

Behavioral Health Conditions Among Military Personnel and Veterans: Prevalence and Best Practices for Treatment

Mira Brancu, Kristy Straits-Tröster, Harold Kudler

The Department of Defense and the Department of Veterans Affairs place a high priority on behavioral health assessment, treatment, and research. We present the national and regional prevalence of the most-common behavioral health problems experienced by Operation Enduring Freedom and Operation Iraqi Freedom veterans and offer resources for best practices for treatment.

Scope of the Problem

Since 2002, approximately 2.1 million troops have served in the military conflicts in Afghanistan and Iraq (Operation Enduring Freedom [OEF] and Operation Iraqi Freedom [OIF], respectively), with more than 1.2 million separated from active duty following deployment. Half of the individuals eligible for Department of Veterans Affairs (VA) health care have enrolled to receive such care, and of these, 50.2% received a diagnosis of a mental health disorder at a VA health care center, with posttraumatic stress disorder (PTSD) being the most common mental health diagnosis, followed by depression [1]. In response to the growing postdeployment mental health needs of service members returning from combat, the Department of Defense (DoD) and the VA have placed a high priority on behavioral health assessment, treatment, and research. The purpose of this commentary is to present the national and regional prevalence of the most-common behavioral health problems experienced by OEF/OIF veterans and to offer resources for best practices in treating these problems. Of note, data in this commentary were gathered from research on OEF/OIF veterans. There are no new data for the new cohort of service members involved with Operation New Dawn, which began in September 2010.

Prevalence proportions of mental health problems vary according to the population assessed, differences in assessment protocols, the duration of the study and the time at which it is performed, and the frequency and intensity (hereafter referred to as "level") of combat exposure. Proportions are also higher after deployment, likely because of the impact of combat exposure on mental health. Soldiers with multiple deployments, particularly those with 3 or 4 deployments and those with a reduced length of time between deployments (ie, "dwell time"), report more psychological

concerns, acute stress, marital problems, and medication use for psychological or combat stress-related problems, as well as lower morale, than do those on their first or second deployment [2].

The combined prevalence of psychological problems (defined as depression, anxiety, or acute stress) in theater (ie, during deployment) among OEF soldiers increased from 10.4% in 2005 to an estimated 21.4% in 2009, with an associated increase in the level of combat exposure [2]. Conversely, for OIF soldiers in theater, the prevalence decreased to 11.9% in 2009, with an associated decline in combat exposure [2]. However, the level of combat exposure remain quite high: up to 83% of combat veterans reported experiencing potentially traumatic combat experiences [2, 3].

The prevalence of psychological problems significantly increases after deployment, ranging from 20% to 38% among active-duty service members and from 42% to 49% among reserve-component service members (ie, individuals in the National Guard or armed forces reserves) [3, 4]. National prevalence proportions of PTSD and depression among service members generally range from 10% to 25% and from 8% to 14%, respectively [5, 6]. These proportions are significantly higher than those in the general population (ie, 3%-5% for depression and 3%-7% for PTSD) [5, 7]. Table 1 lists the most commonly diagnosed mental health disorders for OEF/OIF veterans who sought care at a VA facility between 2002 and 2010. For many veterans, these diagnoses co-occur.

Substance use disorders (SUDs) often co-occur with PTSD and depression, likely because alcohol and drugs are often employed to cope with these difficulties. Substance use often complicates treatment for PTSD and depression and creates additional negative consequences for work performance, health, and relationships [3, 7]. Research indicates that, while some level of heavy or regular alcohol use

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Address correspondence to Dr. Mira Brancu, MIRECC, Bldg 5, Durham VA Medical Center, 508 Fulton St, Durham, NC 27705 (mira.brancu@va.gov). **N C Med J. 2011;72(1):54-60.** ©2011 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2011/72112

The Citizen Soldier Support Program: A Case Study

Robert Goodale, William Abb, Jessica T. Meed, Thu-Mai Christian, Harold Kudler, Kristy Straits-Tröster

The congressionally authorized Citizen Soldier Support Program (CSSP) serves as a model for collaboration between the Department of Defense (DoD), the Department of Veterans Affairs (VA), and state and community health care professionals to expand access to local, culturally and clinically competent behavioral health care among the families of armed forces reservists.

