flow chart.

(**Exhibit 18-1** *continues*)

Exhibit 18-1 *continued*

Soldiers complete the health risk appraisal (HRA II) questionnaire in several venues, administered on computer kiosks, and results are forwarded to providers. The questions encompass the postdeployment health reassessment questions in form DD 2900 (see Attachment). HRA II has 76 questions used to identify risk in soldiers, who are categorized as being at high, moderate, and low risk for disease or mental health conditions. If soldiers are high risk, 60 minutes is allotted for a face-to-face meeting with a credentialed provider, and a soldier at moderate risk is allotted 30 minutes. Credentialed providers include psychologists, psychiatrists, social workers, psychiatric nurse practitioners, and chaplains. Licensed practical nurses and occupational and preventive medicine professionals are also on site to assess needs unrelated to mental health, such as tobacco cessation and medical referrals.

As the program matures, its data will be accessible, comparable, and transparent, allowing for longitudinal follow-up. Currently data pertaining to form DD 2900 are sent to the Army Medial Surveillance Activity to be entered into the Defense Medical Surveillance System. Feedback from this system is sent to commanders via a Web-based report that is compliant with the Health Insurance Portability and Accountability Act of 1996. The data provided to commanders include diagnoses by type and prevalence, deployment-related conditions, safety issues, legal and financial problems, and the overall state of morale.

As Figure 18-3 demonstrates, SWAPP is resource intensive. Though it is not used Army-wide, its elements are encompassed in return processing at other duty stations, and it serves as a model for many other programs in the military. Initial feedback and response from commanders and soldiers alike has been positive. Efforts to expand the SWAPP program to other Army posts are underway.

Case Study18-3: Staff Sergeant C had recently been evacuated from Iraq following an improvised explosive device explosion in which he sustained an injury to his leg. His physical recovery was progressing well and he was hopeful for a full recovery. However, he complained of increasing awareness of disrupted sleep due to nightmares. He stated that he'd had them start before being injured and leaving Iraq and thought they'd go away once he was home. But now, some 2 months later, the nightmares persisted. Typically they involved combat operations and often centered on having to make a choice such as kill or be killed, killing, and then discovering the victim was a child.

Other soldiers often complain of hypervigilance while driving—fearing every piece of trash is an improvised explosive device or other drivers are potential suicide bombers. For many, the lack of sleep alone, without nightmares, represents a problem; often soldiers' spouses report these concerns. Recognizing a more pervasive need to normalize experiences and assist redeploying soldiers in adapting what is a normal and acceptable behavior and response in the combat zone to what is normal and acceptable at home, the Army developed and introduced Battlemind training.

The Battlemind program (Exhibit 18-2) is another intervention with a renewed emphasis on normalizing anticipated feelings and reactions during the deployment cycle. "Battlemind" is the soldier's inner strength and ability to face fear and adversity in combat with courage. Components are designed to build self-confidence and mental toughness. However, although Battlemind skills are helpful in combat, they may cause problems on returning home; for example, tactical awareness in a combat zone might become hypervigilance at home. Battlemind training is a method of aiding soldiers in transitioning to home-front living. Battlemind training emphasizes that

EXHIBIT 18-2

BATTLEMIND

Buddies (cohesion)

Accountability

Targeted aggression

Tactical awareness

Lethally armed

Emotional control

Mission operational security

Individual responsibility

Nondefensive (combat) driving

Discipline and ordering

Adapted from: US Army. Battlemind Web site. http://www.Battlemind.army.mil. Accessed March 31, 2010.

- Battlemind "injuries" (ie, a maladaptive response to a formerly dangerous situation) can occur in any soldier when combat skills are not adapted to the home;
- getting help for a Battlemind injury is NOT a sign of weakness; and
- it takes courage to ask for help and it takes leadership to help a fellow soldier get help.

The training, conducted upon redeployment, initially consists of an educational brief that emphasizes Battlemind concepts. Retraining after 3 to 6 months includes scenario-driven vignettes and videos that recreate typical situations experienced by redeployed soldiers and suggested ways of handling these issues.

The programs and procedures outlined above work towards improving communication between soldiers and family members in an effort to resolve crises and mitigate distress. The inclusion of these programs in command-sponsored and command-driven operations plans and memoranda of understanding highlights a number of important considerations:

- Planners must integrate families and communities early into the planning for reentry and reintegration.
- Distress during this time is expected and should not be medicalized.
- Behavioral health professionals should be available to soldiers and families following return from combat.
- Education of families about available resources and benefits is as important as training soldiers.

