An Assessment of Mental Health Services for Veterans in the State of Texas

Lyndon B. Johnson
School of Public Affairs
The University of Texas at Austin
Policy Research Project Report

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Table of Contents

List of Tables vi

List of Figures viii

List of Acronyms ix

Foreword xi

Acknowledgements and Disclaimer xiii

Executive Summary xv

Chapter 1. Provision of Veterans' Mental Health Care 1

Chapter 2. Who Are Texas Veterans? 7

Chapter 3. Types of Veterans' Mental Health Challenges 12

Chapter 4. Types of Mental Health Services and Treatment 18

Chapter 5. Recent Mental Health Policy Changes 23

Chapter 6. Federal Mental Health Services 26

- Challenges and Opportunities in the Federal System 32

Chapter 7. Texas State and Local Mental Health Services 37

- County-and City Administered Programs 40
- Challenges and Opportunities in the State System 41

Chapter 8. Nonprofit Veterans' Services 46

- Intrepid Fallen Heroes Fund 48

Chapter 9. Economic Impact of Veterans' Mental Health 55

- Cost and Benefits 55
- Funding Mechanisms and Measures 59

Chapter 10. Policy Recommendations 61

Attachment 1. Documentary videos (included on a DVD in a sleeve)

List of Tables

Table 1.1 Structural Barriers to Veterans' Mental Health Care 2

Table 1.2 Cultural Barriers to Veterans' Mental Health Care 3

Table 1.3 Policy Recommendations 4

Table 2.1 Race and Ethnicity of Texas Veterans and Nonveterans, 2011 8

Table 2.2 Percentage of Male and Female Texas Veterans by Period of Service, 2011 9

Table 3.1 Mental Health Issues and Definitions 13

Table 4.1 Services for Mental Health Recovery 19

Table 4.2 Types of Complementary and Alternative Medicine Therapies 20

Table 5.1 VA Performance Measures for Improving Veterans' Mental Health 24

Table 6.1 DoD Mental Health Programs and Services 29

Table 6.2 VA Mental Health Programs and Services 30

Table 6.3 Challenges to Mental Health Care in Federal Systems.........................32

Table 6.4 Opportunities for Veterans' Mental Health Care in Federal System 33

Table 7.1 Veterans' Services Administered by the State of Texas 39

Table 7.2 Veterans' Services Administered by Counties in Texas 40

Table 7.3 Examples of Veterans' Services Administered by Cities in Texas 41

Table 7.4 Challenges for Veterans' Mental Health Care at State and Local Level42

Table 7.5 Opportunities for Veterans' Mental Health Care at State and Local Level 43

Table 8.1 TexVet Services 48

Table 8.2 Notable TexVet Partners..49

Table 8.3 Veterans' Services Administered by National Nonprofits 50

Table 8.4 Veterans' Services Administered by Texas Nonprofits 50

Table 8.5 Challenges for Veterans' Mental Health Care in Non-Profit System 51

Table 8.6 Opportunities for Veterans' Mental Health Care in Non-Profit System 52

Table 9.1 Veterans' Mental Health Estimate of Costs 55

Table 9.2 Outline of Themes in Recommended Funding Mechanisms and Administrative Funding Approaches to Mental Health Funding......60

Table 10.1 Policy Recommendations for Federal Agencies 66

Table 10.2 Policy Recommendations for Texas State Agencies 67

Table 10.3 Policy Recommendations for Nonprofit Organizations.......................67

Table 10.4 System-wide Policy Recommendations..68

List of Figures

Figure 2.1 U.S. Veterans' Period of Service 7

Figure 2.2 Number of Texas Veterans and Percent of Population, 1980-2010 9

Figure 2.3 Distribution of Texas Veteran Population 10

Figure 6.1 Federal Mental Health Service Locations in Texas 27

Figure 7.1 Texas Mental Health Service Locations 37

Figure 8.1 Nonprofit Veterans' Mental Health Service Locations in Texas 47

Figure 9.1 Veterans' Mental Health: RAND Cost Estimate 56

Figure 9.2 Positive Externality Associated with Treatment of Mental Illness for Veterans 59

Figure 10.1 Veterans Service Locations in Texas: Federal, State and Nonprofit ..65

List of Acronyms

AVFAC	Austin Veteran and Family Advocacy Council
CAM	Complementary or Alternative Medicine
CBOC	Community-Based Outpatient Clinics
CBT	Cognitive Behavioral Therapy
CDP	Center for Deployment Psychology
DCoE	Defense Center of Excellence for Phsychological Health and Traumatic Brain Injury
DARS	Department of Assistive and Rehabilitative Services
DFPD	Department of Family and Protective Services
DSHS	Texas Department of State Health Services
DoD	Department of Defense
DSPO	Defense Suicide Prevention Office
EBT	Evidence-Based Therapies
FVA	Texas Veterans Commission Fund for Veterans' Assistance
HHS	Department of Health and Human Services
HHSC	Texas Health and Human Services Commission
IED	Improvised Explosive Device
JCF-T	Joining Community Forces: Texas
MOS	Military OneSource
MST	Military Sexual Trauma
NCVAS	National Center for Veterans Analysis and Statistics
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom

PDHA	Post-Deployment Health Assessment
PDHRA	Post-Deployment Health Reassessment
PTSD	Post-Traumatic Stress Discorder
SATP	Substance Abuse Treatment Program
SPC	Suicide Prevention Coordinator
SUD	Substance Abuse Disorder
TBI	Traumatic Brain Injury
TCCC	Texas Council Community MHMR Center
TCCVS	Texas Coordinating Council for Veterans Services
TIDC	Texas Indigent Defense Commission
TVC	Texas Veterans Commission
TWC	Texas Workforce Commision
TxMF	Texas Military Forces
VA	Department of Veterans Affairs
VA/CT	Department of Veterans Affairs in Central Texas
VES	Veterans Employment Services
VISN	Veterans Integrated Service Network
VRRS	Veterans Resource and Referral Specialists
VSO	Veterans Services Organization
VSPN	Veterans Services Provider Network
WWRC	Wounded Warrior Resource Center

Foreword

The Lyndon B. Johnson School of Public Affairs has established interdisciplinary research on policy problems as the core of its educational program. A major part of this program is the nine-month policy research project, in the course of which one or more faculty members direct the research of ten to twenty graduate students of diverse backgrounds on a policy issue of concern to a government or nonprofit agency. This "client orientation" brings the students face to face with administrators, legislators, and other officials active in the policy process and demonstrates that research in a policy environment demands special talents. It also illuminates the occasional difficulties of relating research findings to the world of political realities.

This report evaluates some of the challenges faced by U.S. military veterans and their families in seeking, navigating, and attaining mental health care in Texas. The report describes veterans' mental health services at the national, state, and local levels within Texas. It assesses barriers to care based on government reports, the scholarly literature, discussions with agency personnel, and interviews with veterans and providers of mental health services. The report offers recommendations for federal, state, and local governments as well as the for-profit and non-profit private sectors to improve mental health care in Texas through more comprehensive, effective, and efficient services.

The curriculum of the LBJ School is intended not only to develop effective public servants, but also to produce research that will enlighten and inform those already engaged in the policy process. The project that resulted in this report has helped to accomplish the first task; it is our hope that the report itself will contribute to the second.

Finally, it should be noted that neither the LBJ School nor The University of Texas at Austin necessarily endorses the views or findings of this report.

Robert Hutchings
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Acknowledgements and Disclaimer

Curtis W. Meadows, Jr., of Dallas developed the concept for this project and encouraged both the Lyndon Baines Johnson School of Public Affairs (LBJ School) at The University of Texas at Austin (UT Austin) and the Meadows Foundation of Dallas to implement the study. This project was an activity of the Curtis W. Meadows Jr. Social Enterprise Fellows Program of the RGR Center for Philanthropy and Community Service of the LBJ School and UT Austin. The report is dedicated to Curtis Meadows and his commitment to enabling LBJ School and UT Austin graduate students to develop career opportunities as non-profit leaders.

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Rebecca Hornbach, Lauren Marcotte and Lindsay Read, all graduate students at the LBJ School, drafted this report during the 2013-2014 academic year. Aileen Ford, Alexander Leist, and Lauren Seymour, also graduate students at the LBJ School, photographed, produced, and edited two video documentaries that are included with this report.

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Executive Summary

This report describes the complex challenges faced by veterans and their families in seeking, navigating, and attaining adequate mental health care in Texas. There are 1.7 million veterans in Texas, comprising 8.6 percent of the adult population. According to the U.S. Department of Veterans Affairs (VA), the number of veterans requiring mental health services has grown dramatically and will continue to increase, making veterans' mental health care an urgent issue in Texas. The federal agencies responsible for the military's and veterans' mental health care, the U.S. Department of Defense (DoD) and the VA, have created new programs and invested significant financial and staff resources. Texas state agencies have increased funding and instituted new mental health programs supporting returning veterans. Nonprofit agencies focused on veterans' mental health have multiplied across Texas and the U.S. over the past decade to fill gaps in care. While these organizations provide a growing and increasingly diverse set of resources for veterans to extend the scope of support, volunteer efforts can suffer from fragmentation and overlap.

The report provides an overview of mental health services at the national, state, and local levels for Texas veterans. It identifies current practices, challenges, and opportunities within and across each group of service providers. The report draws on government reports, scholarly literature, and agency websites, as well as interviews with counselors, Veterans Services Officers, nonprofit providers, state officials, and veterans themselves.

This report offers recommendations toward the goal that veterans' mental health care in Texas become comprehensive, inclusive, effective, and efficient. There are five ways that the network of federal, state, and local service providers and nonprofit agencies and programs can improve veterans' mental health services in Texas. First, there is a need for greater inter-agency communication across organizations, improved outreach efforts, and increased services for hard-to-reach populations, such as homeless veterans. Second, federal agencies ought to address staff shortages, improve the transition from DoD to VA care, and increase feedback. Third, at the state level, specialized services are needed to address unique veterans' needs concentrated in cities across Texas as well as those dispersed in rural areas. Fourth, providers can improve mental health care by integrating social services and law enforcement. Fifth, both veterans and providers can benefit if they recognize opportunities for cooperation and coordination and work towards long-term goals that emphasize outcomes that improve the lives of returning veterans.

Included with this volume are two video documentaries. One documentary describes and assesses mental health services for veterans in Texas and is a companion to this report. A second documentary is a self-analysis by participating graduate students on how this research project has affected their lives and career plans.

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Chapter 1. Provisions of Veterans' Mental Health Care

Since the commencement of the Iraq and Afghanistan conflicts, more than 1.5 million United States troops have been deployed and have returned from combat in the most intensive and prolonged use of the U.S. military since the Vietnam War.[1] The duration and intensity of combat in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) have been characterized by longer and more frequent deployments and exposure to nontraditional, hostile conditions, such as urban conflict, suicide bombings, and improvised explosive devices (IEDs). The psychological costs of these wars and conditions affect a growing number of veterans who suffer from post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and other mental health issues. While technological advances in both medicine and body armor allow more service members to survive experiences that would have been fatal in previous wars,[2] the psychological toll of war on veterans is just as real as the physical injuries of combat. Unlike physical injuries, these invisible wounds of war often go unrecognized and unacknowledged by other service members, family members, and society in general.

Public concern with returning veterans' mental health issues has led to policy changes and funding shifts by both federal and state governments in order to increase the quality of their mental health services. For example, in 2012, the Department of Veterans Affairs (VA), the Department of Defense (DoD), and the Department of Health and Human Services (HHS) created the Interagency Task Force on Military and Veterans Mental Health as a result of an Executive Order from President Obama calling for better access, increased resources, improved communication, and more research on the quality and effectiveness of treatments.[3] During the 81st Texas Legislative Session in 2009, the legislature appropriated $6.2 million in new funding to integrate disparate agency services under the Texas Veterans' Commission administration and to increase coordinated benefit and service provision.[4] These shifts in federal and state funding and policy focus have been complemented by an influx of community-based nonprofit programs providing a wide variety of services to veterans and their families. These nonprofit organizations enhance the management and delivery of veterans' care by relieving the burden on overwhelmed national and state agencies as well as by providing specialized, adaptive, and innovative strategies to treatment that are beyond the limited capability of government bureaucracies.

Despite federal, state, and local commitments to address existing problems with veterans' mental health care, gaps remain between the need for mental health services and their use by returning veterans, reflecting both structural and cultural barriers. Compounding this issue is the persistence of health and mental conditions in prior generations of service members who require increasing care as they age. Tables 1.1 and 1.2 list structural and cultural barriers to care frequently voiced by returning veterans and mental health professionals.

Table 1.1
Structural Barriers to Veterans' Mental Health Care

Issue: Geographic Gaps
Many veterans living in rural areas do not have easy access to federal, state, and nonprofit services. Distance affects whether a veteran will seek regular and recurrent care at VA facilities.[5]
Issue: Overburdened Systems
The number of veterans requiring mental health services has nearly doubled during the past decade, which strains existing mental health care systems and health care providers.[6]
Issue: Generational Differences
Veterans of Operation Enduring Freedom and Operation Iraqi Freedom military service differ from veterans of past wars, including multiple deployments and exposure to hostile conditions, such as urban combat, improvised explosive devices, and suicide bombings. Some existing services address needs of the older generation of veterans and newer veterans may feel out of place.[7]
Issue: Insufficient Outreach
Only a small proportion of veterans who experience mental health symptoms seek care, which is partially a result of veterans not having sufficient knowledge of existing services and available benefits.[8]
Issue: Gender Gaps
The VA has sought to address health needs of female veterans, but gaps remain. Though women are more likely to suffer from mental health trauma, VA service utilization rates by female veterans are similar to that of male veterans (around 58 percent)[9] and programs designed to ensure a safe and sensitive treatment environment have been insufficient. Many nonprofit organizations fail to offer programs that support the unique needs of female veterans.
Issue: Other-than-Honorable Discharge
Veterans who have received an "other than honorable" discharge from the military—given to service members for actions ranging from slight misconduct to criminal acts—are not able to access VA assistance, disability compensation, state services, or nonprofit programs funded by government grants. Some veterans receive "bad paper" based on conduct influenced by PTSD or other mental health injuries; these veterans constitute a significant portion of the homeless population and those with substance-abuse issues.[10]
Issue: Transition Services
Although the military screens for mental health issues both during and after deployment, some service members minimize or fail to disclose symptoms for fear that it could jeopardize their careers or delay their return home. Many service members separate from the military without adequate information about available services and benefits.

Table 1.2
Cultural Barriers to Veterans' Mental Health Care

Issue: Warrior Culture
Military identity promotes self-sacrifice, loyalty, honor, obedience, and commitment to the unit. The "we take care of our own" mentality can hinder veterans' acceptance of civilian health care resources, as veterans may feel that the civilian system fails to understand the uniqueness of military experience. Once veterans separate from the military, they may expect to be strong enough to handle difficulties on their own, even if that is not the case.
Issue: Stigma
Despite its prevalence, the general public has a limited understanding of PTSD and other veterans' mental injuries. Some in the public may assume that veterans suffering from PTSD are violent and likely to cause harm to others without warning. Veterans may be less likely to seek treatment when they fear that it will change how they are perceived by family members, friends, and potential employers.
Issue: Civilian Culture Gap
Fewer than 1 percent of Americans serve in today's armed forces, so a majority of civilians may have a limited frame of reference to understand the transformative nature of military service and warrior culture. This civilian culture gap hinders the recognition of the needs of veterans and an understanding of when and how they seek care.
Issue: Lack of Trust and Credibility
Many veterans do not trust that treatment from the VA will remain confidential and fear negative career and life consequences as a result of seeking care. Some veterans may not believe that civilian doctors can provide effective treatment without an understanding of war-related trauma.

Untreated veterans' mental health conditions can impair their future health, work productivity, and family and social relationships. Individuals afflicted with mental health conditions are at an increased risk of suicide, are more likely to have issues with substance abuse and addiction, and have higher rates of physical health problems and mortality. They also have difficulty finding and maintaining employment or schooling, and are more likely to be homeless. Inadequate care not only affects the individual veteran—mental health conditions also impair relationships, disrupt marriages, and aggravate the difficulties of parenting, which could extend the consequences of trauma across generations.[11]

While the VA and DoD have improved access to and quality of mental health care, many veterans believe they do not receive the care they need to transition successfully from military to civilian life. Treatment of mental health conditions requires an approach that addresses diverse aspects of a returning veteran's experience, including health care, housing, education, employment, family assistance, child support, and legal representation.