Background. Reservists and their families face the same multiple deployments, behavioral health risks, and marital and family problems as members of the active-duty force. Yet reservists continue to lack access to many of the support services available to active-duty service members on military bases, including medical, peer support, and chaplain services. While the federal government has taken steps to increase reserve-component access to services, including expanding TRICARE benefits and creating the Yellow Ribbon Reintegration Program, there continues to be a lack of continuity between programs initiated by the federal government and programs initiated by state governments and local communities. As a result, reservists and their families encounter barriers when they try to access needed behavioral health-related assistance. The CSSP at the University of North Carolina-Chapel Hill is Congressionally authorized to address this problem. The CSSP serves as a unifying model for DoD, VA, state, and community partnerships to meet the needs of reservists and their families.

Assessing the needs. The CSSP employs a combination of quantitative and qualitative methods, including geographic information system (GIS) analysis, to determine the adequacy of health care professional coverage and to identify gaps in behavioral health and family support services accessible to

reservists and their families, by comparing reservist residency and deployment data to the location of military treatment facilities and VA health care centers.

The CSSP also conducts qualitative focus groups to better understand how and where reserve-component members want to access behavioral health services. To identify gaps in the current system, the CSSP challenged support services with hypothetical cases to validate that their process could respond to the needs of reservists' families living throughout the state. Finally, the CSSP participates in work groups focused on improving care for veterans, service members, and their families, including the North Carolina Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families and the North Carolina Governor's Focus on Service Members, Veterans, and Their Families.

Generating solutions. One of the CSSP's most important findings was that even though reservists' families normally get their care from local civilian health care professionals, they want professionals who can identify signs of a deployment-related behavioral health and/or functional problem and refer the individual for appropriate follow-up care. Because most civilian health care professionals do not understand the impact of deployment on behavioral health, the CSSP partnered with staff from Camp Lejeune, the North Carolina Area Health Education Center (AHEC) program, and the VA's Mid-Atlantic Veterans Integrated Service Network Mental Illness Research, Education, and Clinical Center to create courses that introduce civilian community health care professionals to military culture and deployment behavioral health issues (available at: <http://www.aheconnect.com/citizen-soldier>). The courses combine presentations by Operation

may start in the military as part of military culture, individuals who deploy and experience combat are at increased risk for postdeployment alcohol-related problems (eg, difficulty cutting down or drinking more than planned), with a prevalence of 11.8% for active-duty service members and 15% for reserve-component members [3]. Among VA users, almost 22% of veterans with PTSD also received an SUD diagnosis in 2008; the rate was 70% for veterans hospitalized for PTSD [7]. Given the high prevalence of comorbid SUD and PTSD, the VA mandated the addition of an SUD specialist to each of its PTSD clinical teams in 2008.

New Developments and Best Practices for Treatment and Management of Common Behavioral Health Disorders

It is estimated that evidence-based care for treating mental health conditions after deployment would pay for itself within 2 years and could save as much as \$1.7 billion (\$1,063 per veteran) as a result of increased productivity and reduced medical and mortality costs [6]. Evidence-

TABLE 1.
Mental Health (MH) Disorders Diagnosed at Department of Veterans Affairs (VA) Facilities During 2002-2010

Diagnosis	No.	All patients, % (N=625,384)	Patients who used MH services, % (N=398,981)
PTSD*	167,295	27	42
Depressive disorders	122,175	20	31
Anxiety (non-PTSD)	102,767	16	26
Drug abuse	27,714	4.4	7
Drug dependence	16,799	2.7	4
Alcohol abuse	20,834	3.3	5
Alcohol dependence	33,660	5	8
Tobacco use disorder	85,671	14	21

Note. Data are for VA inpatients and outpatients who served in Operation Enduring Freedom or Operation Iraqi Freedom [1].

*Of the total number of individuals with a diagnosis of posttraumatic stress disorder (PTSD), 11,656 received treatment for PTSD at VA medical centers in the Mid-Atlantic Veterans Integrated Health Care System Number 6, which includes North Carolina, Virginia, and parts of West Virginia.

Enduring Freedom and Operation Iraqi Freedom veterans and their family members with lectures by health care experts to illustrate the social and clinical aspects of deployment-associated behavioral health problems and to explain how local health care professionals can work with the DoD and the VA to improve continuity of care. Nationwide, over 9,000 health care professionals have participated on-site or online.