Services for family members need to be easily accessible, perhaps even more so when the soldiers are deployed. Families with preexisting mental health needs frequently have increased demands, and those who did not demonstrate preexisting problems might also need services. Often sources in the community are not readily available or sufficient, even in more populated areas. With active duty mental health professionals deployed, the increased demand for services from family members at home may tax behavioral health resources beyond capabilities. For example, at the Madigan Army Medical Center outpatient psychiatry clinic, patient contacts for fiscal year 2001 numbered approximately 8,000; the same number was logged during just the first 6 months of 2005.

SUMMARY

In current and projected future operations, the burden of soldier reentry and reintegration will be borne equally by the Army and society, who must collaborate to ensure that maximal benefits to the soldier, family members, and society are realized. Since the beginning of GWOT, OEF, and OIF, the US Army has developed and refined its efforts to reset the force, reaching out to all returning and redeploying service members with a variety of mental and behavioral health initiatives. How well these efforts are working must be tracked and analyzed, so that the programs may continue to evolve to serve the changing needs of soldiers, families, the Army, and US society.

REFERENCES

1. Adler AB, Castro CS. *US Soldiers and Peacekeeping Deployments*. Heidelberg, Germany: US Army Medical Research Unit-Europe; 2001. Research Report.

2. Schumm WR, Bell DB, Knott B. Characteristics of families of soldiers who return prematurely from overseas deployments: an assessment from Operation Restore Hope (Somalia). *Psychol Rep*. 2000;86(3 Pt 2):1267–1272.

3. Hoge CW, Castro CA, Messer SC, et al. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N Engl J Med*. 2004;351(10):13–22.

4. Kirkland FR. Postcombat reentry. In: Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, Stokes JW, eds. *War Psychiatry*. In: Zajtchuk R, Bellamy RF, eds. *Textbooks of Military Medicine*. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute; 1995: 291–317.

5. Grossman D. *On Killing: The Psychological Cost of Learning to Kill in War and Society.* New York, NY: Little Brown and Company; 1995.

6. I (US) Corps OPLAN 04-10 (Return to Readiness). Unclassified. Fort Lewis, Wash. April 2004.

7. Peter Geren, Acting Secretary of the Army. *Deployment Cycle Support (DCS) Directive*. Washington, DC: US Department of the Army. Memorandum, March 26, 2007. Available at: http://www.armyg1.army.mil/dcs/docs/DCS%20Directive.pdf. Accessed September 15, 2009.

8. Memorandum of Understanding Between Washington State Military Department, Washington State Department of Veterans Affairs, Washington State Employment Security Department, US Department of Veterans Affairs, Benefits Administration, US Department of Veterans Affairs, Health Administration, US Department of Labor, Association of Washington Business, Governor's Veterans Affairs Advisory Committee, November 2004.

9. Robertson M, Humphreys L, Ray R. Psychological treatments for posttraumatic stress disorder: recommendations for the clinician based on review of the literature. *J Psychiatr Pract.* 2004;10:106–118.

10. *Getting Back Together (Homecoming/Reunion)* [videotape]. Washington, DC: US Army; 1994. US Army training video TVT20-1048.

ATTACHMENT: HEALTH ASSESSMENT FORMS

33823

PRE-DEPLOYMENT Health Assessment

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health before possible deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: **(Military personel and DoD civilian Employees Only)** Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

Demographics

Last Name

First Name **MI**

Deploying Unit

Today's Date (dd/mm/yyyy) / /

Social Security Number - -

DOB (dd/mm/yyyy) / /

Gender

- ○ Male
- ○ Female

Service Branch

- ○ Air Force
- ○ Army
- ○ Coast Guard
- ○ Marine Corps
- ○ Navy
- ○ Other

Component

- ○ Active Duty
- ○ National Guard
- ○ Reserves
- ○ Civilian Government Employee

Pay Grade

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

Location of Operation

- ○ Europe
- ○ SW Asia
- ○ SE Asia
- ○ Asia (Other)
- ○ South America
- ○ Australia
- ○ Africa
- ○ Central America
- ○ Unknown

Deployment Location (IF KNOWN) (CITY, TOWN, or BASE):