Texas is seeking better strategies for addressing mental health challenges among its veterans. This report culminates with a series of policy recommendations, based on the ideas and insights of key informants around the state, as listed in Table 1.3. The policy recommendations in this report build on the many strengths of the existing system of veterans' services in Texas and provide targets for moving forward in future initiatives.

Table 1.3
Policy Recommendations

- Coordinate organizational efforts.
- Create and refine community feedback loops.
- Engage and educate the larger community.
- Expand and improve peer-to-peer approaches.
- Facilitate transitions between programs.
- Reach underserved populations.
- Increase access to services.

Notes

[1] U.S. Department of Veterans Affairs, *The Veteran Population Projection Model* (2011), accessed April 23, 2014, at http://www.va.gov/vetdata/Veteran_Population.asp.

[2] Warden, Deborah, "Military TBI during the Iraq and Afghanistan wars," *Journal of Head Trauma Rehabilitation* 21, no. 5 (2006): 399.

[3] U.S. Department of Defense, U.S. Department of Veterans Affairs, U.S. Department of Health and Human Services, *Interagency Task Force on Military and Veterans Mental Health: 2013 Interim Report* (2013), accessed April 15, 2014, at https://www.whitehouse.gov/sites/default/files/uploads/2013_interim_report_of_the_interagency_task_force_on_military_and_veterans_mental_health.pdf.

[4] Texas Department of State Health Services, *Integrated Services and Supports for Returning Veterans and Their Families: Services, Gaps, and Recommendations* (Feb 2011), accessed March 1, 2014, at http://mhtransformation.org/documents/reports/vets2011/VeteransServices_SupplementalMHTReport_Feb2011.pdf.

[5] U.S. Department of Veterans Affairs, *National Survey of Veterans, Active Duty Service Members, Demobilized National Guard and Reserve Members, Family Members, and Surviving Spouses* (October 18, 2010), 128.

[6] U.S. Department of Veterans Affairs, *2013 Performance and Accountability Report*, accessed April 15, 2014, at http://www.va.gov/budget/docs/report/2013-VAPAR_FullWeb.pdf.

[7] Texas veterans and healthcare professionals, interviewed by 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project, Spring 2014.

[8] U.S. Department of Veterans Affairs, *National Survey of Veterans, Active Duty Service Members, Demobilized National Guard and Reserve Members, Family Members, and Surviving Spouses.*

[9] U.S. Department of Veterans Affairs, "Women Veterans Health Care," accessed March 3, 2014, at http://www.womenshealth.va.gov/WOMENSHEALTH/latestinformation/facts.asp.

[10] Texas veterans and healthcare professionals, interviewed by 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project, Spring 2014.

[11] Tanielian, Terri, and Lisa Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recover* (Santa Monica, CA: RAND Corporation, 2008).

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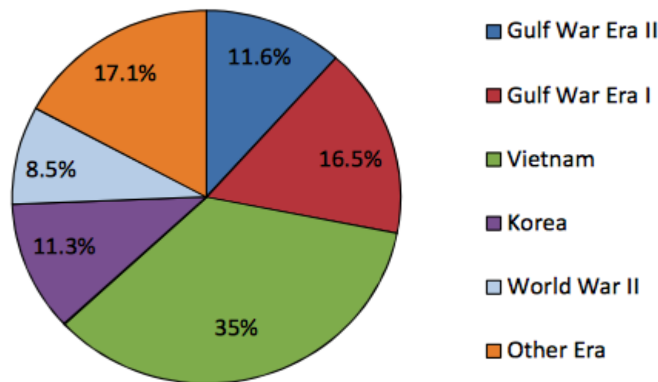
Chapter 2. Who Are Texas Veterans?

In March 2013, the National Center for Veterans Analysis and Statistics (NCVAS) estimated that in 2011 there were 21.6 million U.S. veterans, comprising 8.9 percent of the U.S. population. Of those veterans, 1.6 million (7.3 percent) are female and 20 million are male. Male veterans tend to be older than female veterans. The median age of male veterans is 64, with the largest cohort of men serving during Vietnam. The median age of female veterans is 49, with the largest cohort having served in the second Gulf War. Women are the fastest growing subgroup of veterans, making up over 11 percent of OEF/OIF veterans.[1]

The highest percent of veterans served in Vietnam (see Figure 2.1). The Army accounts for 44 percent of veterans, the most common service branch. The breakdown by service branches is Navy (23 percent), Air Force (18 percent), Marines (11 percent), Reserves[1] (3 percent), and Non-Defense, which includes Coast Guard, Public Health Service, and National Oceanic Atmospheric Administration (1 percent).[2] The majority of veterans (80.9 percent of males and 66.9 percent of females) are White and Non-Hispanic, so the veteran population is less ethnically diverse than nonveterans in the U.S. The NCVAS projects that by 2040 the percentage of minority veterans, particularly Blacks and Hispanics, will increase from 20.9 to 34.0 percent.[3]

Figure 2.1
U.S. Veterans' Period of Service



Source: Texas Workforce Investment Council, "Veterans in Texas: a Demographic Study" (December 2012), accessed April 10, 2014, at http://governor.state.tx.us/files/twic/Veterans_in_Texas.pdf.

Notes: 2011 ACS summary table data. Period of service is determined by the most recent era served. The Gulf War Era I is from August 1990 to August 2001. Gulf War Era II is from September 2001 to the present.

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[1] Reserve Forces include only those who have had active federal military service as a result of their membership in the reserves or National Guard. Reserve Forces with prior active military services in the regular military are classified according to the branch in which they served while in the regular military.

Veterans are concentrated in certain areas of the nation, with four states being home to over a million veterans: California (1.9 million), Texas (1.7 million), Florida (1.6 million), and Pennsylvania (1.0 million). Veterans number close to a million in both New York and Ohio. These concentrations largely reflect the distribution of the general population of the U.S.

Nearly 30 percent of veterans live in rural areas, and these veterans tend to be less ethnically diverse than urban veterans, which mirrors the geographic distribution of race in the general population.[4] More rural veterans fall within the 55 to 74 age range, whereas veterans living in urban areas tend to be younger or over 75. Rural veterans are more likely to report at least one service disability from their service but are less likely to be living in poverty. In 2009, approximately 150,000 veterans were homeless, comprising 0.7 percent of the total veteran population and 16 percent of the homeless adult population. Thus, veterans account for a disproportionate number of homeless adults in the U.S. Moreover, 10.1 percent of female veterans and 6.7 percent of male veterans live in poverty.[5]

Texas is home to 1.7 million veterans, or 6.7 percent of the total population and 8.6 percent of the civilian population age 18 and older.[6] For over 30 years, the number of veterans in Texas has hovered around 1.7 million. The veteran percent of the population in Texas has decreased over the last three decades, but this reflects rapid population growth in Texas rather than a decrease in the number of veterans (see Figure 2.2).

Similar to national trends, the distribution of veterans across the state reflects the distribution of Texas' general population. The highest concentrations of veterans reside in the most populous counties (see Figure 2.3).[7] However, the demographics of Texas veterans differ from the general state population. The Texas veteran population is disproportionately non-Hispanic white males (see Table 2.1), a pattern similar to the national veterans' pool.[8] Hispanics (36.2 percent), African-Americans (11.3 percent), and other ethnic groups (5.7 percent) comprise 53.2 percent of the Texas nonveteran population; these groups comprise only 31.4 percent of Texas veterans.

Table 2.1
Race and Ethnicity of Texas Veterans and Nonveterans, 2011

Race / Ethnicity	Veterans		Nonveterans (18+)	
	Number	Percent	Number	Percent
White	1,092,241	68.7%	8,151,319	46.8%
Hispanic	256,517	16.1%	6,301,569	36.2%
African American	199,777	12.6%	1,961,750	11.3%
Other	28,212	1.8%	248,360	1.4%
Asian	13,617	0.9%	744,969	4.3%
Total	1,590,364		17,407,967	

Source: Texas Workforce Investment Council, "Veterans in Texas: a Demographic Study" (December 2012), accessed April 10, 2014, at http://governor.state.tx.us/files/twic/Veterans_in_Texas.pdf (2011 ACS microdata).

In earlier eras, women comprised less than 8 percent of veterans (see Table 2.2). However, the number of female veterans in Texas is increasing, with almost 20% from the most recent Gulf War, and female veterans now comprise 9 percent of the overall Texas veteran population.

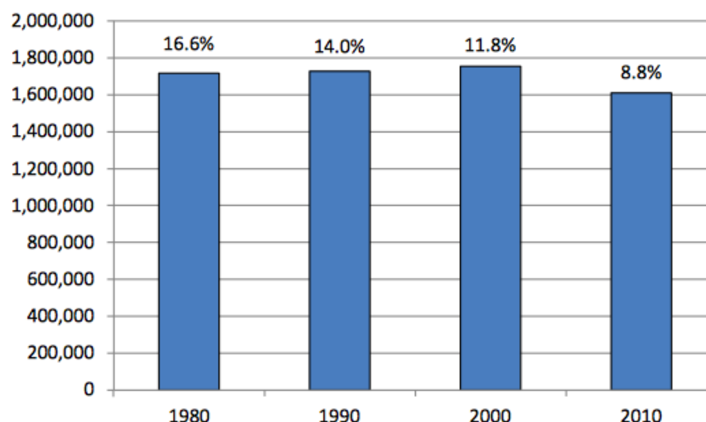
Table 2.2
Percentage of Male and Female Texas Veterans by Period of Service, 2011

Period of Service	Male		Female		Total
	Number	Percent	Number	Percent	Number
Gulf War Era II	194,390	80.4%	47,245	19.6%	241,635
Gulf War Era I	206,495	83.3%	41,383	16.7%	247,878
Vietnam	507,449	96.3%	19,362	3.7%	526,811
Korea	121,110	97.5%	3,066	2.5%	124,176
World War II	87,411	96.5%	3,145	3.5%	90,556
Other	330,776	92.1%	28,532	7.9%	359,308
Total	1,447,631	91.0%	142,733	9.0%	1,590,364

Source: Texas Workforce Investment Council, "Veterans in Texas: a Demographic Study" (December 2012), accessed April 10, 2014, at http://governor.state.tx.us/files/twic/Veterans_in_Texas.pdf (2011 ACS microdata).

The average Texas veteran is younger than the average national veteran but older than the average Texas resident. Despite a relatively younger veteran population, Texas veterans report a high prevalence of disabilities. Approximately 19 percent of Texas veterans have a service-connected disability and 27 percent of Texas veterans report a general disability. Vietnam veterans comprise the highest percentage of Texas veterans with disabilities.[9]

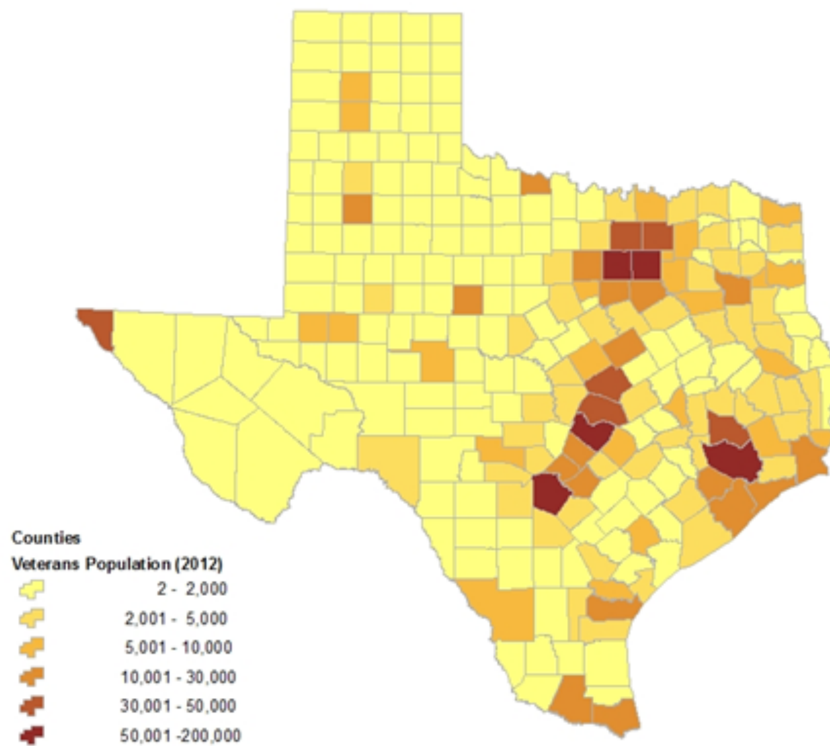
Figure 2.2
Number of Texas Veterans and Percent of Population, 1980-2010



Source: Texas Workforce Investment Council. "Veterans in Texas: a Demographic Study" (December 2012), accessed April 10, 2014, at http://governor.state.tx.us/files/twic/Veterans_in_Texas.pdf .

Note: 1980 through 2000 data are from the Census and 2010 data are from ACS summary data. 1980 and 1990 percentages represent the portion of the 16 and older civilian population that are veterans. The 2000 and 2010 percentages represent the portion of the 18 and older civilian population that are veterans.

Figure 2.3
Distribution of Texas Veteran Population



Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project. Data from U.S. Census Bureau.

Notes

[1] U.S. Department of Veterans Affairs, "Women Veterans Health Care," accessed March 3, 2014, at http://www.womenshealth.va.gov/WOMENSHEALTH/latestinformation/facts.asp.

[2] U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, "Table 4L: VETPOP2011 Living Veterans by Branch," accessed February 13, 2014, at http://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/4lVetPop11_Branch.xlsx.

[3] Ibid.

[4] U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Veterans: 2011* (March 2013), accessed February 24, 2014, at http://www.va.gov/vetdata/docs/SpecialReports/Profile_of_Veterans_2011.pdf.

[5] Ibid.

[6] U.S. Department of Veterans Affairs, *Profile of Veterans: 2011.*

[7] Texas Workforce Investment Council, "Veterans in Texas: a Demographic Study" (December 2012), accessed April 10, 2014, at http://governor.state.tx.us/files/twic/Veterans_in_Texas.pdf.

[8] Ibid.

[9] Ibid.

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Chapter 3. Veterans' Mental Health Challenges

According to the VA, the number of veterans requiring mental health services has grown from 927,000 in 2006 to more than 1.46 million in 2013, with the demand continuing to increase.[1] Veterans' mental health issues include traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), military sexual trauma (MST), substance use disorders (SUDs) and depression, with significant overlap among conditions, as listed in Table 3.1.