Our GIS analysis indicated a shortage of TRICARE health care professionals in certain counties, particularly rural counties. To address this problem, the CSSP partnered with Health Net Federal Services to recruit professionals into the TRICARE system. Particular emphasis was placed on recruiting professionals who had taken a course delivered through the AHEC program.

Increasing the number of TRICARE health care professionals is not enough to solve the problem of access to care. High unemployment among reservists not currently activated means that many lack access to affordable health insurance for themselves and their dependents. Reservists who never deployed are ineligible for care through the VA or TRICARE. The lack of access to care provided by informed health care professionals can hinder unit readiness and may contribute to increased morbidity. To address concerns related to insurance, the CSSP worked with the Mountain AHEC to place culturally competent health care professionals in community health clinics.

Finally, needs assessments showed that finding appropriate care for reservists and members of their extended families, many of whom (ie, parents, siblings, and spouses or significant others) are not dependents of the service member, was an issue. Nondependent family members are not eligible for TRICARE, VA, or Military OneSource coverage, yet they may still desire treatment for deployment-related behavioral health problems from health care professionals who understand military culture and deployment. To improve the ability

of reservists and their family members to find local, culturally competent health care, the CSSP created an online directory (available at: <http://www.warwithin.org>) that lists behavioral health and primary care professionals who have expressed a specific interest in working with military members and their families. The directory provides the user with information about culturally competent health care professionals within their own communities, including the professional's clinical specialty, special training on deployment health issues or military experience, and type of insurance accepted (with special attention to TRICARE). NCMJ

Robert Goodale, MBA Citizen Soldier Support Program, Odum Institute for Research in Social Sciences, University of North Carolina-Chapel Hill, Chapel Hill, North Carolina.

William Abb Citizen Soldier Support Program, Odum Institute for Research in Social Sciences, University of North Carolina-Chapel Hill, Chapel Hill, North Carolina.

Jessica T. Meed, MPA Citizen Soldier Support Program, Odum Institute for Research in Social Sciences, University of North Carolina-Chapel Hill, Chapel Hill, North Carolina.

Thu-Mai Christian, MA Citizen Soldier Support Program, Odum Institute for Research in Social Sciences, University of North Carolina-Chapel Hill, Chapel Hill, North Carolina.

Harold Kudler, MD associate director, Mid-Atlantic Mental Illness Research, Education, and Clinical Center, Durham Veterans Affairs Medical Center, and Duke University, Durham, North Carolina.

Kristy Straits-Tröster, PhD, ABPP assistant director, Mid-Atlantic Mental Illness Research, Education, and Clinical Center, Durham Veterans Affairs Medical Center, and Duke University, Durham, North Carolina.

Address correspondence to Mr. Robert Goodale, Citizen Soldier Support Program, University of North Carolina-Chapel Hill, Campus Box 3355, Chapel Hill, NC 27599 (goodale@email.unc.edu).

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based treatment guidelines on best practices are available to all clinicians, from a number of sources; most are available online at no cost (Table 2). A summary of best practices for treating these disorders is presented in Table 3.

Other Related Behavioral Health Concerns

Traumatic brain injury (TBI). In addition to mental health problems, TBI, especially mild TBI (ie, concussion), is considered a signature injury of the Iraq and Afghanistan wars. The prevalence of TBI has increased since past wars, largely because of modern technology, which has improved survival rates from blast-related injuries. The postdeployment prevalence of probable TBI among OEF/OIF veterans is estimated to be between 19% and 22% [6, 7]. Within the VA, from April 2007 through fiscal year 2009, a total of 66,023 OEF/OIF veterans were identified on the basis of VA outpatient screening as possibly having a TBI [10]. Of these, 37% had a confirmed TBI. Battle-injured individuals are also more likely to have additional TBIs, compared with individuals injured outside of battle [10].

The presence of PTSD, depression, or other psycho-

logical problems often complicates recovery from TBI. Approximately 5% of OEF/OIF veterans report experiencing co-occurring PTSD, depression, and TBI, since many TBIs are related not only to a blast-related physical injury, but also to a traumatic event [6]. Among OEF/OIF veterans with physical injuries, chronic pain is also seen. In June 2009, a VA/DoD interdisciplinary consensus panel was convened to make specific practice recommendations to improve health care services, educational programs, and systems coordination at VA health care centers for veterans with PTSD, pain, and/or mild TBI [7]. The panel's recommendations include improved routine screening and comprehensive assessment, which will require clinician education and outreach across multiple models of care, and increased dissemination of current clinical practice guidelines for mild TBI, PTSD, chronic pain, and related disorders. The VA currently has established more than 100 VA medical centers that offer specialized rehabilitation care including rehabilitation centers, regional network sites, and interdisciplinary clinical teams.