List country (IF KNOWN):

Name of Operation:

Administrator Use Only

Indicate the status of each of the following:

Yes	No	N/A	
○	○	○	Medical threat briefing completed
○	○	○	Medical information sheet distributed
○	○	○	Serum for HIV drawn within 12 months
○	○	○	Immunizations current
○	○	○	PPD screening within 24 months

33823

DD FORM 2795, MAY 1999

ASD (HA) APPROVED SEPTEMBER 1998 Ver 1.3

Reset

Adobe Professional 7.0

33823

PLEASE FILL IN SOCIAL SECURITY # ☐☐☐ - ☐☐ - ☐☐☐☐

Health Assessment

1. Would you say your health in general is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
2. Do you have any medical or dental problems? ○ Yes ○ No
3. Are you currently on a profile, or light duty, or are you undergoing a medical board? ○ Yes ○ No
4. Are you pregnant? (FEMALES ONLY) ○ Don't Know ○ Yes ○ No
5. Do you have a 90-day supply of your prescription medication or birth control pills? ○ N/A ○ Yes ○ No
6. Do you have two pairs of prescription glasses (if worn) and any other personal medical equipment? ○ N/A ○ Yes ○ No
7. During the past year, have you sought counseling or care for your mental health? ○ Yes ○ No
8. Do you currently have any questions or concerns about your health? ○ Yes ○ No

Please list your concerns: _____

_____

Service Member Signature

I certify that responses on this form are true. ☐

Pre-Deployment Health Provider Review (For Health Provider Use Only)

After interview/exam of patient, the following problems were noted and categorized by Review of Systems. More than one may be noted for patients with multiple problems. Further documentation of problem to be placed in medical records.

REFERRAL INDICATED

○ None
○ Cardiac
○ Combat / Operational Stress Reaction
○ Dental
○ Dermatologic
○ ENT
○ Eye
○ Family Problems
○ Fatigue, Malaise, Multisystem complaint
○ GI
○ GU
○ GYN
○ Mental Health
○ Neurologic
○ Orthopedic
○ Pregnancy
○ Pulmonary
○ Other _____

FINAL MEDICAL DISPOSITION: ○ **Deployable** ○ **Not Deployable**

Comments: (If not deployable, explain)

_____

_____

_____

I certify that this review process has been completed.

Provider's signature and stamp: ☐

Date (dd/mm/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

End of Health Review

Reset

33823

DD FORM 2795, MAY 1999 ASD (HA) APPROVED SEPTEMBER 1998 Ver 1.3

33348

POST-DEPLOYMENT Health Assessment

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health after deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: (Military personnal and DoD civilian Employees Only) Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

Demographics

Last Name

First Name **MI**

Name of Your Unit or Ship during this Deployment

Today's Date (dd/mm/yyyy) / /

Social Security Number — —

DOB (dd/mm/yyyy) / /

Date of arrival in theater (dd/mm/yyyy) / /

Date of departure from theater (dd/mm/yyyy) / /

Gender
- ○ Male
- ○ Female

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

Component
- ○ Active Duty
- ○ National Guard
- ○ Reserves
- ○ Civilian Government Employee

Pay Grade

○ E1	○ O01	○ W1
○ E2	○ O02	○ W2
○ E3	○ O03	○ W3
○ E4	○ O04	○ W4
○ E5	○ O05	○ W5
○ E6	○ O06	
○ E7	○ O07	○ Other
○ E8	○ O08	
○ E9	○ O09	
	○ O10	

Location of Operation
- ○ Europe
- ○ SW Asia
- ○ SE Asia
- ○ Asia (Other)
- ○ Australia
- ○ Africa
- ○ Central America
- ○ Unknown
- ○ South America
- ○ North America
- ○ Other _____

To what areas were you mainly deployed: (mark all that apply - list where/date arrived)
- ○ Kuwait _____
- ○ Qatar _____
- ○ Afghanistan _____
- ○ Bosnia _____
- ○ On a ship _____
- ○ Iraq _____
- ○ Turkey _____
- ○ Uzbekistan _____
- ○ Kosovo _____
- ○ CONUS _____
- ○ Other _____

Name of Operation:

Occupational specialty during this deployment (MOS, NEC or AFSC)

Combat specialty: _____

Administrator Use Only

Indicate the status of each of the following:

Yes	No	N/A	
○	○	○	Medical threat debriefing completed
○	○	○	Medical information sheet distributed
○	○	○	Post Deployment serum specimen collected

33348

Reset

DD FORM 2796, APR 2003 PREVIOUS EDITION IS OBSOLETE. ASD(HA) APPROVED

Please answer all questions in relation to THIS deployment

1. Did your health change during this deployment?

- ○ Health stayed about the same or got better
- ○ Health got worse

2. How many times were you seen in sick call during this deployment?

No. of times

3. Did you have to spend one or more nights in a hospital as a patient during this deployment?

- ○ No
- ○ Yes, reason/dates: _____

_____

_____

4. Did you receive any vaccinations just before or during this deployment?

- ○ Smallpox (leaves a scar on the arm)
- ○ Anthrax
- ○ Botulism
- ○ Typhoid
- ○ Meningococcal
- ○ Other, list: _____
- ○ Don't know
- ○ None

5. Did you take any of the following medications during this deployment?
(mark all that apply)

- ○ PB (pyridostigmine bromide) nerve agent pill
- ○ Mark-1 antidote kit
- ○ Anti-malaria pills
- ○ Pills to stay awake, such as dexedrine
- ○ Other, please list _____
- ○ Don't know

6. Do you have any of these symptoms now or did you develop them anytime during this deployment?

No	Yes During	Yes Now		No	Yes During	Yes Now	
○	○	○	Chronic cough	○	○	○	Chest pain or pressure
○	○	○	Runny nose	○	○	○	Dizziness, fainting, light headedness
○	○	○	Fever	○	○	○	Difficulty breathing
○	○	○	Weakness	○	○	○	Still feeling tired after sleeping
○	○	○	Headaches	○	○	○	Difficulty remembering
○	○	○	Swollen, stiff or painful joints	○	○	○	Diarrhea
○	○	○	Back pain	○	○	○	Frequent indigestion
○	○	○	Muscle aches	○	○	○	Vomiting
○	○	○	Numbness or tingling in hands or feet	○	○	○	Ringing of the ears
○	○	○	Skin diseases or rashes				
○	○	○	Redness of eyes with tearing				
○	○	○	Dimming of vision, like the lights were going out				

7. Did you see anyone wounded, killed or dead during this deployment?
(mark all that apply)

○ No ○ Yes - coalition ○ Yes - enemy ○ Yes - civilian

8. Were you engaged in direct combat where you discharged your weapon?

○ No ○ Yes (○ land ○ sea ○ air)

9. During this deployment, did you ever feel that you were in great danger of being killed?

○ No ○ Yes

10. Are you currently interested in receiving help for a stress, emotional, alcohol or family problem?

○ No ○ Yes

11. Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?

None	Some	A Lot	
○	○	○	Little interest or pleasure in doing things
○	○	○	Feeling down, depressed, or hopeless
○	○	○	Thoughts that you would be better off dead or hurting yourself in some way

33348

Reset

DD FORM 2796, APR 2003

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

No	Yes	
○	○	Have had any nightmares about it or thought about it when you did not want to?
○	○	Tried hard not to think about it or went out of your way to avoid situations that remind you of it?
○	○	Were constantly on guard, watchful, or easily startled?
○	○	Felt numb or detached from others, activities, or your surroundings?

13. Are you having thoughts or concerns that ...

No	Yes	Unsure	
○	○	○	You may have serious conflicts with your spouse, family members, or close friends?
○	○	○	You might hurt or lose control with someone?

14. While you were deployed, were you exposed to:
(mark all that apply)

No	Sometimes	Often	
○	○	○	DEET insect repellent applied to skin
○	○	○	Pesticide-treated uniforms
○	○	○	Environmental pesticides (like area fogging)
○	○	○	Flea or tick collars
○	○	○	Pesticide strips
○	○	○	Smoke from oil fire
○	○	○	Smoke from burning trash or feces
○	○	○	Vehicle or truck exhaust fumes
○	○	○	Tent heater smoke
○	○	○	JP8 or other fuels
○	○	○	Fog oils (smoke screen)
○	○	○	Solvents
○	○	○	Paints
○	○	○	Ionizing radiation
○	○	○	Radar/microwaves
○	○	○	Lasers
○	○	○	Loud noises
○	○	○	Excessive vibration
○	○	○	Industrial pollution
○	○	○	Sand/dust
○	○	○	Depleted Uranium (If yes, explain) _____
○	○	○	Other exposures _____