Table 3.1
Mental Health Issues and Definitions

Issue	Definition
Traumatic brain injury	Disruption of brain function due to external force
Post-traumatic stress disorder	Response due to previous injury, fear, horror, helplessness, etc.
Military-sexual trauma	Response due to previous sexual assault or harassment
Depression and suicide	Psychological response to stress related to active duty
Substance use disorders	Abuse of alcohol, medicines, or drugs as a response to stress
Family strain	Consequences for families reflecting veterans' problems readjusting to civilian life

Recent research indicates that about 20 percent of returning service members from Operation Iraqi Freedom and Operation Enduring Freedom have reported a probable traumatic brain injury while deployed,[2] defined as a "traumatically induced structural injury and/or physiological disruption of brain function as a result of external force."[3] TBIs include injuries caused by penetration by a foreign object, acceleration or deceleration movements, blunt force trauma, and/or pressure waves from explosive blasts.[4] Mild TBI is the most frequent type among military personnel and its prevalence has more than tripled in the past 12 years, likely due to advancements in body armor that have drastically increased a soldier's chance of surviving a head injury.[5] Symptoms of mild TBI include headaches, difficulty sleeping, irritability, memory problems, mood and anxiety disorders, suicidal thoughts, chronic pain, and dizziness. Studies suggest that those with mild TBI have a "greater risk of developing PTSD than those with severe brain injuries and longer periods of unconsciousness."[6]

For centuries, veterans of war have suffered from post-traumatic stress disorder —what has been called "shell shock," "combat fatigue," or "combat neurosis" in the past. Current diagnosis criteria include exposure to a traumatic event that involved actual or threatened death or serious injury and having a response that involves intense fear, helplessness, or horror.[7] Symptoms include reliving the trauma through intense flashbacks or nightmares and the adoption of a state of persistent hyper arousal, which is associated with irritability or anger, sleep disturbances, and

difficulty concentrating. For some veterans, symptom onset may be delayed for years. For other veterans, symptoms may ease and then worsen again as the veteran ages. PTSD is often associated with TBI, military sexual trauma, sleep problems, substance abuse, and other psychiatric disorders.[8]

One 2008 report estimated that 31 percent of current veterans have PTSD, around four times the prevalence rate in the general population.[9,10] More specifically, some analysts believe that PTSD occurs in 11 to 20 percent of veterans of Iraq and Afghanistan, as many as 10 percent of Desert Storm veterans, and about 30 percent of Vietnam veterans.[11,12]

According to a 2013 report from the Department of Defense (DoD), the DoD received 5,061 reports of alleged sexual assault in 2013 involving 5,518 total victims, 4,605 of which were service members,[13] a 50 percent increase in reports from the previous year.[14] Among veterans who have sought VA health care, 55 percent of women and 38 percent of men have reported experiencing sexual harassment when in the military.[15] Though MST is more common for women, over half of veterans who suffer MST are men because there are significantly more male veterans than female veterans.[16]

Veterans are automatically screened for MST when seeking health care from the VA. Data from screenings show that about 25 percent of women and 1 percent of men respond "yes" to the question asking if they have experienced MST.[17] Problems associated with MST include nightmares, difficulty feeling safe, depression, substance abuse, social isolation, and sleep disturbances.[18]

Female veterans are more than twice as likely to develop PTSD than male veterans because sexual assault is more likely to cause PTSD than other events. Women are more likely to blame themselves for trauma experiences, thus internalizing the trauma.[19]

Recent combat in Iraq and Afghanistan has increased stress on service members due to multiple deployments to the war zones. The higher stress levels are reflected in the increasing suicide rate among veterans. According to the DoD, veterans' suicide rates across the U.S. were higher in 2008 than anytime between 2001 and 2005.[20] The most recent study by a VA mental health research team estimated that 22 veterans die by suicide each day, a number over three times the average rate in the general population.[21,22] A report from the DoD estimated that an additional 12 percent of active-duty military personnel attempted suicide.[23] The DoD has sought to prevent suicides among service members, reflected in Section 733 of the National Defense Authorization Act for Fiscal Year 2009, which convened the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces "to examine matters relating to prevention of suicide by members of the Armed Forces."[24]

Substance abuse frequently accompanies veterans' mental health problems and is often involved in suicide attempts and other harmful behaviors.[25] A large and growing number of active duty and retired military personnel suffer from substance use disorders. Substance abuse is often a form of coping with stress and is particularly prevalent among those who were exposed to combat during their military service.[26] In a 2006 survey of all veterans, 7.1 percent (1.8 million people) met criteria for a substance use disorder.[27] The most prevalent type of SUD is excessive alcohol consumption.[28] Over the past 15 years prescription drug abuse among military personnel

has risen dramatically and is a new SUD concern.[29] Screening and accessible treatment is critical for addressing SUDs, particularly when substance abuse is compounded by mental health challenges. In these cases, veterans could benefit if service providers offer co-occurring care for substance abuse and mental illness.

Combat experience also may increase a veteran's risk for anxiety, depression, and anger, which places a burden on families. One survey reported that 44 percent of post-9/11 veterans reported that their readjustment to civilian life was difficult, in contrast to just 25 percent of veterans who served in earlier eras.[30] About half said they experienced strains in family relations since leaving the military.[31] As families are the main support system for returning service members, they are key in providing emotional support as well as encouragement to seek mental health care and treatment. Furthermore, since military caregivers tend to be younger mothers with small children, the strain of parenting is amplified and could have generational effects.[32]

Notes

[1] U.S. Department of Veterans Affairs, *2013 Performance and Accountability Report*, accessed April 15, 2014, at http://www.va.gov/budget/docs/report/2013-VAPAR_FullWeb.pdf.

[2] Tanielian, Terri, and Lisa Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corporation, 2008).

[3] U.S. Department of Veterans Affairs and U.S. Department of Defense, *Departments of Defense and Veterans Affairs Consensus Definition of Traumatic Brain Injury* (2009), 5.

[4] Ibid.

[5] Contrada, Emily, "CE Test 3.1 Hours: Enhancing Veteran-centered care: A Guide for Nurses in Non-VA Settings," *AJN The American Journal of Nursing,* 113, no. 7 (2013): 31.

[6] Warden, Deborah, "Military TBI during the Iraq and Afghanistan wars," *Journal of Head Trauma Rehabilitation* 21, no. 5 (2006): 400.

[7] Department of Veterans Affairs, "Post-Traumatic Stress Disorder: Implications for Primary Care," *Veteran Health Initiative,* (March 2002), 80.

[8] Ibid., 83.

[9] The U.S. Department of Veterans Affairs estimates that about 7 or 8 out of every 100 people (or 7-8 percent) of the population will have PTSD at some point in their lives.

[10] U.S. Department of Veterans Affairs, "How Common is PTSD?" accessed February 13, 2014, at http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp.

[11] Tanielian, *Invisible Wounds,* 434.

[12] U.S. Department of Veterans Affairs, "How Common is PTSD?"

[13] U.S. Department of Defense, *Annual Report on Sexual Assault in the Military* (2013), 69.

[14] Ibid.

[15] U.S. Department of Veterans Affairs, "How Common is PTSD?"

[16] Ibid.

[17] U.S. Department of Veterans Affairs, "Military Sexual Trauma" (April 2014), accessed April 29, 2014, at http://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf.

[18] U.S. Department of Veterans Affairs, "Military Sexual Trauma" (last updated December 20, 2013), accessed on April 15, 2014, at http://www.womenshealth.va.gov/WOMENSHEALTH/trauma.asp.

[19] U.S. Department of Veterans Affairs, "Women, Trauma, and PTSD," last updated January 3, 2014, accessed April 10, 2014, at http://www.ptsd.va.gov/public/PTSD-overview/women/women-trauma-and-ptsd.asp.

[20] Acosta, Joie, Rajeev Ramchand, Amariah Becker, and Alexandria Felton, "Development and Pilot Test of the RAND Suicide Prevention Program Evaluation Toolkit" (2013), accessed April 10, 2014, at http://www.rand.org/pubs/research_reports/RR283.html, 1.

[21] Kemp, Janet, and Robert Bossarte, "Suicide Data Report, 2012," Department of Veterans Affairs, Mental Health Services, Suicide Prevention Program, accessed July 29, 2014, at http://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf, 15.

[22] National Center for Injury Prevention and Control, CDC, "Fatal Injury Reports, National, 2011," accessed July 29, 2014, at http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html.

[23] U.S. Department of Defense, "2008 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel" (Washington, D.C., 2009), 97.

[24] U.S. Senate and Armed Services Committee, "National Defense Authorization Act for fiscal year 2009," 110th Congress (Washington, D.C.: 2008).

[25] National Institute of Drug Abuse, "Topics in Brief: Substance Abuse Among Military, Veterans, and their Tamilies," April 2011, accessed April 30, 2014, at http://www.drugabuse.gov/publications/topics-in-brief/substance-abuse-among-military-veterans-their-families.

[26] Ibid.

[27] Substance Abuse and Mental Health Services Administration, *2004-2006 National Survey on Drug Use and Health* (2007).

[28] U.S. Department of Veterans Affairs, "Topics in Brief."

[29] Ibid.

[30] Morin, Rich, *The Difficult Transition from Military to Civilian Life* (Washington, D.C.: Pew Research Center, 2011).

[31] Ibid.

[32] Tanielian, Terri, Rajeev Ramchand, Michael P. Fisher, Carra S. Sims, and Racine Harris, *Military Caregivers: Cornerstones of Support for Our Nation's Wounded, Ill, and Injured Veterans* (RAND Corporation, 2013).

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Chapter 4. Types of Mental Health Services and Treatment

A number of studies report that a key strategy to mental health recovery is comprehensive care, a combination of treatments, services, and support activities (see Table 4.1).[1] Counseling and psychiatric treatment are common services. Support services may include employment training, legal guidance, and connection to community resources. Some federal, state, and nonprofit programs already provide multiple services, as discussed later in this report.

Therapy is a term for many methods to help a patient deal with his/her mental health challenges. Psychosocial treatment or talk therapies are common therapeutic types that include cognitive behavioral therapy (CBT), reality therapy, self-help, support groups, exposure therapy, psychotherapy, and other types.[2] Veterans can also access non-traditional therapies, also known as complementary or alternative medicine (CAM) therapies.[3] Table 4.2 lists examples of CAM therapies.

Table 4.1
Services for Mental Health Recovery

Type of Service	Code
Benefit advocacy/claims representation	(B)
Indigent legal representation	(I)
Housing services	(H)
Counseling/therapy/psychiatric treatment	(C)
Policy research	(P)
Employment services	(Em)
Education services	(Ed)
Resource connection/case management	(R)

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project.

Table 4.2
Types of Complementary and Alternative Medicine (CAM) Therapies

1	Equine-assisted psychotherapy (EAP)
2	Other animal-assisted therapy
3	Yoga
4	Mindfulness
5	Acupuncture
6	Massage

Source: OMEGA, "Complementary and alternative therapies for veterans: focusing on the present" (September 24, 2013), accessed April 22, 2014, at http://www.eomega.org/learning-paths/body-mind-spirit-mindfulness/complementary-and-alternative-therapies-for-veterans.

Therapy methods vary in the degree to which they have been tested for likelihood of successful outcomes, particularly for treatment of PTSD and veteran-specific mental health problems. Therapies that have repeatedly proven to have measurable positive consequences for patients have been classified as "evidence-based therapies" (EBT). Some federal and state programs for veterans' mental health only use evidence-based therapies. For example, VA clinicians are trained to treat PTSD with two evidence-based therapies—prolonged exposure therapy or cognitive processing therapy. Other programs, particularly those in the nonprofit sector, incorporate more CAM therapy methods, such as peer-to-peer counseling without the benefit of a psychological professional.[4]

Given the unique nature of combat experience and the nature of military culture that emphasizes a "take care of your own" attitude, some veterans prefer to work through their issues with a peer support network composed of fellow veterans, rather than using civilian health agencies. Peer networks foster trust and credibility, which may help veterans develop relationships in which to share experiences and discuss difficulties. Formal peer-to-peer networks usually provide individuals an opportunity to talk with a trained peer facilitator who can offer educational and social support and provide avenues for additional help as needed. Particular benefits of military peer networks are that they are self-reinforcing and sustainable, encourage participation, reduce stigma, provide access to veterans who otherwise may not seek help, and can respond flexibly to the needs identified by veterans themselves. Peer support networks are most effective when used to augment rather than replace formal mental health counseling. Professional intervention may be necessary in cases such as severe trauma.

Within the VA system, a patient is seen first by a primary care physician and then referred to a mental health provider for any mental illness.[5] As any referral appointment may not occur the same day or even in the same clinic, treatment for mental health issues can be delayed. Under an integrated care model, a patient would be referred immediately to a mental health provider, called the Post-Deployment Stress Specialist, and a social worker, called the Combat Case

Manager, based in the same clinic as the primary care physician.[6] A recent study reported that a combined clinic approach was found to be particularly beneficial for female veterans and younger veterans.[7] Many stakeholders interviewed for this research expressed an opinion that veterans would benefit from integrated care because it can increase coordination among services and improve responsiveness to veterans and their families.[8] Integrated services can facilitate more comprehensive support to veterans and thereby more effectively address mental health needs. The Bridge in Dallas is a good example of a "one-stop shop" or integrated care model. At The Bridge, providers offer medical, mental health, professional development, and VA services all in one building.[9] The Texas Council Community MHMR Centers (TCCC) and The City of Houston Office of Veterans Affairs, which are discussed later in this report, also provide good examples of integrated care.

Notes

[1] National Alliance on Mental Illness, "Treatments and Services," accessed April 1, 2014, at https://www.nami.org/template.cfm?section=About_Treatments_and_Supports.

[2] Ibid.

[3] OMEGA, "Complementary and alternative therapies for veterans: focusing on the present" (September 24, 2013), accessed April 22, 2014, at http://www.eomega.org/learning-paths/body-mind-spirit-mindfulness/complementary-and-alternative-therapies-for-veterans.

[4] Texas veterans and healthcare professionals, interviewed by 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project, Spring 2014.

[5] Nauert, Rick, "Integrated care clinics improve access for vets," *PsychCentral* (June 13, 2011), accessed March 12, 2014, at http://psychcentral.com/news/2011/06/13/integrated-care-clinics-improve-access-for-vets/26876.html.

[6] Ibid.

[7] Seal, Karen H., Greg Cohen, Daniel Bertenthal, Beth E. Cohen, Shira Maguen, and Aaron Daley, "Reducing barriers to mental health and social services for Iraq and Afghanistan veterans: outcomes of an integrated primary care clinic," *Journal of general internal medicine* 26, no. 10 (2011): 1160-1167.

[8] Texas veterans and mental health professionals, interviewed by 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project, Spring 2014.

[9] Participant observation during 2014 by members of the 2014 LBJ School Veterans' Mental Health-Texas Policy Project in Dallas, Texas.

Chapter 5. Recent Mental Health Policy Changes

Federal and Texas policymakers have placed new priority on addressing mental health in recent years, especially among veterans, through funding increases, new leadership, encouraging partnerships, and new policies to improve programming for veterans in Texas. In 2008, the U.S. Congress passed the Veterans' Mental Health and Other Care Improvements Act that authorized the VA to expand and improve treatment and services for veterans with PTSD and substance abuse.[1] In 2009, President Obama appointed Secretary Erik K. Shinseki to overhaul and modernize the VA. The VA adopted three guiding principles to better serve veterans: to be people-centric, results-driven, and forward-looking. It has implemented 16 new initiatives, one of which was to improve veterans' mental health through four specific performance measures (see Table 5.1).

In 2012, President Obama signed an Executive Order to the VA, DoD, and HHS to improve access to mental health services for veterans, service members, and military families through an Interagency Task Force on Military and Veterans Mental Health.[2] The Task Force has worked to increase resources for existing services, expand staffing, improve communication, increase research and development, and improve the VA's internal resource allocation. For example, in 2013 the VA increased its mental health budget by 39 percent as compared to 2009 budget levels, and increased the number of mental health providers by 1,600 from the previous year. The VA now monitors veterans' use and knowledge of existing mental health services.[3]

Texas has acquired a reputation for leadership in veterans issues based on its legislative changes that include the transfer by executive order of Veterans Employment Services (VES) and the Veterans Education Program (State Approval Authority) by executive order to the Texas Veterans Commission (TVC). House Bill 1299 created a lottery scratch-off game to fund the Texas Veterans Commission Fund for Veterans' Affairs (FVA) in 2009. In June 2010, the Texas Senate partnered with the Texas Workforce Commission and Texas Higher Education Coordinating board to pass Senate Bill 1736, College Credit for Heroes. The program awards course credit to veterans for military experience and training.[4] In 2012, Senate Bill 1796 created the Texas Coordinating Council for Veterans Services (TCCVS), which released its first report for review and recommendations for the 83rd Texas Legislative session beginning in January 2013.[5] The Texas Legislature authorized the creation of Veterans Courts in 2009 in response to the large proportion of veterans with mental health issues currently in the general prison population.[6] As of 2014, 20 veterans court programs have been established in Texas, serving primarily 17 counties.[7]

Table 5.1
VA Performance Measures for Improving Veterans' Mental Health

By the end of 2010, 97 percent of all eligible patients will be screened at required intervals for alcohol misuse; 96 percent will be screened for depression.
By the end of 2011, 96 percent of patients will receive a mental health evaluation within 15 days following their first mental health encounter.
By the end of 2011, 97 percent of eligible patients will be screened at required intervals for PTSD.
Veterans with a primary diagnosis of PTSD will receive a minimum of eight psychotherapy sessions within a 14-week period. Percentage goals: baseline (20 percent); 2010 target (35 percent); strategic target (60 percent).

