

# The Citizen Soldier Support Program: A Case Study

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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, %<br>(N=625,384) | Patients who used<br>MH services, %<br>(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

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#### Acknowledgment

Presented in part: Interagency Medical Service Corps Chief poster session, 116th Annual Meeting of the Association of Military Surgeons of the United States; November 2, 2010; Phoenix, AZ.

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%,