Military sexual trauma (MST). The lifetime prevalence of sexual victimization among male military members is 3%,

TABLE 2.
Sources of Information on Best Practices for Postdeployment Treatment of Mental Health Conditions in Veterans

Source	Disorder(s)	Reference
VA/DoD Practice Guidelines	Depression, acute stress, PTSD, SUD, TBI, co-occurring chronic pain	http://www.healthquality.va.gov/
VA National Center for PTSD	Depression, acute stress, PTSD, SUD, TBI, co-occurring chronic pain	http://www.ptsd.va.gov
Defense Centers of Excellence for Psychological Health & Traumatic Brain Injury	Depression, acute stress, PTSD, SUD, TBI, co-occurring chronic pain	http://www.dcoe.health.mil
Integrated report of recommended PTSD treatments across multiple international sources	PTSD	Forbes et al. [8]
Invisible Wounds of War Series—Citizen Soldier Support Program ^a	PTSD, women veterans' issues	http://www.aheconnect.com/citizensoldier

Note. DoD, Department of Defense; PTSD, posttraumatic stress disorder; SUD, substance use disorder; TBI, traumatic brain injury; VA, Veterans Affairs.

^aAn online accredited training program for non-VA clinicians [9].

which is approximately equal to the rate for the general US population [11]. However, for military women, the prevalence is estimated to be 23%-33%, which is significantly higher than the 17% prevalence for the general female population in the United States. Women are also more likely to be revictimized in the military than in the civilian world.

Sexual trauma is 4 times as likely to result in a PTSD diagnosis than is combat-related stress, and it usually results in more-adverse consequences when it occurs during military service, because of associated psychological, physical, and readjustment problems; reduced safety options; difficulty filing a complaint; and other issues related to military life and career. In addition to a high prevalence of PTSD for those with MST experiences, almost a third also experience at least 1 episode of depression during their lives. Furthermore, victims of sexual assault are approximately 3 times as likely to use marijuana, 6 times as likely to use cocaine, and 10 times as likely to use other major drugs [11, 12].

Among returning veterans seeking treatment at a VA health care center, approximately 1 in 5 women and 1 in 100 men told their VA health care professionals that they experienced sexual trauma in the military. Given concerns about stigmatization, these proportions likely underestimate of the actual prevalence among VA patients. According to national VA data for 242,099 OEF/OIF veterans who were screened for MST in 2009, 3% (7,274) screened positive for potentially having experienced an MST [12]. Of these, 5,590 were women, and 1,684 were men.

Since 1992, Congress has passed several laws that address MST-related treatment for veterans, including (1) that VA health care professionals receive training and education related to MST, (2) that the VA provides counseling services for male and female victims of MST, and (3) that there be no limits on the duration of care provided. The VA has also (1) required that all VA patients undergo screening for MST, (2) ensured that each medical center has a MST coordinator to oversee screening, treatment, and staff education related to MST, and (3) guaranteed that MST-related physical and mental health treatment is provided free of

charge to all veterans, regardless of whether they are eligible for other VA care [11]. Behavioral health interventions for MST are generally similar to treatment of PTSD and any trauma-related co-occurring problems, such as depression and substance use.

Suicide. Approximately 1% of service members who were deployed report having thought about suicide at least some of the time [13]. Suicide is the second-leading cause of death in the Marine Corps. The Army has the highest proportion of suicides among the armed services [14, 15]. Until 2005, military suicide rates were generally lower than those for the general US population. For example, during 1999-2005, there were 12.0 suicides per 100,000 population among personnel in the Department of the Navy (10.7 cases/100,000 for the Navy and 14.6 cases/100,000 for the Marine Corps), compared with approximately 18 suicides per 100,000 population for the US civilian population, after adjustment for demographic characteristics [14]. However, since 2005, suicides have increased, surpassing civilian rates each year since 2005 for the Army and each year since 2007 for the Marine Corps [14]. In the past 2 years, the rates have finally stabilized, likely because of the significant suicide prevention efforts by all branches of the military and the VA (discussed below). The 2008 in-theater suicide rate among all OIF service members was 21.5 cases per 100,000 population; this was the first time the annual suicide rate had not increased since 2004 [2]. Key risk factors include depression, PTSD, SUD, and TBI, especially when a number of these problems occur together.