Source: Department of the Secretary, "Department of Veterans Affairs Strategic Plan FY 2010-2014" (June 2010), accessed March 25, 2014, at http://www1.va.gov/op3/docs/strategicplanning/va_2010_2014_strategic_plan.pdf.

Notes

[1] Tanielian, Terri, and Lisa Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corporation, 2008).

[2] Office of the White House Press Secretary, "Executive order – Improving access to mental health services for veterans, service members, and military families," *White House Press Release* (August 31, 2012), accessed March 3, 2014, at http://www.whitehouse.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-veterans-service.

[3] U.S. Department of Veterans Affairs, *2013 Performance and Accountability Report*, accessed April 15, 2014, at http://www.va.gov/budget/docs/report/2013-VAPAR_FullWeb.pdf.

[4] Office of the Governor, Rick Perry, "Background, Purpose, and Policy Recommendations Related to the Governor's Committee on People with Disabilities," accessed March 15, 2014, at http://governor.state.tx.us/files/disabilities/Veterans_Policy_Brief_for_83rd_Legislative_Session.pdf.

[5] Ibid.

[6] Texas Veterans Commission, "Presentation to House Committee on County Affairs" (March 10, 2014), accessed July 11, 2014, at http://www.legis.state.tx.us/tlodocs/83R/handouts/C2102014031010001/d3532f6b-8127-4d96-9ebc-f8e6410493c8.PDF.

[7] Ibid.

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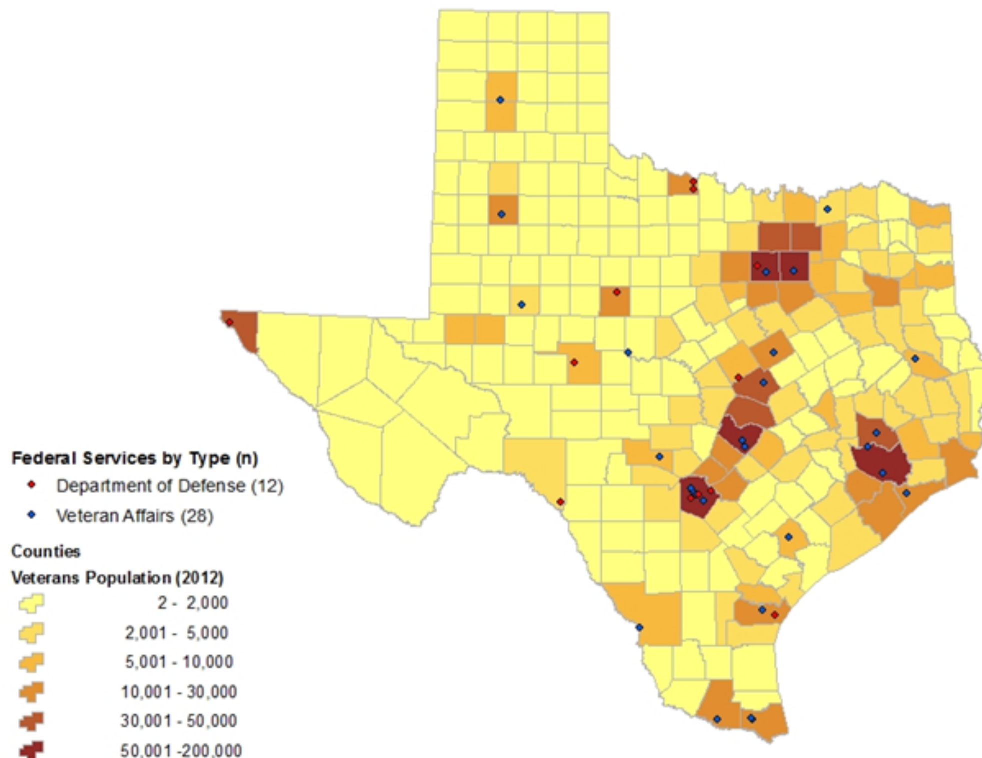
Chapter 6. Federal Mental Health Services

Both the U.S. Department of Defense and the U.S. Department of Veterans Affairs design programs, allocate resources, and deliver mental health services for current and former military personnel. The U.S. Department of Health and Human Services assists both agencies. The DoD provides mental health services for active duty service members and veterans reintegrating into civilian life. The VA offers mental health services for former military personnel, as well as their families and survivors, experiencing behavioral health problems.

Figure 6.1 illustrates the locations of federal mental health facilities in Texas as well as the number of veterans by county. The map shows that all counties with more than 50,000 veterans have at least one federal mental health facility, with operations concentrated in the San Antonio area. There are several counties with high numbers of veterans (10,000 to 49,999) that lack a federal mental health facility.

Figure 6.1
Federal Mental Health Service Locations in Texas



Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project. Data from U.S. Census Bureau, Department of Veterans Affairs, and Department of Defense.

The DoD provides mental health coverage, screening, and resources to military personnel during their service and as they initiate the transition to civilian life. The DoD conducts research on mental health issues, monitors the mental health of its troops, provides appropriate care and resources, and seeks to integrate mental health into existing health services. For example, in 2008, the DoD established the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) to conduct research on military-related mental health topics and provide guidance to the agency.[1] In 2011, the DoD established the Defense Suicide Prevention Office (DSPO) to "oversee the development of policies, procedures, and message to prevent suicide across the U.S. Armed Forces."[2]

The DoD provides basic mental health care for enlisted men and women and their families, including mental health screening, a crisis hotline, information and education, comprehensive health insurance, and mental health treatment. Screening is administered in two stages to all service members deployed to combat zones, through the Post-Deployment Health Assessment (PDHA) towards the end of combat deployment and through the Post-Deployment Health Reassessment (PDHRA) upon return from a combat zone. In 2005, 20 percent of service members who screened positive for PTSD were referred for care; fewer actually followed through with treatment.[3]

Over the past ten years the DoD has increased the number, size, and efficacy of its mental health services. As of 2012 about 50 percent of those testing positive for PTSD were referred for care and about 70 percent followed up with treatment.[4] Some veterans still report disincentives to admitting PTSD symptoms and seeking treatment while under DoD care.[5] In addition to stigma and fear of career repercussions, seeking treatment may delay service members' ability to go home and be reunited with family and friends. Once military members complete their service and are cleared regarding mental health problems, the DoD transitions veterans to the VA.[6]

The DoD seeks to deliver high-quality, accessible mental health services with a myriad of national programs and services, described in Table 6.1. Some programs were created during the past decade in response to new policies and system critiques, and many specifically fill mental health service and information gaps for military personnel and their families.

Texas boasts 14 military facilities: seven Air Force bases (one of which is a business-science center run by the local authorities), four Army bases (one of which is an army depot), and three Navy bases. Twelve of the bases are secure bases with active military personnel. Eleven of these have a mental health clinic or hospital that provides treatment to active military personnel, and some provide services to their families. The one active base that does not have a mental health clinic is the Kingsville naval base, which uses mental health services at Corpus Christi naval base 15 miles away. Some military treatment sites offer more extensive services than others. For example, Wilford Hall Medical Center (WHMC) on Lackland Air Force Base in San Antonio is the Air Force's largest accredited general psychiatry residency training program in the nation and provides training, patient care, and support to current military personnel.[7] Some military treatment centers, including all Texas Navy clinics and one Texas Army clinic, refer to their services online as "behavioral health services." Air Force clinics in Texas specifically refer to services as "mental health services," which may reflect an effort to increase transparency and normalize mental health treatment.[8]

Table 6.1
DoD Mental Health Programs and Services

Program	Description	Who Served	Service Type
Vets4Warriors	Call center with 24/7 peer support, information, and referrals for active duty, National Guard, Reserves, and families	In-service	R
The National Resource Directory	Website that connects wounded warriors, service members, veterans, and families to programs and services	In-service, transition, veterans, families	R
Office of Warrior Care Policy	Quality assurance assures that recovering wounded, ill, injured, and transitioning members receive support and services	In-service, transition, veterans	B P
Center for Deployment Psychology (CDP)	Offers resources to health care providers	Clinicians	Ed R
In-Transition Program	Provides help to service members and families in any transition	In-service, transition	R
Military Family Support Centers: Employment Assistance	Provides counseling and education	In-service, families	C Ed
Military OneSource (MOS)	Helps service members and their families find community resources and provides up to 12 free and confidential therapy sessions to soldiers	In-service, families	C R
Real Warriors Program from DCoE	Campaign for reintegration of returning service members, vets, and families; includes AfterDeployment website	Transition, veterans, families	R
Re-Engineering System of Primary Care Treatment in the Military (RESPCT-Mil)	Resources/systems to enhance PTSD depression recognition and management	In-service, clinicians	R Ed
Wounded Warrior Resource Center (WWRC)	Immediate assistance to wounded, ill, and injured service members and families (accessed through MOS)	In-service	R

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project. (See Table 4.1 for list of service-type codes.)

The VA addresses veterans' mental health issues once soldiers transition out of active service. The VA gathers and distributes information regarding the veteran population and its mental health needs. The VA coordinates mental health programs and services among federal, state, and local providers through a Veterans Integrated Service Network (VISN). It distributes federal

budget allocations to service agencies and benefit-eligible veterans. During the second half of the 20th century, the roles and responsibilities of the VA expanded to include comprehensive veterans care, though it was not until the late 1980s that the VA dedicated resources to serving homeless and mentally ill veterans.[9] Over the past 25 years the VA has invested increasing resources for mental health needs and has sought to integrate mental health care, staff, and services into every level of programming.[10] For example, mental health staff are active throughout the VA's primary care system and in every VA facility across the U.S. The VA has created in-patient treatment programs and a full array of supportive services for veterans facing mental health challenges. Like the DoD, the VA has developed new programs to serve the mental health needs of veterans and their families, addressing recognized service gaps (see Table 6.2).

Table 6.2
VA Mental Health Programs and Services

Program	Description	Who Served	Service Code
National Mental Health Program: Vet Centers	Provision of care at Community Based Outpatient Clinics (CBOCs); Includes support services for caregivers	Veterans, caregivers	C Ed R
Veterans Crisis Line	Suicide prevention	Veterans	C R
Make the Connection public awareness campaign	Online vet testimonials and information to connect vets/families to resources	Veterans, families	Ed R
National Center for PTSD/ AboutFace	Includes a resource website ("AboutFace"), and a PTSD phone app	Veterans	Ed R
Coaching into Care	Counselors who coach family members to encourage vet care	Family and friends of veterans	C Ed
Disability/Service Connection	Health benefits for vets who qualify; can apply online and with help from Vet Service Officers	Veterans	B R
Homelessness Resource Line and Website	Toll-free number and website for housing information	Veterans	R

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project. (See Table 4.1 for list of service-type codes.)

The VA divides its administrative services into 23 distinct geographic regions, called Veterans Integrated Service Networks. Three VISNs cover the state of Texas: VISN 16, the South Central VA Health Care Network; VISN 17, the VA Heart of Texas Health Care Network; and VISN 18, the VA Southwest Health Care Network.[11]

Each VISN includes a VA Medical Center and a network of outpatient clinics, community-based outpatient clinics (CBOCs), and/or vet centers. All VA Medical Centers and many VA clinics and centers offer PTSD treatment and other mental health services.[12] For example, the outpatient

clinic in Austin, which opened in 2013, is the largest in the nation.[13] Figure 6.1 displays the location of all VA facilities that offer mental health services in Texas.

The VA operates three distinct mental health programs: the General Mental Health Program, the Substance Abuse Treatment Program (SATP), the PTSD Program, and the Mental Health Intensive Case Management Program. Each program has its own strengths and challenges. For example, in Austin, the General Mental Health Program faces the challenge of chronic understaffing, and the SATP is challenged by the absence of a detox facility closer than Temple. The Mental Health Intensive Case Management Program, on the other hand, which serves veterans with severe mental health illness, was recently strengthened with the addition of new staff positions.[14]

Although the three programs are distinct, there is some overlap among services, so veterans with “dual diagnoses” can receive co-occurring care. For example, if a client goes to the SATP, she or he is assessed by a psychologist who evaluates the client for any mental health problem, not just problems related to substance use.[15] SATP treatment is not limited to addictions. Each client’s treatment plan includes goals related to addiction as well as any current mental health problems. Within SATP, several “dual diagnosis” groups treat addiction in combination with other mental health problems, such as PTSD or mood disorders like depression or bipolar disorder. For example, the Austin SATP and PTSD Clinical Team employs clinicians with expertise in both addiction and PTSD as specialists in both programs.[16]

The VA in Central Texas (VA/CT) has established timeliness of care, suicide prevention, and continuity of care as priorities for veterans’ mental health service. For example, the VA/CT requires, in principle, that clinicians see new mental health patients within 15 days of the initial request for services. In practice, overburdened clinicians find it difficult to schedule and provide quality care to new patients with little notice while maintaining appointments with existing clients and conferring with colleagues about cases. One former VA clinician reported that counselors are getting “burned out” with large caseloads, and that it is “unethical” to spread care so thin with high-risk cases.[17]

The VA has created specific measures to decrease suicide among veterans. For example, every time a clinician meets with a client, the clinician is required to ask whether the client is contemplating suicide.[18] This policy ensures that therapists and patients are communicating about suicide intentions and taking preventative measures. The VA has created Suicide Prevention Coordinators (SPCs) to provide extra support to any veteran showing signs of suicidal behavior.[19] The coordinators speak with, email, or text patients several times per week and work closely with care providers. According to VA staff, this program is effective because clinicians develop full treatment plans for each patient and revise those plans regularly through assessments.[20] The VA’s investment in continuity of care is a response to complaints that veterans were getting lost in the system.

The DoD and VA share the responsibility of ensuring that veterans receive continued care during their transition out of military service and into civilian life. The DoD identifies military personnel who require mental health treatment, ensures continual treatment through the DoD to the VA, and provides service members and their families with information and education regarding future mental health problems and care. The VA delivers mental health treatment to

any new DoD-referred patients and screens new clients for mental health problems through primary care services. Based on veteran accounts, efforts to coordinate these services and ensure continuity of care has yielded mixed results, as the quality of transition experiences varies. For example, as of 2003 only 52 percent of service members with serious mental illness successfully entered the VA health system and veterans repeatedly report being inadequately prepared to handle mental health challenges after leaving the military.[21] According to VA staff, they rarely receive referrals directly from the DoD and usually acquire new patients through VA primary care screenings and referrals or through court mandates, which indicate poor transition services.[22] In fact, when asked about patient transfers from the DoD, one former VA clinician said, “what transition?” and reported never having seen DoD files come to the VA mental health center.[23] To improve upon these failures, in 2008 the National Defense Authorization Act required the DoD and VA to develop a joint comprehensive care management and transition policy for service members with serious injury or illness. Elements of the plan include electronic health records, recovery care coordinators for each patient, patient tracking, and expedited VA benefit enrollment. However, these improvements have been slow to be implemented.[24]

Challenges and Opportunities in the Federal System

Despite the significant efforts and resources that the federal government has invested into veterans’ mental health services, federal agencies face challenges in delivering effective mental health care to armed service members and veterans. Critics have voiced numerous concerns, as discussed below. Table 6.3 lists challenges to mental health care through the federal systems. Although the federal government has sought to provide quality mental health services to current and former military personnel, opportunities exist to improve management of mental health services. Table 6.4 lists some of these opportunities.