15. On how many days did you wear your MOPP over garments?

No. of days

16. How many times did you put on your gas mask because of alerts and NOT because of exercises?

No. of times

17. Were you in or did you enter or closely inspect any destroyed military vehicles?

○ No ○ Yes

18. Do you think you were exposed to any chemical, biological, or radiological warfare agents during this deployment?

○ No ○ Don't know
○ Yes, explain with date and location

_____

_____

_____

33348

Reset

DD FORM 2796, APR 2003

Health Care Provider Only

SERVICE MEMBER'S SOCIAL SECURITY # ___ — ___ — ____

Post-Deployment Health Care Provider Review, Interview, and Assessment

Interview

1. Would you say your health in general is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
2. Do you have any medical or dental problems that developed during this deployment? ○ Yes ○ No
3. Are you currently on a profile or light duty? ○ Yes ○ No
4. During this deployment have you sought, or do you now intend to seek, counseling or care for your mental health? ○ Yes ○ No
5. Do you have concerns about possible exposures or events during this deployment that you feel may affect your health? ○ Yes ○ No
   Please list concerns: _____
6. Do you currently have any questions or concerns about your health? ○ Yes ○ No
   Please list concerns: _____

Health Assessment

After my interview/exam of the service member and review of this form, there is a need for further evaluation as indicated below. (More than one may be noted for patients with multiple problems. Further documentation of the problem evaluation to be placed in the service member's medical record.)

REFERRAL INDICATED FOR:

- ○ None
- ○ Cardiac
- ○ Combat/Operational Stress Reaction
- ○ Dental
- ○ Dermatologic
- ○ ENT
- ○ Eye
- ○ Family Problems
- ○ Fatigue, Malaise, Multisystem complaint
- ○ Audiology
- ○ GI
- ○ GU
- ○ GYN
- ○ Mental Health
- ○ Neurologic
- ○ Orthopedic
- ○ Pregnancy
- ○ Pulmonary
- ○ Other _____

EXPOSURE CONCERNS (During deployment):

- ○ Environmental
- ○ Occupational
- ○ Combat or mission related
- ○ None

Comments: _____

I certify that this review process has been completed.
Provider's signature and stamp:

This visit is coded by V70.5 _ _ 6

Date (dd/mm/yyyy) ___ / ___ / ____

End of Health Review

DD FORM 2796, APR 2003

ASD(HA) APPROVED

Reset

33348

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

POST-DEPLOYMENT HEALTH RE-ASSESSMENT (PDHRA)

PRIVACY ACT STATEMENT

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

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

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

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

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

DEMOGRAPHICS

Last Name _____

First Name _____

Middle Initial _____

Social Security Number _____

Date of Birth *(dd/mmm/yyyy)* _____

Today's Date *(dd/mmm/yyyy)* _____

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

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

Gender
- ○ Male
- ○ Female

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

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

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

Pay Grade

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

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

○ Country 1	_____	Months ____
○ Country 2	_____	Months ____
○ Country 3	_____	Months ____
○ Country 4	_____	Months ____
○ Country 5	_____	Months ____

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

Current Contact Information:
Phone: _____
Cell: _____
DSN: _____
Email: _____
Address: _____

Total Deployments in Past 5 Years:

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

Current Unit of Assignment
_____

Current Assignment Location
_____

Point of Contact who can always reach you:
Name: _____
Phone: _____
Email: _____
Mailing Address: _____

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

Service Member's Social Security Number:

1. Overall, how would you rate your health during the PAST MONTH?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

2. Compared to before your most recent deployment, how would you rate your health in general now?

- ○ Much better now than before I deployed
- ○ Somewhat better now than before I deployed
- ○ About the same as before I deployed
- ○ Somewhat worse now than before I deployed
- ○ Much worse now than before I deployed

3. During the past 4 weeks, how difficult have physical health problems *(illness or injury)* made it for you to do your work or other regular daily activities?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

4. During the past 4 weeks, how difficult have emotional problems *(such as feeling depressed or anxious)* made it for you to do your work, take care of things at home, or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

5. Since you returned from deployment, about how many times have you seen a healthcare provider for any reason, such as in sick call, emergency room, primary care, family doctor, or mental health provider?