There have been numerous suicide prevention efforts within the VA and DoD, including the Veterans Crisis Line (1-800-273-TALK) and online resources (available at: <http://www.suicidepreventionlifeline.org>), which offer veterans 24/7 access to trained counselors. Call center staff can make immediate direct referrals to any VA treatment center across the country. In addition, each branch of the military has developed a comprehensive suicide prevention program that includes training for personnel in leadership positions, education about risk factors and intervention/prevention measures

TABLE 3.
Common Mental Health Conditions and Treatment Recommendations for Veterans Who Served in Operation Enduring Freedom or Operation Iraqi Freedom

Condition	Recommendations	
	General	Other
PTSD [5, 7, 8]	Psychotherapy: CBTs such as prolonged exposure and cognitive-processing therapy, as well as eye-movement-desensitization reprocessing, are considered first-line treatments for PTSD. Brief psychodynamic therapy can also be considered, although its evidence base is less strong. Medication: SSRIs—in particular, fluoxetine, paroxetine, and sertraline—are strongly recommended (they can also be considered for veterans with co-occurring SUDs), as are SNRIs, specifically venlafaxine. There is also some support for mirtazapine, nefazodone, tricyclic antidepressants, amitriptyline, and imipramine or monoamine oxidase inhibitors (eg, phenelzine). Atypical antipsychotics (eg, risperidone, olanzapine, or quetiapine) are only recommended as adjunctive therapy for PTSD. Acupuncture can be considered for patients with PTSD. Imagery rehearsal therapy or prazosin, a generically available alpha-1 adrenoreceptor antagonist, can be considered as adjunctive treatment for nightmares and sleep disruption. Relaxation techniques should be considered for alleviating symptoms associated with physiological hyperreactivity. Hypnotic techniques can be considered for symptoms associated with PTSD, such as pain, anxiety, dissociation, and nightmares. Additional recommendations for early interventions (within the first month after trauma exposure) and co-occurring problems (eg, insomnia, anger, agitation, and pain) can be found in the sources listed in Table 2.	Additionally, CAM approaches (eg, mindfulness, yoga, and massage) that facilitate a relaxation response can be considered for adjunctive treatment.
Depression [5]	Mild depression can be effectively treated with either medication or psychotherapy. Moderate-to-severe depression may require combining medication and psychotherapy. Medication: SSRIs, excluding fluvoxamine, along with the SNRIs, such as bupropion and mirtazapine, are considered a first-line treatment options. No particular antidepressant agent is superior to another with regard to efficacy or time to response. Psychotherapy: Short-term psychotherapies, such as CBT, interpersonal therapy, and problem-solving therapy, for the primary care setting are recommended for the treatment of uncomplicated major depression. For severe depression, behavioral activation is recommended, with CBT as a secondary treatment option. For severe, recurrent (ie, ≥ 3 episodes), or chronic major depression, CBT in combination with pharmacotherapy is recommended. Continuing therapy (up to 9-12 months after acute symptoms resolve) decreases the incidence of relapse of major depression. Electroconvulsive therapy, with some medical caveats, should be considered for patients with severe major depressive disorder who cannot tolerate or have not responded to several trials of antidepressant treatment.	Additional CAM approaches that have some support include exercise, St. John's wort, and light therapy (for seasonal pattern depression).
SUDs [5, 7]	Initial and ongoing screening is strongly recommended, and specific screening instruments are recommended. A combination of medications and addiction-focused counseling is recommended, with consideration of the patient's previous treatment experience, the patient's preference, and the use of motivational interviewing. Medications: Naltrexone and disulfiram should be offered as a treatment strategy for alcohol-use disorders, if indicated, and there is some preliminary evidence they may have some direct benefit for PTSD symptoms. Benzodiazepines are generally recommended only for alcohol detoxification/withdrawal stages. Buprenorphine/naloxone should be used, when clinically indicated, for opiate dependence. Addiction-focused counseling: Psychotherapy options that are rated include behavioral couples therapy, cognitive behavioral coping-skills training, the community-reinforcement	...