Table 6.3
Challenges to Mental Health Care in Federal Systems

Challenge: Personal/Military Culture Barriers
Research suggests that military personnel facing mental health challenges may not seek out services because they fear breaches of confidentiality, are influenced by the stigma of mental health problems, fear negative career effects, do not believe treatment is effective, and/or have limited access to mental health services in some areas.[25]
Challenge: DoD Organizational Barriers
The DoD has approximately 211 mental health programs fragmented across service branches and not entirely integrated into previously existing services. The quality of evaluation, leadership, and access to the mental health services is uneven throughout the agency.
Challenge: Inter-agency Coordinated Transition
The DoD and VA do not consistently provide continuity of care when service members transition from active duty. In 2003 only 52 percent of those who exited the service with serious mental illness continued to receive care through the VA system. Although the DoD and VA have attempted to address

this shortcoming through a joint comprehensive care management and transition policy, the agencies still face challenges.[26]
Challenge: Inter-agency Coordination and Service Duplication
In the past 25 years both agencies have initiated dozens of mental health care programs. As a result, both agencies have fragmented systems of mental health service that lack coherence and coordination. It is unclear whether the overlap is intentional or the result of duplication of efforts.[27]
Challenge: Access to Care at the VA
Veterans report difficulty accessing mental health services at VA facilities, arising in part from staff shortages and inadequate facilities. Veterans complain of the VA's inability to schedule consistent visits with the same provider, meet outside of normal working hours, and provide services to veterans who live far from a facility. Although the agency has significantly increased its staff and resources for mental health services, insufficiencies persist.[28]
Challenge: Environment at the VA
Veterans report that they do not feel comfortable seeking mental health services at the VA. Some say that they are uncomfortable at the VA facilities because they are uneasy surrounded by elderly and chronically ill veterans.[29] Others states that the VA tries to "place them in a box" or "funnel them through a system."[30] Overall, the VA mental health system fails to provide a comfortable setting that invites a partnered approach to mental wellness.
Challenge: Techniques at the VA
Partly as a result of being a large, complex organization, the VA faces challenges in effectively adopting innovative approaches to mental health care. As previously explained in this report, mental health services are a new focus area at the VA. As a result, there is little coherency regarding the approach and importance to addressing veterans' mental health. Without a linkage to agency goals and values nor effective engagement with organizational processes, VA staff persons are unlikely to support and engage new mental health programming, despite its importance.[31]
Challenge: Nature of the Federal System
Federal U.S. agencies like the DoD and VA are large organizations with many offices and divisions, with staff scattered across the nation and world. It has been difficult for agency leaders to make swift organizational changes that respond to the growing mental health needs of veterans in Texas and beyond or adapt to emerging veteran needs, leading to persistent service gaps.

Table 6.4
Opportunities for Veteran Mental Health Care in Federal System

Opportunity: Widespread Support
The issue of military mental health has widespread support from Republican and Democratic policymakers as well as from the general public, which has increased opportunities to assemble both funding and political will for new measures.

Opportunity: Diffuse Benefits
A healthy veteran population benefits all Americans. Not only do veterans and their families benefit from the services, but the American public itself gains value from knowing that its government provides comprehensive care and rehabilitation to those who have fought to protect the nation.
Opportunity: Agency Commitment
The federal agencies themselves have demonstrated a commitment to addressing the issue of mental health. Both the DoD and the VA appear to have accepted their directives to increase mental health services and staff and have demonstrated an interest in promoting veteran mental health. Both agencies monitor their progress on mental health issues and services and appear to be invested in addressing existing system weaknesses.

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project.

Notes

[1] Defense Centers of Excellence, "About DCoE" (last updated July 10, 2014), accessed February 16, 2014, at http://www.dcoe.mil/About_DCoE.aspx.

[2] Defense Suicide Prevention Office, "About us," accessed February 16, 2014, at http://www.suicideoutreach.org/AboutUs.aspx

[3] Merlis, Mark, "The future of health care for military personnel and veterans," Academy Health, accessed February 17, 2014, at http://www.academyhealth.org/files/publications/AH_RIBrief MilVetsFinal.pdf

[4] Ibid.

[5] Texas veterans and healthcare professionals, interviews by 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project, Spring 2014.

[6] Texas Department of State Health Services, "Behavioral Health Services for Returning Veterans and their Families" (2008), accessed March 2, 2014, at http://www.mhtransformation.org/documents/reports/MHTWorkgroupReport_ReturningVeterans010809.pdf

[7] Capt. Alvi Azad, et al., "Snapshot of Air Force: Wilford Hall Medical Center," *Psychiatry*, 6 (June 2009) 52, accessed April 7, 2014, at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2720844/.

[8] Information about mental health clinics on Texas bases was gathered through Internet searches for each base and largely relied on the official VA website at http://www2.va.gov/directory/guide/state.asp?dnum=ALL&STATE=TX.

[9] U.S. Department of Veterans Affairs, "VA history in brief," accessed February 2, 2014, at http://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf.

[10] American Psychological Association, "Veterans' mental health care emphasizes recovery and return to full and meaningful lives" (November 10, 2011), accessed March 6, 2014, at http://www.apa.org/news/press/releases/2011/11/recovery-return.aspx

[11] U.S. Department of Veterans Affairs, "Veterans Health Administration" accessed April 3, 2014, at http://www2.va.gov/directory/guide/division.asp?dnum=1.

[12] U.S. Department of Veterans Affairs, "Veterans Health Administration."

[13] Krebs, Natalie, "Austin's new outpatient VA clinic is the largest in the country" (July 11, 2013), accessed April 6, 2014, at http://kut.org/post/austins-new-outpatient-va-clinic-largest-country.

[14] Texas veterans and healthcare professionals, interviews by 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project, Spring 2014.

[15] Ibid.

[16] Ibid.

[17] Ibid.

[18] Ibid.

[19] Ibid.

[20] Merlis, "The future of health care for military personnel and veterans."

[21] Ibid.

[22] Texas veterans and healthcare professionals, interviews by 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project, Spring 2014.

[23] Ibid.

[24] Merlis, "The future of health care for military personnel and veterans."

[25] Tanielian, Terri, and Lisa Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corporation, 2008).

[26] Ibid.

[27] Ibid.

[28] Tanielian, *Invisible Wounds of War*; Texas veterans and healthcare professionals, interviews by 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project, Spring 2014.

[29] Tanielian, *Invisible Wounds of War.*

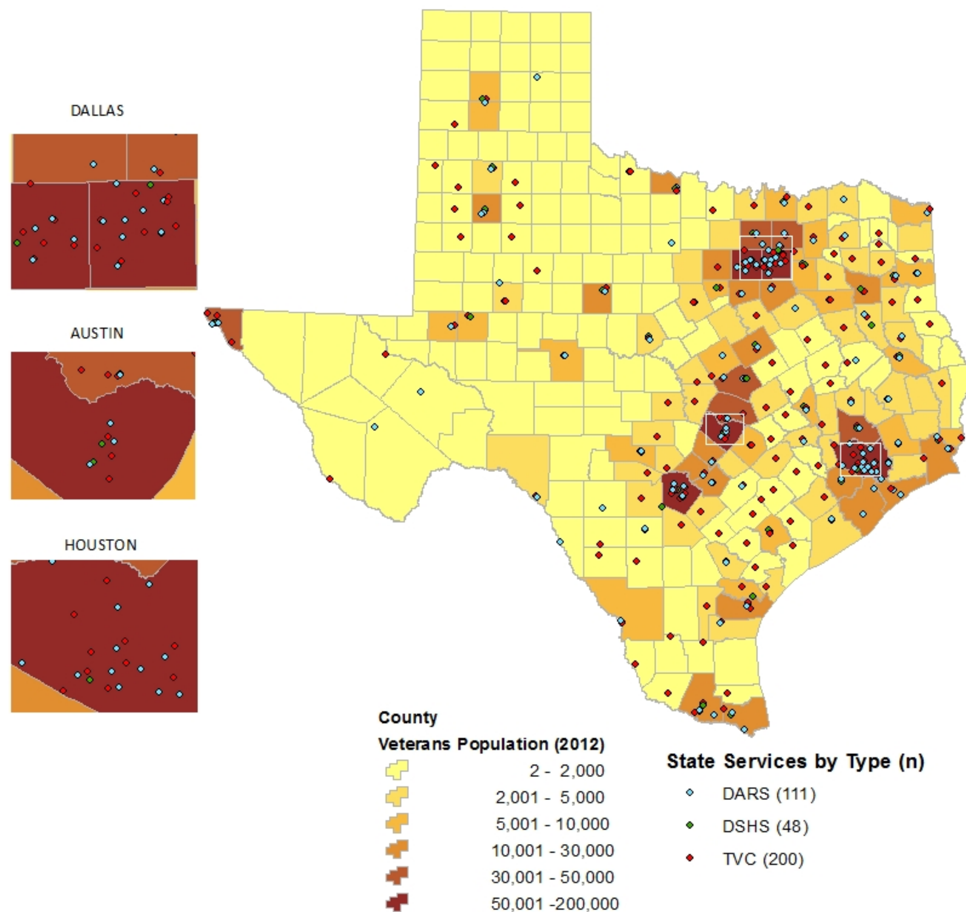
[30] Texas veterans and healthcare professionals, interviews by 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project, Spring 2014.

[31] Rosenheck, R., "Stages in the implementation of innovative clinical programs in complex organizations," *Journal of Nervous and Mental Disease*, 189:12 (Dec 2001), 812-21.

Chapter 7. Texas Mental Health Services

Multiple government organizations at both the state and local levels provide mental health services to Texas veterans, as discussed below. Figure 7.1 illustrates the location of diverse Texas mental health services. Table 7.1 lists Texas state service providers.

Figure 7.1
Texas Mental Health Service Locations



Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project. Data from U.S. Census Bureau and Texas Department of State Health Services.

The Texas Veterans Commission (TVC), which began in 1927, perceives itself as a state-designated advocate for veterans' service benefits. Through its several divisions and programs, the TVC provides an integrated system of care and utilizes outreach and peer-to-peer networking.[1] Texas Military Forces (TxMF) comprises the Texas Army National Guard, the

Texas Air National Guard, and the Texas State Guard. Through its Yellow Ribbon Program, the TxMF conducts reintegration training events for its service members returning from combat situations. The organization also has a Joint Behavioral Health Team and Director of Psychological Services who organize its mental health services and administer training programs for service providers, veterans, and families.[2]

The Texas Health and Human Services Commission's (HHSC) role in state veterans' services is oversight, coordination, and administration of health and human services programs in Texas. Its 2-1-1 Call Centers offer live help from professionals trained in connecting people to veterans' services. The HHSC Office of Acquired Brain Injury (OABI) coordinates federal, state, and local information and services for acquired brain injuries.[3]

The Texas Department of State Health Services (DSHS) has 39 local mental health authorities that provide contract services including crisis services, rehabilitation, and family services for those with mental illness. These local mental health authorities are a resource to veterans during times of crisis and offer referrals for continuing care within the VA system. DSHS also funds psychiatric emergency services and outpatient treatment facilities, substance abuse treatment and prevention, and law enforcement training for dealing with mental health situations. It also has an integrated Medicaid managed care plan that provides comprehensive mental health and substance abuse treatment to indigent and Medicaid-eligible populations. For mental illnesses that require specialized treatment or long-term care, DSHS offers in-patient services at ten state-owned mental health facilities across the state, which include Austin State Hospital, Big Spring State Hospital, El Paso Psychiatric Center, Kerrville State Hospital, North Texas State Hospital, Rio Grande State Center/South Texas Health Care System, Rusk State Hospital, San Antonio State Hospital, Terrell State Hospital, and Waco Center for Youth.[4]

The Department of Assistive and Rehabilitative Services (DARS) is a resource to veterans recovering from injuries and adapting to a variety of disabilities. In concert with the VA, DARS provides case management to facilitate employment and independent living for its clients.[5]

The Department of Family and Protective Services' (DFPS) divisions of Child Protective Services (CPS) and Adult Protective Services (APS) assist in cases of abuse, neglect, or exploitation of children, elderly, or disabled persons. In major military base areas, such as Ft. Bliss and Ft. Hood, DFPS partners with base personnel in case management to coordinate rehabilitative services such as substance abuse treatment, anger management, and parenting skills courses.[6]

The Texas Workforce Commission's (TWC) Texas Veterans Leadership Program (TVLP) connects veterans to resources to facilitate service members' leading productive lives. The program employs Veterans Resource and Referral Specialists (VRRSs) to provide peer-to-peer outreach and coordinate access to federal, state, local, and community-based services.[7]

The Texas Council Community MHMR Centers (TCCC) is an association of the 39 local Texas mental health authorities that cooperate to provide services to address mental illness across the state. The TCCC also initiates and seeks the adoption of policy and pooled resource initiatives designed to enhance and improve community services.[8]

Table 7.1
Veterans' Services Administered by the State of Texas

Agency	Programs/Services	Service Type
Texas Veterans Commission (TVC)	The Veterans Employment Services Division, Claims Representation and Counseling Division, Veterans Education Program, Transition Assistance, and Bring Everyone In the Zone	Em B Ed C
Texas Military Forces (TxMF)	Yellow Ribbon Program, Joint Behavioral Health Team, and Director of Psychological Services provide mental health services and training in the areas of combat readiness, resiliency, coping skills, suicide prevention, readjustment, stigma, combat stress, and TBI	C Ed
Health and Human Services Commission (HHSC)	Coordinates and administers 2-1-1 Call Centers, the Office of Acquired Brain Injury (OABI), and other services to provide access to symptom and treatment information	R
Department of State Health Services (DSHS)	Delivers crisis services, rehabilitation, and family services for mental illness; psychiatric emergency services; outpatient treatment facilities; substance abuse treatment and prevention; law enforcement training for dealing with mental health situations; integrated Medicaid managed care plan provides comprehensive mental health and substance abuse treatment to indigent and Medicaid-eligible; in-patient services at state-owned mental health facilities	C Ed
Department of Assistive and Rehabilitative Services (DARS)	Manages cases to facilitate employment and independent living for its clients; primary programs include vocational rehabilitation and independent living services and centers	R Em B C
Department of Family and Protective Services (DFPS)	Case management in situations of abuse, neglect, or exploitation of children, elderly, or disabled persons; rehabilitative services such as substance abuse treatment, anger management, and parenting skills courses partnering with military base programs	R Ed
Texas Workforce Commission (TWC)	A system of resource connections for Iraq and Afghanistan veterans to facilitate service members' leading productive lives; peer-to-peer outreach and coordinated access to federal, state, and local services	R
Texas Council Community MHMR Centers (TCCC)	Provides psychiatric and substance abuse treatment, counseling and case management, and crisis response; refers veteran to local, state, and community-based care including the VA; delivers supplemental services such as finding or supporting housing and employment, as well as criminal justice case management; policy and partnership promotion for improved community resources	C R I H Em P

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project. (See Table 4.1 for list of service-type codes.)

County and City Administered Programs

Eleven Texas Veterans Courts provide benefits advocacy/claims representation (B) and indigent legal representation (I) to Texas veterans. The Governor's Criminal Justice Division (CJD), Texas Veterans Commission (TVC), and Texas Indigent Defense Commission (TIDC*)* grant funds to cover start-up costs for new Veterans Courts.[9] For example, Table 7.2 lists veterans' services in Bexar and Travis Counties.

Table 7.2
Veterans' Services Administered by Counties in Texas

Veterans Court Examples	Programs/Services	Service Type
Bexar County Veterans Treatment Court	Bexar County's Veterans Court partners with the VA, VBA, Volunteer Veteran Mentors, veterans family support organizations, the Center for Health Care Services, and the Bexar County Veterans Services Office to address veterans' mental health issues within the context of criminal justice. The primary issues of the court are PTSD, TBI, and addiction; other forms of mental illness are also addressed. The court administers two case tracks, which are generally completed within a year: pre-trial (no recorded conviction) and probation (treatment under legal terms).[10]	B I
Travis County Veterans Court	In Travis County, a pre-trial diversion program is offered for non-violent misdemeanor offenses related to mental health problems resulting from military service. Eligibility is restricted to current service members and those with honorable/general under honorable conditions discharge codes. Eligibility is also based on a diagnosis of PTSD, TBI, or other mental health issue resulting from combat or hazardous military duty, which affects the current charge.[11]	B I

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project. (See Table 4.1 for list of service-type codes.

The other nine veterans courts in Texas include Dallas County Veterans Court, Denton County Veterans Court, El Paso Veterans Court Program for Felony Cases, El Paso Veterans Treatment Court, Guadalupe County Veterans Treatment Court, Harris County Veterans Court, Hidalgo County Veterans Court, Nueces County Veterans Court Program, and Tarrant County Veterans Court.[12] Counties that administer veterans court programs often also have county-level veterans affairs or mental health offices that work with the courts.[13]

Some Texas cities deliver supplemental local veterans' services; these vary, depending on the needs and any federal or state coverage gaps in individual cities. City services usually concentrate on benefits advocacy/claims representation, resource connection/case management,

education services, and/or policy research and recommendations, but some counseling and supplemental support services are offered by cities as well. Table 7.3 describes three examples.