○ No visits ○ 1 visit ○ 2-3 visits ○ 4-5 visits ○ 6 or more

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Service Member's Social Security Number:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Service Member's Social Security Number: **Date** *(dd/mmm/yyyy)*:

Health Care Provider Only

Provider Review and Interview

1. Review symptoms and deployment concerns identified on form:

○ Confirmed screening results as reported

○ Screening results modified, amended, clarified during interview:

_____

2. Ask behavioral risk questions. Conduct risk assessment.

a. Over the PAST MONTH, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way? ○ Yes ○ No

IF **YES**, about how often have you been bothered by these thoughts? ○ Very few days ○ More than half of the time ○ Nearly every day

b. Since return from your deployment, have you had thoughts or concerns that you might hurt or lose control with someone? ○ Yes ○ No ○ Unsure

3. If member reports positive or unsure response to 2a. or 2b., conduct risk assessment.

a. Does member pose a current risk for harm to self or others? ○ No, not a current risk ○ Yes, poses a current risk ○ Unsure

b. Outcome of assessment ○ Immediate referral ○ Routine follow-up referral ○ Referral not indicated

4. Alcohol screening result

○ No evidence of alcohol-related problems.

○ Potential alcohol problem (positive response to either question 13a. or 13b. and/or AUDIT-C (questions 13c.-e.) score of 4 or more for men or 3 or more for women).
Refer to PCM for evaluation. ○ Yes ○ No

5. Traumatic Brain Injury (TBI) risk assessment

○ No evidence of risk based on responses to questions 9.a. - d.

○ Potential TBI with persistent symptoms, based on responses to question 9d.
Refer for additional evaluation. ○ Yes ○ No

6. Record additional questions or concerns identified by patient during interview:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DD FORM 2900, JAN 2008

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

Service Member's Social Security Number: **Date** *(dd/mmm/yyyy)*:

Assessment and Referral: After my interview with the service member and review of this form, there is a need for further evaluation and follow-up as indicated below. (More than one may be noted for patients with multiple concerns.)

7. Identified Concerns	Minor Concern	Major Concern	Already Under Care	
			Yes	No
○ Physical Symptom(s)	○	○	○	○
○ Exposure Symptom(s)	○	○	○	○
○ Depression symptoms	○	○	○	○
○ PTSD symptoms	○	○	○	○
○ Anger/Aggression	○	○	○	○
○ Suicidal Ideation	○	○	○	○
○ Social/Family Conflict	○	○	○	○
○ Alcohol Use	○	○	○	○
○ Other: _____	○	○	○	○

9. Comments:

8. Referral Information	Within 24 hours	Within 7 days	Within 30 days
a. Primary Care, Family Practice	○	○	○
b. Behavioral Health in Primary Care	○	○	○
c. Mental Health Specialty Care	○	○	○
d. Other specialty care:			
Audiology	○	○	○
Cardiology	○	○	○
Dentistry	○	○	○
Dermatology	○	○	○
ENT	○	○	○
GI	○	○	○
Internal Medicine	○	○	○
Neurology	○	○	○
OB/GYN	○	○	○
Ophthalmology	○	○	○
Optometry	○	○	○
Orthopedics	○	○	○
Pulmonology	○	○	○
Urology	○	○	○
e. Case Manager, Care Manager	○	○	○
f. Substance Abuse Program	○	○	○
g. Health Promotion, Health Education	○	○	○
h. Chaplain	○	○	○
i. Family Support, Community Service	○	○	○
j. Military OneSource	○	○	○
k. Other: _____	○	○	○
l. No referral made ○			

I certify that this review process has been completed.

10. Provider's signature and stamp:

ICD-9 Code for this visit: V70.5 _ F

S A M P L E

Ancillary Staff/Administrative Section

11. Member was provided the following:	12. Referral was made to the following healthcare or support system:
○ Health Education and Information	○ Military Treatment Facility
○ Health Care Benefits and Resources Information	○ Division/Line-based medical resource
○ Appointment Assistance	○ VA Medical Center or Community Clinic
○ Service member declined to complete form	○ Vet Center
○ Service member declined to complete interview/assessment	○ TRICARE Provider
○ Service member declined referral for services	○ Contract Support: _____
○ LOD	○ Community Service: _____
○ Other: _____	○ Other: _____
	○ None

DD FORM 2900, JAN 2008 Page 5 of 5 Pages