TABLE 3 CONTINUED.
Common Mental Health Conditions and Treatment Recommendations for Veterans Who Served in Operation Enduring Freedom or Operation Iraqi Freedom

Condition	Recommendations	
	General	Other
	approach, contingency management/motivational incentives, motivational enhancement therapy, and 12-step facilitation. Coordinate addiction-focused interventions with evidence-based interventions for other biopsychosocial problems (eg, CBT for PTSD) in the least restrictive setting necessary for safety and effectiveness. Tobacco-cessation treatment should be offered to all patients with nicotine dependence. Employ stabilization/relapse-prevention interventions, such as motivational interviewing techniques and Seeking Safety therapy.	
TBI [5, 7]	Specific behavioral and medication interventions are based on severity of TBI and co-occurring symptoms and are patient specific. Since 90% of patients have mild cases and experience full recovery, early intervention involving education and a focus on recovery is strongly recommended. PTSD treatments such as cognitive processing therapy, prolonged exposure, or SSRIs can also work well for veterans with mild TBI and emotional trauma. Memory aids, occupational rehabilitation, and case management should be considered, depending on the severity of the injuries. Patients should be referred to specialists (ie, neurologists, neuropsychologists, and substance abuse counselors) as needed. Collaborative interdisciplinary care is a critical element of treatment success, especially for more-severe cases.	Comprehensive neuropsychological/cognitive testing should not be done within 30 days after injury.

Note. CAM, complementary and alternative medicine; CBT, cognitive behavioral therapy; PTSD, posttraumatic stress disorder; SNRI, serotonin norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor; SUD, substance use disorder; TBI, traumatic brain injury.

for all service members, and collaboration across support services and national veterans programs.

Family impact. Psychological stress among family members of deployed and returning OEF/OIF veterans, while yet to be fully quantified, is also an area of concern [6]. Family members experience high caregiver burdens and stress related to caring for veterans who have sustained physical and psychological wounds of war. Additionally, more than 5,500 US service members have been killed in action during OEF/OIF [1], and their bereaved family members often require support and, sometimes, mental health care. The VA has declared family support a top priority for mental health research, assessment, and treatment.

Population-Based Approaches

On a final note, the VA has partnered with the Citizen Soldier Support Program [9], administered by the Odum Institute for Research in Social Sciences at the University of North Carolina–Chapel Hill, and the North Carolina Area Health Education Centers, to improve access to quality care for service members, veterans, and their family members who seek services outside of DoD and VA medical systems. The educational public health initiative Painting a Moving Train: Working with Veterans of Iraq and Afghanistan and

Their Families provides military cultural-competence training for mental health and primary care providers, informs them about the nature of deployment stress, introduces them to DoD and VA treatment resources, and reviews available best practices and community resources. Particular emphasis has been made in working with rural providers, who may be treating reserve-component members and veterans who do not have immediate access to a DoD or VA medical center. To date, more than 9,000 providers have completed at least 1 of the 3 Painting a Moving Train program trainings in PTSD, TBI, and Issues Facing Women Veterans (Table 2).

Conclusion

A broad range of mental health problems, including PTSD, depression, substance use, and TBI, may affect returning OEF/OIF veterans and their family members. Early interventions may increase the likelihood of recovery and readjustment and are now described in new national clinical practice guidelines. Although the majority of service members will transition to civilian life without developing a mental health problem, ready access to best treatments and an understanding of key issues for service members, veterans, and their families are foundational if North Carolina medical providers are to deliver informed care. NCMJ

Mira Brancu, PhD clinical psychologist and managing director, VISN 6 Registry Project, Mid-Atlantic Mental Illness Research, Education, and Clinical Center, Durham Veterans Affairs Medical Center, and Duke University, Durham, North Carolina.

Kristy Straits-Tröster, PhD, ABPP assistant director, VISN 6 Mid-Atlantic Mental Illness Research, Education, and Clinical Center, Durham Veterans Affairs Medical Center, and Duke University, Durham, North Carolina.

Harold Kudler, MD associate director, VISN 6 Mid-Atlantic Mental Illness Research, Education, and Clinical Center, Durham Veterans Affairs Medical Center, and Duke University, Durham, North Carolina.

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