Challenges and Opportunities in the State System

In a December 2008 report, the Texas Department of State Health and Human Services identified gaps in the administration of veterans' services in Texas, which serves as a useful categorization of the challenges faced in this arena. Table 7.4 lists some of these challenges.

Table 7.3
Examples of Veterans' Services Administered by Cities in Texas

City Veterans Office	Programs/Services	Service Type
The City of Austin's Veterans Services Office	Austin's VSO is primarily a support organization for its National Guard, reserve, and veteran employees and their families. The VSO offers training to Austin municipal departments on legislation related to hiring, leave, and benefits, and monitors health and welfare issues. It also advocates fair treatment of its veterans and service families by all government agencies and collects and distributes furniture donations for veterans and families recovering from homelessness.	B Ed H
The City of Houston Office of Veterans Affairs	Houston's Office of Veterans Affairs professed mission is to "assist Houston in becoming the best city in the nation through unparalleled service to our serving military, veterans, and their families." It provides a variety of local public services to Houston Veterans including advocacy, representation, counseling, and resource accessibility coordination.	B C R
The City of San Antonio's Veterans Service Commission	San Antonio's Veterans' Commission tasks itself with the obligation to advise the City Council on legislative issues that affect the City's active and retired military service members. It acts as liaison and advocate for local veterans' service organization and veterans' affairs initiatives and makes policy recommendations for improved services and coverage.	P

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project. Note: See Table 4.1 for list of service codes.

As is often the case, challenges also represent opportunities for administrators of veterans' services. Table 7.5 describes some of these opportunities.

Table 7.4
Challenges for Veterans' Mental Health Care at State and Local Level

Challenge: Information Systems Inefficiencies
Several state organizations (including DSHS) have recommended that state and local organizations improve how they collect, assess, and present information to provide veterans' mental health. Much of the available data are provided in formats that make it difficult to work with. Some information that could be useful to veterans' service organizations and/or the public is kept confidential for no apparent reason.[3]
Challenge: Under-utilization of Services
Despite service needs within veteran populations, concerns of stigma and career repercussions may dissuade current or former service members from taking advantage of the benefits of these resources.[2]
Challenge: Lack of Evidence-Based Care
RAND Corporation studies have found that "treatments for post-traumatic stress disorder and major depression vary substantially in their effectiveness." A gap exists between funding for veterans' mental health services and utilization of that funding in provision of evidence-based treatment programs.[4] This raises the question of how priorities are being set on the national level and how coordination with and input from licensed mental health practitioners is currently organized and should be facilitated moving forward through care implemented at all levels. Another challenge is how to train law enforcement, social workers, and other social service providers to deliver evidence-based mental health treatments.
Challenge: Barriers to Access and Coverage
Veterans' family members often face gaps in coverage, especially with respect to mental health. Moreover, both veterans and their families often face barriers in accessing mental health services. Some of these barriers to entry might include distance and time involved in travel to mental health facilities provided to veterans, as well as cost involved in treatment of their families. Restrictions of diagnosis and discharge status can become barriers to many veterans with mental illness in utilizing state services.[14]
Challenge: Limited Inter-organizational Coordination and Communication
Texas has no shortage of organizations that have adopted a mission of providing services to veterans, as public opinion and donor funding are concentrated on provision of veterans services. Weak service coordination represents a systematic challenge. For example, it may be easier for state policy makers to justify investments in service coordination than ask non-profit organizations to invite donors to contribute towards policy analysis or information systems management.

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project.

Table 7.5
Opportunities for Veterans' Mental Health Care at State and Local Level

Opportunity: Technological Advancement
Within the arena of data, the rapidly advancing technical sophistication of network and information systems, collaborative technologies, and their users is a promising opportunity for collecting and standardizing useful data related to veterans' services.[15] This technology could help facilitate collaborative integration of databases of Texas' myriad veterans' services organizations in the future as well as engage with and foster the participation of veterans and the public in identifying needs and assessing performance.
Opportunity: Increased Funding for Evidence-Based Services and Training
Funding from 2005 Substance Abuse and Mental Health Services Administration (SAMHSA) grants represent a major resource for Texas, with more than $190 million allocated for mental health spending during 2013-14, approximately $30 million of which is discretionary.[16] One of the results of initial funding from SAMHSA grants was the development of a behavioral health clearinghouse, which links users to searchable databases, comprehensive resource lists, and best practices mapping, which can enhance access to best practices and enable practitioners to assess evidence-based coverage gaps.[17]
Opportunity: Widespread Organizational Coverage
One opportunity for heightening health coverage and access for veterans in Texas is leveraging the existing network of local providers throughout the state. There are already more than 600 veterans' services organizations in Texas.[18] Moreover, the raw material for an integrated network between these nodes is ready and available, and several strong partnership initiatives have already been formed.
Opportunity: Inter-organizational Partnerships
Coordination and communication could help build an integrated network of care among various non-profit programs and services for Texas veterans. Coordination among state veteran services agencies and other VSOs could be advanced through analysis of legislative appropriations and mechanisms of how funds are disbursed, with resulting service types and coverage. Communication could help stakeholders define Veterans Affairs' priorities, increase efficiency in resource allocation, and reduce costs for provision of publicly-funded services. Coordination at the state level could provide connections and strategic direction, while taking pressure off of local organizations to respond to requests from donors for immediate direct service provision.

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project.

Notes

[1] Office of the Governor, Rick Perry, "Criminal Justice Division, " at http://governor.state.tx.us/cjd/.

[2] Texas Military Forces, "Texas Military," at http://www.txmf.us/.

[3] Texas Health and Human Services Commission, "Texas Health and Human Services Commission," at http://www.hhsc.state.tx.us/.

[4] Texas Department of State Health Services, "Texas Department of State Health Services," at http://www.hhs.state.tx.us/.

[5] Texas Department of Assistive and Rehabilitative Services, "Texas Department of Assistive and Rehabilitative Services," at http://www.dars.state.tx.us/.

[6] Texas Department of Family and Protective Services, "Texas Department of Family and Protective Services," at http://www.dfps.state.tx.us/.

[7] Texas Workforce Commission, "Texas Workforce Commission," at http://www.twc.state.tx.us/.

[8] Texas Council of Community Centers, "Texas Council of Community Centers," at http://www.txcouncil.com/.

[9] Texas Indigent Defense Commission, "Texas Indigent Defense Commission," at http://www.txcourts.gov/tidc/TFID_Grant_Program.asp.

[10] Bexar County Veterans Treatment Court, "Bexar County Veterans Treatment Court," at http://gov.bexar.org/vtc/.

[11] TexVet, "TexVet- Get Connected," at http://www.texvet.com/partners/travis-county-veterans-court-program.

[12] Marchman, J., "Veterans Courts in Texas," *Texas Bar,* accessed April 20, 2014, at http://www.texasbar.com/AM/Template.cfm?Section=Texas_Bar_Journal&Template=/CM/ContentDisplay.cfm&ContentID=19656.

[13] Levin, Marc, "Veterans' Courts" (Center for Effective Justice, Nov. 2009), accessed April 20, 2014, at http://www.justiceforvets.org/.

[14] Department of State Health Services, Returning Veterans Subgroup of the Mental Health Transformation Working Group, "Behavioral Health Services for Returning Veterans and Their Families: Services, Gaps, and Recommendations" (Dec. 2008), accessed March 25, 2014, at http://www.mhtransformation.org/documents/reports/MHTWorkgroupReport_ReturningVeterans010809.pdf.

[15] Chapman, Gary, and Sherri Greenberg, project directors, *Texas Transparency: Beyond Raw Data* (Austin, Tex.: Lyndon B. Johnson School of Public Affairs, May 2011).

[16] Substance Abuse and Mental Health Services Administration, "State Summaries FY 2013/2014, Texas," accessed April 10, 2014, at http://www.samhsa.gov/Statesummaries/StateSummaries.aspx.

[17] Department of State Health Services, "Texas Mental Health Transformation," accessed April 6, 2014, at http://www.mhtransformation.org/.

[18] Texas Connector, "Texas Connector," at http://www.texasconnects.org/Default.aspx. Data is derived from both the 2-1-1 Texas and GuideStar USA, Inc., Texas datasets.

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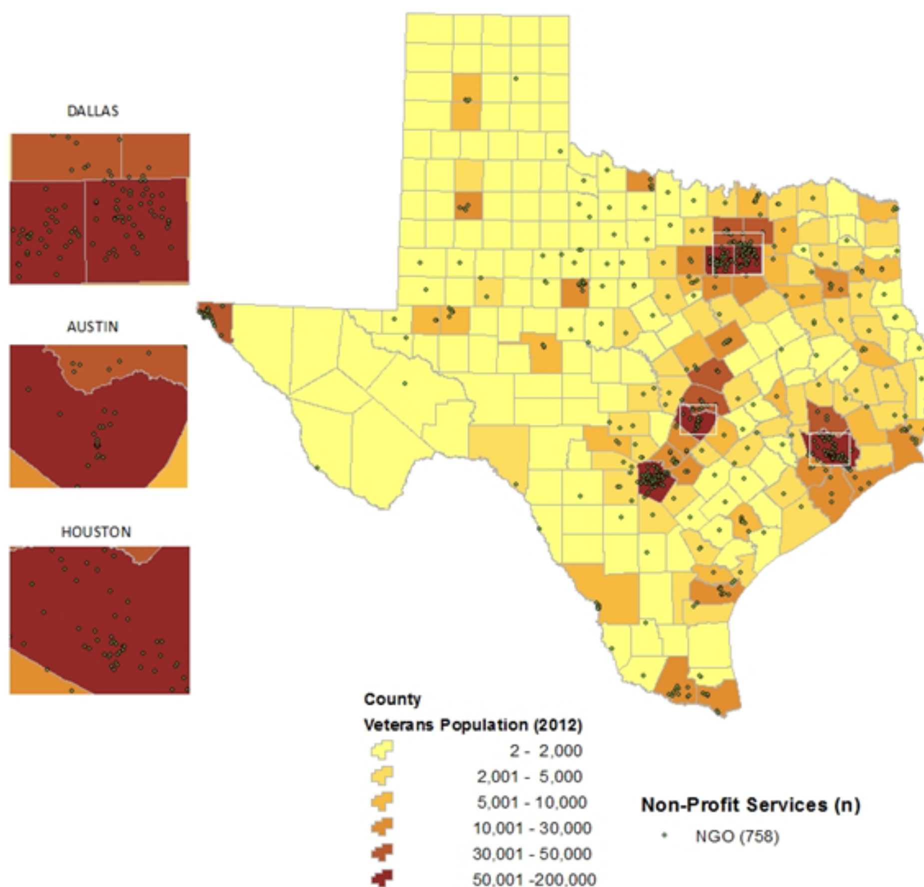
Chapter 8. Nonprofit Veterans' Services

More than 7,800 nonprofit organizations have registered with the federal government since 2001 to provide care for service members, veterans, and their families, a third of those just within the last three years.[1] In Texas alone, almost 600 different nonprofit organizations operate from nearly 800 locations, providing key services to troops and veterans or advocating for veterans' care.[2] Figure 8.1 illustrates the locations of nonprofit services dedicated to veterans' affairs within Texas. These numbers do not include the number of *national* organizations that serve veterans throughout the U.S. that also operate in Texas. Nonprofit programs collectively seek to provide for every aspect of a veteran's care, including mental health counseling, crisis intervention, financial assistance, scholarships, family and childcare support, workforce reintegration, housing, and advocacy.

Figure 8.1
Nonprofit Veterans' Mental Health Service Locations in Texas



Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project. Data from U.S. Census Bureau and Texas Connector at https://texasconnects.org/.

Federal, state, and local governments work with nonprofits to deliver key services, although the strength of contracting relationships often ebb and flow according to policy priorities and demand for services. Public-private collaboration has intensified as more nonprofits work under government contracts or access government grants, particularly in the area of veterans' affairs and health care. By partnering with capable local providers, the DoD, the VA and state institutions can enhance the management and delivery of veterans' care without increasing the number of public employees as well as provide specialized and innovative strategies for care.

For example, TexVet is a collaborative effort among federal, state, and local organizations that provides resources and enhances benefits for military veterans and their family members. These collaborative services seek "to minimize the strains associated with mobilizations and deployments for military service and family members, and to encourage the member's use of all services and benefits which may assist in their reintegration adjustment after re-deployment."[3] TexVet has expanded care to target and remedy military care issues throughout the state. Table 8.1 describes TexVet's current services and Table 8.2 lists its partnering agencies.

Intrepid Fallen Heroes Fund

Another example of public-private cooperation is the Intrepid Fallen Heroes Fund (the IFH Fund), which became an independent not-for-profit organization in 2003 and has provided close to $150 million in support for "the families of military personnel lost in service to our nation, and for severely wounded military personnel and veterans." The IFH Fund was created in 2000 to provide unrestricted grants to families of United States and British military personnel killed on duty, mostly in service in Iraq and Afghanistan, and in 2005 shifted direction to focus on building a series of rehabilitation centers for the severely wounded.[4]

Table 8.1
TexVet Services

Program	Description	Service Type
Military Veteran Peer Network	Offers mentorship and guidance to veterans and family members as well as help accessing available services and resources. Shared experience is the foundation of peer support, fostering trust and credibility.	B C R
Veteran Services Provider Network (VSPN)	A collection of all federal, state, and local Veterans Services Organizations (VSO) information to provide veterans, military members, and their families equal access to information on available services.	Ed R
Joining Community Forces: Texas (JCF-T)	Coordinates all existing veteran coalitions and helps establish coalitions where none exist. JCF-T is focused on full-spectrum quality of life services: employment and education assistance, health and mental health, housing and transportation, financial and legal support, VSOs, and family support services. See A Table 8.2 for list of notable partners.	Ed R
Austin Veteran and Family Advocacy Council (AVFAC)	Works with the VA Mental Health Clinic to establish a true partnership among veterans, veterans' families, caregivers, VA mental health professionals, VA administrators, and community mental health organizations.	Ed P

Source: "Partners and Resources 2014," TexVet, accessed February 26, 2014, at https://www.texvet.org/partners-and-resources-2014. (See Table 4.1 for list of service codes.)

Table 8.2
Notable TexVet Partners

- Department of State Health Services (DSHS)
- Iraq and Afghanistan Veterans of America (IAVI)
- The Military Child Education Coalition (MCEC)
- Mental Health America-Texas (MHA-T)
- National Alliance on Mental Illness- Texas (NAMI-Texas)
- The Military Order of the Purple Heart
- The Veterans County Service Ifficers Association of Texas
- Bring Everyone in the Zone (BEITZ)
- Veterans Administration Central Office (VACO)

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project

In January 2007, the IFH Fund completed construction of The Center for the Intrepid, a physical rehabilitation center in San Antonio, Texas, that serves military personnel catastrophically disabled in operations in Iraq and Afghanistan. After Congress mandated in 2007 that the DoD create a center for understanding the invisible wounds from the Iraq and Afghanistan wars, the National Intrepid Center of Excellence (NICoE) was created in 2010, operating under the purview of the DoD. The NICoE offers advanced diagnostic tests, initial treatment, family education, introduction to therapeutic modalities, referrals, and reintegration support for military personnel and veterans with TBI and post-traumatic stress. The NICoE conducts research, tests new protocols, and provides comprehensive training and education to patients, providers, and families while maintaining ongoing telehealth follow-up care with patients across the country and throughout the world. To enhance TBI research, diagnosis, and treatment, the IFH Fund plans to build additional centers that will serve as satellites to NICoE, to be located at some of the largest military deployment bases around the country. Data from these centers will be transmitted back to NICoE to aid its ongoing research program.

Many nonprofit organizations operate independently from government support or oversight. These organizations vary widely in their goals, programs, and breadth, offering a multitude of services on a national, statewide, or local scale. It is beyond the scope of this report to describe or even list the large numbers of nonprofit in Texas that provide services for veterans. Table 8.3 lists a few examples of well-known national nonprofit organizations and Table 8.4 includes some nonprofits working solely within Texas on veterans' mental health care issues. Despite the recent upsurge in the number of organizations dedicated to serving veterans and their families, challenges remain in the structure and delivery of care. Critics have voiced numerous concerns (see Table 8.5). National and local nonprofit organizations have demonstrated their commitment to engage with communities on the issue of veterans' care. Table 8.6 lists some opportunities for nonprofit providers add value to the arena of veterans' mental health treatment.

Table 8.3
Veterans' Services Administered by National Nonprofits

Organization	Description	Service Type
Wounded Warrior Project	Assists the newest generation of veterans who have incurred a physical or mental injury in recent wars. Services include an outdoor rehabilitative retreat, family retreat weekends, physical health and wellness programs, transitional care backpacks, a transition training academy, and peer support services.	C Ed R
Give an Hour	Recruited more than 6,700 licensed mental health professionals in a network that spans all 50 states to provide free mental health services to Iraq and Afghanistan veterans. Offers flexible hours for treatment and ensures that treatment is confidential, which many veterans fear is not available from the VA and other organizations within the military system.	C
Hope for the Warriors	Provides services including career transition and education, clinical care, sports and recreation, community outreach, and family support. The organization has a nationwide presence, with offices in North Carolina, New York, Washington, D.C., Virginia, and Florida, and representatives in California, Texas, Illinois, and Wyoming.	C Em
Veterans of Foreign Wars	Advocates for veterans and their support. VFW was instrumental in establishing the VA, creating a new GI bill, and gaining compensation for Vietnam veterans exposed to Agent Orange and veterans diagnosed with Gulf War Syndrome. The VFW also fought to improve VA medical center services for female veterans.	B P

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project.

Table 8.4
Veterans' Services Administered by Texas Nonprofits

Organization	Description	Service Type
Heroes Night Out	Offers a relaxed environment that encourages participation of veterans who are otherwise dissatisfied with the formality of the VA and other military institutions. Houses VA claims specialists, a therapist, a counselor, peer facilitators, a home loan specialist, a life coach, a computer room with internet access, and a family support room. Coordinates free sporting events, activities, and services geared towards veterans' appreciation.	C B R H
Bring Everyone in the Zone	Trains peer facilitators to provide therapeutic support and to recognize cases that require additional medical help as part of the Military Peer Network. The Zone's activities include: screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education and consultation.	C R Ed

Hope For Heroes	An umbrella program for services provided to active military, veterans, and their families by the Samaritan Center, an interfaith nonprofit organization located in Austin, Texas. The organization provides confidential counseling for service members and their families, integrative medicinal treatments (such as acupuncture, massage and herbal medicines), and access to military peer networks.	C R

Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project.

Table 8.5
Challenges for Veterans' Mental Health Care in Non-Profit System

Challenge: Service Gaps
Although nonprofits are characterized by great diversity in goals and projects, financial resources are concentrated in a small number of organizations. Activities are fragmented, resulting in services gaps based on geographic location.
Challenge: Lack of Transparency
Public confidence and trust are crucial to the success of nonprofits. However, most people have a limited understanding of the scope and operations of nonprofits. Financial and activity-level information is often either limited in detail, inaccessible without membership fees, or entirely absent. Lack of transparency and any scandals that emerge can undermine the effectiveness of the whole sector as the public loses trust.
Challenge: Fleeting Passions
Veterans' issues have emerged as a topic for national and local media seeking to support service members returning home. Goodwill may wane as media coverage declines or other issues take precedence.
Challenge: Leadership Gap
Neither the DoD nor the VA takes responsibility for, oversees, or guides community-based nonprofit organizations. Even limited oversight and strategic guidance could reduce overlap and inefficiencies. For example, there is no office at the VA providing technical support to the countless community volunteers who assist veterans, nor is there any mechanism that facilitates coordination, learning, improvement, or accountability.[5] The only such resource known to exist at the federal level "comes from the Warrior and Family Support Office, which resides in the Office of the Chairman of the Joint Chiefs of Staff, whose stated purview is the military, not veterans."[6]
Redundancy and Overlap
The groundswell of support for troops has led to a large number of well-meaning groups and individuals in veteran-related organizations. Some groups may hesitate to integrate or cooperate with other groups. Individuals often decide to start a new organization rather than work with existing programs. With redundant efforts, groups may compete for the same resources. Donors may become skeptical that the cause they support is being addressed successfully.

Table 8.6
Opportunities for Veterans' Mental Health Care in Non-Profit System

Opportunity: Capacity and Efficiency
This new generation of veteran-focused nonprofits, especially those that cater specifically to the needs of the most recent generation of veterans, provide vital services that government agencies are unable to supply. Though the DoD and VA have increased budgets and refocused resources to more efficiently address crucial veterans' needs, programs have been stretched to capacity by the flood of ill, injured, and unemployed veterans returning home. Nonprofits can provide specialized and innovative strategies for treatment that fall outside of the limits of government bureaucracies.
Opportunity: Personalized Care
Nonprofits are able to provide both services that address the unique needs of individual veterans in specific communities, as well as varied and comprehensive treatment for veterans and their families, ranging from emergency financial and child-care assistance to integrated health-services and employment-readiness training.
Opportunity: Trust
A large fraction of both current soldiers and veterans do not seek mental health care in the system because they fear ineffective treatment or negative career/life consequences. The military's "we take care of our own" perspective limits the effectiveness of government outreach programs. Community-based nonprofits represent a route that can provide services in a manner acceptable to veterans, who may otherwise fall through the cracks.
Opportunity: Ability to Engage the Public
Nonprofits can be rapid in their response to deploy volunteers quickly and efficiently as new demands arise.
Opportunity: Integration
Because of their missions, the DoD and the VA focus on treating active-duty soldiers, military members in transition, and veterans one need at a time. Nonprofit organizations can have the flexibility to partner with federal, state, and local governments, as well as other nonprofits, to encourage integrated and collaborative approaches to care that address simultaneous needs.

Notes

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[5] Nancy Berglass and Margaret C. Harrell, *Well After Service: Veteran Reintegration and American Communities* (Center for a New American Security, 2012), 19.

[6] Ibid.

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Chapter 9. Economic Impact of Veterans' Mental Health

Costs and Benefits

In 2008 the RAND Corporation (RAND) evaluated the costs and benefits associated with mental illness related to military service, including two-year costs, traumatic stress disorder, major depression, and traumatic brain injury in returning OEF/OIF veterans. The study estimated that two-year costs of mental illness of the 1.6 million U.S. service members deployed since 2001 resulting from PTSD and major depression could range from $4.0 to $6.2 billion.[1] Two-year, per-case, post-deployment costs related to PTSD were between $5,904 and $10,298; costs for major consequences ranged between $15,461 to $25,757. Annual costs in 2005 associated with TBI were between $25,571 to $30,730 per case for mild cases and from $252,251 to $383,221 for moderate to severe cases. The RAND model estimated "status quo" treatment outcomes assuming that (a) 30 percent of individuals with mental health condition receive treatment and (b) 30 percent of individuals receive evidence-based care.[2]

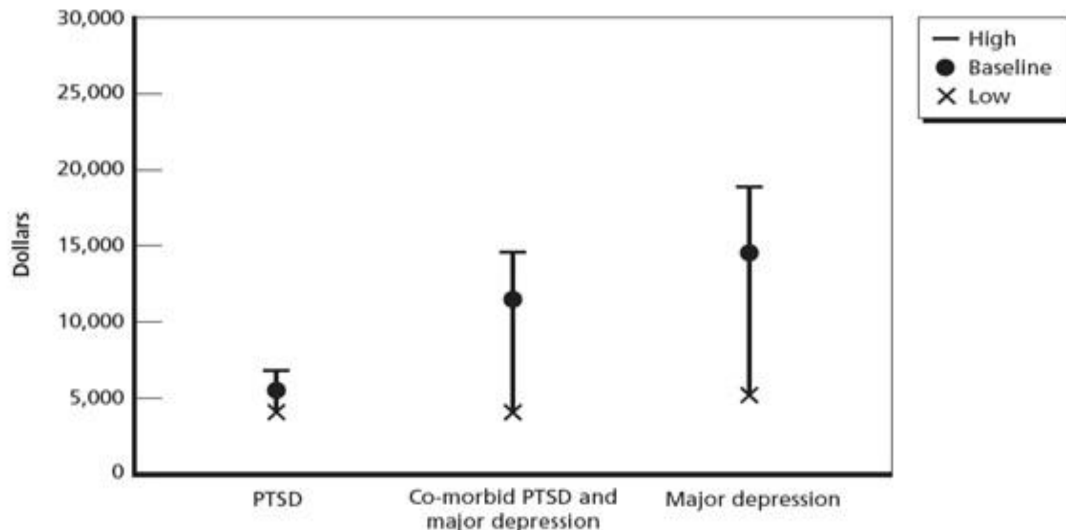
Table 9.2 lists per-case costs for PTSD, depression, and TBI. Figure 9.1 illustrates costs associated with lost productivity, health care expenses, and mortality, based on a variety of treatment conditions and probabilities.

Table 9.1
Veterans' Mental Health Estimate of Costs
(For 1.6 million returning OEF/OIF veterans over two years)

Condition	Range of Costs
Post-traumatic stress disorder (PTSD), per case	$5,904 to $10,298
Major depression, per case	$15,461 to $25,757
Total cost for PTSD/major depression	$4 to $6.2 billion
Traumatic brain disorders: -Mild case, per case -Moderate to severe case, per case	$25,571 to $30,730 $252,251 to $383,221

Source: Tanielian, Terri, and Lisa H. Jaycox, eds. *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (RAND Corporation, vol. 720, 2008).

Figure 9.1
Veterans' Mental Health: RAND Cost Estimate



Source: Tanielian, Terri, and Lisa H. Jaycox, eds. *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (RAND Corporation, vol. 720, 2008), p. 195.

Although the RAND study evaluates the economic impact of veterans' mental illness under a variety of treatment conditions, it omits administrative costs associated with large scale treatment, such as outreach, provider training, and intangible costs. Cost estimates are limited to a two-year time horizon and do not address lifelong costs of untreated illness. The RAND study does not include costs associated with major downstream effects of veterans' mental illness, such as homelessness, substance abuse, or domestic abuse. Some of the RAND study's recommendations for evidence-based treatment have been implemented, as illustrated by the VA's Center of Excellence at Waco efforts to promote evidence-based treatments in Texas.[5]

U.S. Bureau of Labor Statistics employment data from 2013 provide another view of the relationship between veterans' mental illness and productivity. U.S. veterans have a higher level of unemployment than the civilian population, even when controlling for demographic and educational differences in population composition. Returning veterans experience more unemployment than previous veteran populations, which is also reflected in unemployment figures. For example, unemployment was 9 percent in 2013 for returning veterans (September 2001 to present) versus 6.6 percent for the general veteran population.[1] Females make up only a small percentage of the veteran population while making up a much greater percentage of the civilian population—a complicating factor for random studies of the general population. When

studied independently, female veterans were found to have a harder time finding work than their female civilian counterparts.[7]
The average income among individuals with TBI is 48 percent lower one year after a typical injury.[8] Major depression decreases on-the-job baseline productivity an average of 6 to 10 percent. Productivity loss related to work absences ranges between approximately 17 and 25 percent. Job turnover is 20 percent for those with major depression, and 33 percent take lower-paying jobs for health reasons.[9]

The impact of PTSD on productivity measures is an understudied subject. However, preliminary studies indicate that OEF-OIF veterans with diagnosis-level and sub-threshold PTSD are more likely than those without significant symptoms to have trouble finding a job, difficulties with co-workers, and more absentee days from work.[1]

The relationship between mental illness and homelessness in the general population is well-established. Individuals with untreated mental illness make up one-third of the homeless population.[11] Mental illness is the second most frequently cited reason for homelessness.[12] An estimated 131,000 U.S. veterans are homeless on any given night, while 45 percent of them live with mental illness. Housing programs without any rehabilitative components that address mental illness and increase the productivity of an individual represent a net cost to society,[13] as the chronically homeless cost $35,000 to $50,000 annually per family in shelter costs.[14]

Substance use disorders represent another downstream cost of mental illnesses, as veterans are prone to a high incidence of self-medication. The National Bureau of Economic Research (NBER) reported that mental illness increases the use of addictive substances relative to the overall population by 20 percent for alcohol, 27 percent for cocaine, and 86 percent for cigarettes.[15] In total, it is estimated that SUDs cost the nation $276 billion a year with significant losses in productivity and increased healthcare spending.[16]

Domestic abuse is another consequence of mental illness[17] that adds to psychological harm. Domestic abuse costs the nation between $5 to $10 billion in social service provision.[18] Domestic violence cases involving veterans account for over 20 percent of incidents in the U.S.[19]

The RAND study does not estimate the economic cost associated with the negative impact of mental illness stigma and discrimination. However, a Cambridge study found mental health stigma to be a statistically significant cause of negative effects on employment, income, and public views about resource allocation and healthcare costs. Stigma also inhibits many veterans from seeking treatment, which is associated with increased productivity; interventions that reduce stigma could increase treatment and as a downstream result, increase productivity.[20]

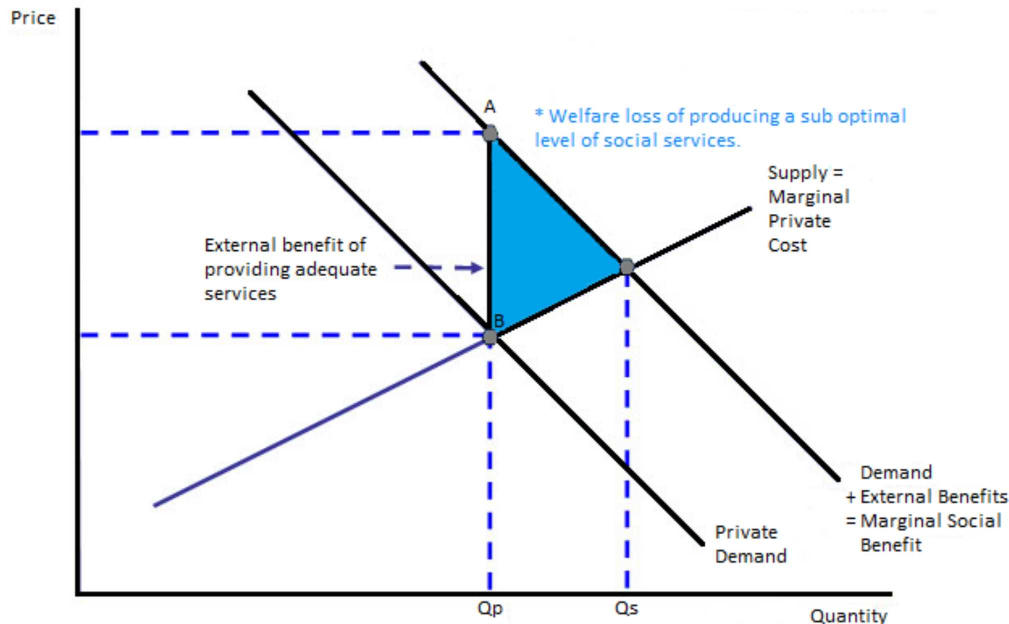
There are intangible costs of service which have gone unmeasured, such as the pain and suffering of veterans and relatives living with mental illness. For example, it is hard to estimate the "opportunity cost" from a veteran's illness on her/his reduced positive leadership contributions to the community. Soldiers entering military service and society may overlook the "invisible wounds" that military men, women, and their families incur as a result of service.

This propensity towards so-called "optimism bias" is well established[21]: the belief that individuals hold that they are less likely to experience negative events than the statistical average or a tendency to underestimate their own risks. Studies have found that individuals are particularly susceptible to this bias when they perceive a risk to be within their own control.[22] This bias may be prevalent with respect to risk assessments of mental health, as common cultural view of mental illness is that it is rooted in a lack of emotional self-control.[23]

Intangible mental illness externalities are difficult to measure and hard to track over time. This means that there is likely to be a disparity between the marginal social benefits and marginal private benefit of treatment. Figure 9.2 illustrates the welfare cost to society of producing a sub-optimal level of social services that arises from the disparity between private demand for treatment and a socially optimal level of treatment in general. These costs of illness are left to service members and their loved ones to pay, as long as they go unrecognized. The prevalence of unsupported needs means veterans and their families have to fend for themselves in the face of untreated illness and associated hardship, even as the true costs and responsibility is shared by society as a whole.

Studies have found that investment in evidence-based care of U.S. veterans' mental illness yields a high positive return. For example, the 2008 RAND model estimates that for every dollar invested on evidence-based treatment, there is $2.50 of savings over two years; an investment would pay for itself within two years.[25] This is a conservative estimate of benefit, as it excludes downstream costs. The RAND model likely further underestimates benefits of evidence-based treatment, as the study assumes a remission rate of 37 percent. More recent studies indicate significantly higher remission rates from evidence-based treatment, upwards of 50 percent.[26] A benefit-cost-and-meta-analysis by the Washington State Institute for Public Policy estimated a benefit-to-cost ratio for *evidence based* PTSD treatment at $156.14 to every $1 spent treating a general population of patients.[27] Taking into account the benefits, adequate investments in mental health treatment could make sense from the DoD's standpoint because of higher remission and recovery rates as well as the associated increase in productivity of returning service members. Taxpayers also benefit from this investment not only because of the economic boost of productivity gains but because of the decreased downstream social services expenses of unemployment, shelter, and criminal justice expenses, particularly those resulting from domestic abuse cases.

Figure 9.2
Positive Externality Associated with Treatment of Mental Illness for Veterans



Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project.

Funding Mechanisms and Measures

Funding mechanisms can affect a policy's economic impact; Table 9.2 lists examples of some of the prevailing proposals of administrative and funding mechanisms as viable systemic components or models.

New financial and administrative mechanisms could facilitate a shift towards a community-based approach to outreach and service provision. Some analysts describe these elements as critical improvements to a system that is simply not functional or adaptive in responding to changing demographics and health care needs.[7] Some system inefficiencies were identified in a RAND study of the U.S. Department of Veterans Affairs:[34] a potential for duplication and lack of coordination among organizations that contribute to inefficiency, particularly in the area of inpatient care. The RAND report recommended an approach of coordination across both VA and private sector systems with specific emphasis on so-called "best practices" to slow increasing costs.

Table 9.2
Outline of Themes in Recommended Funding Mechanisms and Administrative Funding Approaches to Mental Health Funding

Funding Mechanisms	Administrative Best Practice
Pooled funding that links medical care, social services, rehabilitation, housing, and other rehabilitative support into a flexible, responsive system.[28]	Network approach including private-public and multi-level public partnerships to capitalize on the strengths of each provider.[29]
A voucher system that enables patients to purchase health and support from private providers.[30]	Use of a network administrative organization for cost and quality control monitoring while recognizing key agencies involved in the system to maintain legitimacy.[31]
Federal funds administration through subcontracting arrangements with states to provide regulation and monitoring of local contracts and service standards, local government, and community organization services provision.[32]	Government-administrated managed care with input from stakeholders with or without the use of private subcontracting for service provision, depending on needs and cost assessments.[33]

Some analysts perceive the existing system of institutional mental health services as an impediment to the development of funding mechanisms that would provide for broadly-based service provision efficiences.[35] The Government Accountability Office estimates that more than $1 million a day is lost on the upkeep of outdated and underutilized facilities, as the system of in-patient care is unable to keep up with the needs of the population or provide adequate access. For example, if the two largest healthcare systems—the VA and the DoD—could integrate administrative systems to minimize overlap and coverage gaps, and could improve administrative efficiencies and continuity of care, together they could save $53 and $49 billion respectively.[36]

Regardless of the scope of the study, it is clear that the benefits of providing veteran health services outweigh the costs and have a significant positive effect on productivity. With further study, this investment might be maximized by targeting specific health care interventions, as well as identifying fiscal and administrative best practices. Although it is beyond the scope of this report, a comprehensive model-based evaluation of prospective funding mechanisms and administrative best practices would be helpful for identifying the best opportunities for maximizing return on investment of veterans' health and social service programs.

Notes

[1] Tanielian, Terri, and Lisa H. Jaycox, eds. *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (RAND Corporation, vol. 720, 2008).

[2] Ibid.

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[18] United Nations Children's Fund, "Domestic violence against women and girls," *Innocenti Digest*, accessed April 25, 2014, at http://www.hawaii.edu/hivandaids/Domestic%20Violence%20Against%20Women%20and%20Girls.pdf.

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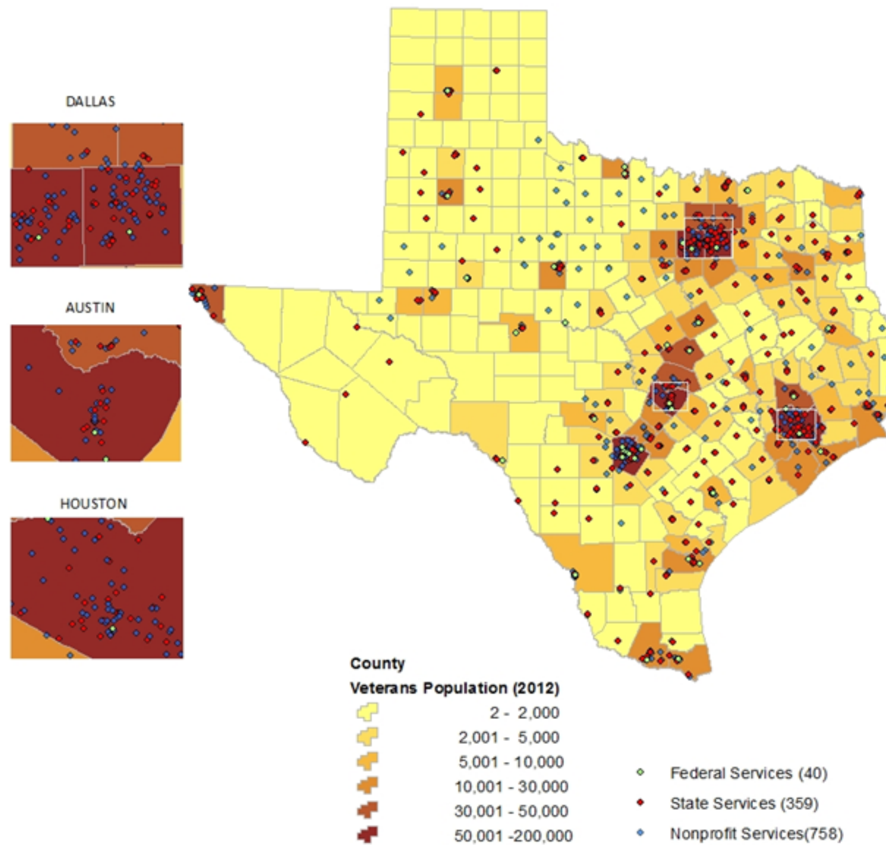
Chapter 10. Policy Recommendations

The network of federal, state, and local service providers and nonprofit agencies and programs can improve veterans' mental health services. Tables 10.1, 10.2, and 10.3 list recommendations for filling service gaps and addressing weaknesses within the network of veterans' mental health services at the national level, within Texas, and within nonprofits, respectively. Table 10.4 offers strategies to improve the network between all three levels, with an emphasis on facilitating communication and cooperation based on suggestions made by key informants during this research. Figure 10.1 illustrates federal, state, and nonprofit mental health facilities in Texas as well as the number of veterans by county. This map shows how services from the three levels of government are delivered primarily in urban areas that have a large population of veterans. This service pattern means that many rural Texas counties lack mental health facilities.

Figure 10.1
Veterans Service Locations in Texas: Federal, State and Nonprofit



Source: 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project. Data from U.S. Census Bureau, Department of Veterans Affairs, Department of Defense, and Texas Department of State Health Services.

Table 10.1
Policy Recommendations for Federal Agencies

Address mental health staff shortages at VA	Two approaches to reduce staff shortages would be to increase the budget for VA mental health staff or partner with the private sector. For example, the VA could certify qualified therapists in private practice and then coordinate and monitor treatment of patients who are veterans. The VA could extend its treatment hours beyond the limited VA hours of operation or lower the agency's charge for service provision costs.
Improve transition to VA care	When military personnel transition out of service, few of them and their families transition into VA mental health services. DoD programming should directly link those who are in DoD treatment programs to VA service providers. Transition programs could be created for veterans who did not seek care in the DoD due to stigma, but who require care. For example, the DoD could conduct debriefing group sessions prior to service completion or assign peer contacts to act as mentors in the transition out of service for all new veterans in their home regions. Peer-to-peer approaches could encourage a more consistent transition into VA and other veterans' services for mental health challenges.
Offer guidance and support to community-based nonprofit organizations	The VA and DoD have experience with bringing services to scale, knowledge of evidence-based treatments, and insight into how to select effective strategies for implementing care. Efficiency in the nonprofit sector can be gained with increased guidance that facilitates coordination and directs services toward joint wellness objectives.
Increase feedback at VA and DoD	The VA and DoD should create more opportunities for veterans, families, advocates, and smaller organizations to provide feedback about federal programs and services. An example is the monthly feedback meetings held at the Austin VA Mental Health Outpatient Clinic, facilitated by Austin Veterans and Family Advocacy Council. At these open public meetings, the clinic Director personally addresses concerns and bring those concerns to his team members. This type of personal touch and responsiveness facilitates communication and can improve services. Another method is to involve veterans and their families in the creation and evaluation of federal programs. Periodic focus groups could be particularly useful for eliciting insights and encouraging communication.

Table 10.2
Policy Recommendations for Texas State Agencies

Improve information systems and transparency	Texas state veterans' organizations could use emerging information systems information for veterans and their families. They also could cooperate with their providers to provide usable data to NGOs and the public in formats that are more accessible and easier to process to enable more effective interventions. Stakeholder surveys could help agencies assess existing systems, as well as estimate budget needs for additional information or technology.
Train social service and law enforcement agencies in mental health best practices	Service providers could increase training initiatives that ensure providers are able to recognize mental health symptoms and become knowledgeable about both best practices in crisis situations as well as evidence-based treatment, especially with respect to the unique needs of individuals and families associated with combat service.
Provide additional specialized services for veterans	Special courts for veterans has been successful at identifying behavioral health needs, indigent representation, and channeling veterans into mental health and other services provided by VA organizations. However, veterans' courts are reactive rather than preventative: they link veterans to mental health care only after they have entered the criminal justice system. Veterans with mental illness may be excluded from state services, including those who do not have diagnoses of schizophrenia, bipolar disorder, and/or major depression and those with other-than-honorable discharge status. By designing and subsidizing additional programs that are modeled after the special courts, as well as formulating less exclusive coverage qualifications, the benefits of this successful program might be multiplied through a preemptive and comprehensive strategy for addressing recidivism and initial entry of veterans into criminal courts. Additional specialized services could come in various forms. There are also opportunities to engage the private sector in the provision of these specialized services.

Table 10.3
Policy Recommendations for Nonprofit Organizations

Identify opportunities for cooperation and consolidation	As nonprofit organizations compete for funding based on their ability to serve a high number of veterans, this can lead to the creation of multiple programs fighting to provide services to the same veterans rather than expanding outreach to bring in new veterans not receiving care currently. Increasing the breadth of outreach could improve outcomes from the entire nonprofit sector. Long-term, stable funding that rewards partnerships and cooperation would reduce overlap and redundancy while expanding the impacts and outcomes of services. Creation of an information hub for organizations and providers, including maps of service provision, could also facilitate coordination.
Strengthen training of peer mentors to	Peer-to-peer networks show the potential to increase participation of reluctant veterans by reducing stigma and promoting an environment of

ensure standards of accountability	trust and camaraderie. However, in the absence of formal rules and guidelines for peer mentors, treatment may be damaging for veterans with severe or unfamiliar cases of trauma, particularly military sexual trauma. Service members are taught to "finish the mission" at all costs, which may deter some mentors to correctly encourage peers to seek professional support when it is needed.[1] Training and performance standards could enable peer mentors to understand their role as augmenting professional treatment rather than replacing it. Mentors can be evaluated regularly to promote accountability and upkeep of training standards.
Provide stable, long-term funding	Many grants distributed by foundations to nonprofit organizations are project-based, conditional, and expect immediate outputs. When grants must be renewed often, organizations may invest heavily in continuous fundraising, rather than focusing on providing care. Stable, long-term funding that rewards *impact* more than outputs will result in a more efficient use of time and resources, encourage cooperation, and deter opportunistic organizations.

Table 10.4
System-wide Policy Recommendations

Create community feedback loops	It is important that veterans and their families have opportunities to evaluate the programs that aim to serve them and express their preferences for services that succeed. Creating feedback loops facilitates communication, responsiveness, and trust. One possible method is to establish regular meetings at federal or state service facilities that invite community feedback. Meetings facilitated by Austin Veterans and Family Advocacy Council have been successful at the Austin Outpatient Clinic and could be replicated throughout the state. Other possible methods include periodic focus groups, designated personnel at agencies for receiving and responding to complaints, and veteran-selected service awards that recognize excellent organizations and staff.
Enhance outreach efforts	Federal, state, and community-level services are utilized primarily by proactive veterans who seek out care. While a multitude of agencies provide data on available resources, many veterans do not have the impulse to seek out services or have the capacity to seek information, which is often complex and sometimes even conflicting. Outreach efforts with unconventional tactics could target reluctant and neglected veterans. Outreach could move beyond existing military structures to attract veterans, such as via media awareness campaigns, or by placing VSOs or information booths at large social gatherings such as concerts or sporting events. As newer more technologically-aware veterans utilize social media, the DoD and VA could encourage more OEF and OIF veterans to seek necessary treatment, supply information on existing resources, and provide a space for veterans to connect and share experiences.
Rebrand existing services to appeal to newer veterans	Many OIF/OEF veterans have expressed feeling out-of-place at VA facilities that serve older veterans with chronic illnesses. Some well-funded nonprofit veteran associations suffer from an image that could discourage the newest generation of veterans from seeking support.

	While many veterans' concerns transcend generational gaps, some attributes of post-9/11 military service are distinct and unfamiliar to older veterans, which limits opportunities for newer veterans to find a space for camaraderie and shared values. Creating institutions and programs geared specifically to the needs of OIF/OEF veterans, either stand-alone or branched from an existing organization, could address current image issues.
Expand services to underserved veteran populations	Veterans' services are neither all-inclusive nor comprehensive, nor do they provide universal accessibility standards. VA and many other VSO health care benefits do not extend to substance abuse treatment or alternative therapies. Services do not fully address the range of needs in the veterans' community, such as homelessness. The system does not serve those with other-than-honorable discharge papers nor does it provide equal access across urban and rural communities.
Improve documentation and awareness of programs	Improving documentation of existing programs would enable better evaluation of performance, allocation of resources, and provide documentation for evidence-based for interventions that better serve those negatively affected by public service. Through innovations in information systems, organizations will be able to communicate with each other through crowd-sourcing efforts to provide a comprehensive resource for connecting veterans with mental health issues to rehabilitative services. Using veteran time contributions to build a resource network would decrease stigma as participants become aware of the real costs of mental illness through educating others.
Build upon successes	Opportunities exist at all levels of the veterans' service system to improve efficiency of resource allocation. Competitive funding mechanisms could increase innovation, creating a "race to the top" and expanding the scope of services that are working well.
Provide increased support to families and caretakers	Veterans rely on physical and emotional support from families and caretakers, yet few services are offered to families to assist with the burden of care. So-called "secondary PTSD," where children and spouses mirror PTSD behaviors, is an emerging concern in the field of veterans' mental health where family support is absent.[2]
Community education and engagement	There are many opportunities to break down widely-held stereotypes about veterans and their mental health challenges. Texans are proud of their veterans and want to support them. It is matter of leveraging opportunities to educate the public. One method is to show educational video clips or invite veteran speakers to public events and venues that already honor veterans, such as baseball games and other sporting events, at airports or on flights, at military exhibitions, or at national museums and monuments.

Notes

[1] Texas Veterans and Peer Mentors, interviewed by 2014 LBJ School Veterans' Mental Health in Texas Policy Research Project, Spring 2014.

[2] Ibid.