2024

Veteran Behavioral Health Literature Review

Best Practices: Service Implementation Overview

CREATED BY

VitAL Improving Wellness in Alabama

ADMH Alabama Department of Mental Health

Created by VitAL

The report was compiled by VitAL.
VitAL thanks the following individuals who created, drafted, and reviewed components in the *Veteran Behavioral Health Literature Review*.

Contributors
Paige Parish, LICSW, EdD
Tamekia Wilkins, PhD
Scott Parrott, PhD
Shanna McIntosh, MS, AADC
David L. Albright, PhD

Reviewers
M. Bryant Howren, PhD
VHA Office of Rural Health

Jake Proctor
Executive Director of the Alabama Military Stability Foundation
and the Director of Government Relations at Parry Labs

Angela Wright
SAMHSA Service Members, Veterans, and
their Families Technical Assistance Center

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BEST PRACTICE SERVICES INCLUDE

Services that meet the needs of veterans through the use of;

- Trauma-Informed Care.
- Knowledge of the veteran population.
- Implementation of specific practices that veterans are more likely to use, across age groups.
- Evidence-based, stigma-free clinical service provision.
- Professionals and organizations who practice cultural humility.

Services that are accessible

- By proximity.
- Through services already being used by the client (such as primary care).
- According to the needs of the population.
- Because they do not turn patients away.
- From a financial standpoint.

COMMON COMMUNITY RESOURCES USED BY VETERANS

- Benefit Navigation
- Education Support Navigation
- Family Support
- Housing
- Job Attainment and/or Training
- Medical and Behavioral Health Referrals and/or Service Navigation (Case Management)
- Partial Hospitalization
- Targeted Case Management
- Peer Support Services
- Non-clinical Groups

***Evidence-based best practices* (EBP) are clinical practices that stem from three overlapping pillars of influence:** the best available behavioral health research, clinical expertise, and the traits, culture, and preferences of the individual seeking treatment.[1] According to the U.S. Department of Veterans Affairs (VA) (2024):[2]

1. EBPs have been shown to improve a variety of behavioral health conditions.
2. EBPs have been shown to improve an individual's overall well-being.
3. EBPs are treatments that are:
    a. tailored to each veteran's needs,
    b. consider and prioritize each veteran's priorities and values, and
    c. integrate the voice of the veteran into goals for treatment.

COMMON RELATED TERMS	
EVIDENCE-BASED PRACTICES	Behavioral health practices that stem from the best available behavioral health research, clinical expertise, and the traits, culture, and preferences of the individual seeking treatment. In veteran spheres, this includes treatment that is trauma-informed and tailored to the individual veteran (person-centered).
TRAUMA-INFORMED CARE	The purposeful effort of an organization to train all professional, administrative, and support staff on the impact of trauma in order to create an organization that is empathetic, knowledgeable, and driven to provide trauma clients with a caring, warm, and understanding environment in which they can work through identified needs.
ACCESSIBILITY AND ENGAGEMENT	Behavioral health services must be geographically, financially, and culturally accessible to veterans. Streamlined engagement pathways and telehealth options enhance service uptake.
INTEGRATED CARE MODELS	Models of care that combine behavioral and physical health, thus reducing fragmentation and enhancing effectiveness.
VETERAN-CENTERED CARE	Incorporating the voice of the veteran in treatment planning fosters adherence and satisfaction. A cultural understanding of veterans' unique challenges is essential for effective service delivery.
BARRIERS TO CARE	Elements that prevent a veteran from accessing treatment. These may include: transportation challenges, stigma, and workforce shortages—which are significant barriers, particularly in rural states like Alabama.
COMPREHENSIVE SUPPORT SYSTEMS	High-quality case management, peer support, and community partnerships play crucial roles in ensuring veterans receive holistic and sustained care.
ORGANIZATIONAL COMMITMENT	Successful implementation of EBPs requires alignment at all levels of an organization, from policy to frontline service delivery.
PATIENT NAVIGATION MODEL	A model of case management service delivery implemented by the VA specifically designed to limit disconnect between assessment and treatment implementation.

Chart 1: Common, EBP-related terms that are utilized within the report.

EBPs are integrated practices supported by rigorous scientific research demonstrating effective outcomes across various settings, populations, and demographic considerations. Unlike promising practices or practice-based evidence interventions, EBPs undergo extensive scrutiny through widely disseminated, peer-reviewed research to ensure their reliability and effectiveness.[3]

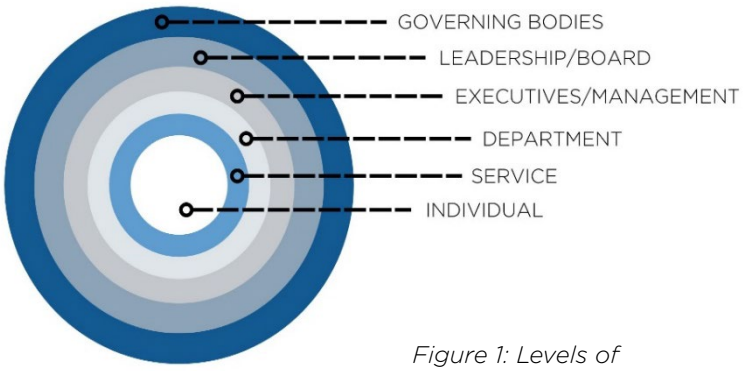

Figure 1: Levels of organizational structure

These practices are not solely the goal in individual therapy settings, but EBPs are also achievable goals through each of the varying levels of care: in both organizational structure and service implementation.[4] Single service elements of an overarching program should be considered within the context of the larger organization structure as illustrated in *Figure 1*. There are EBPs for each level of the organization in which the service is implemented, and within each level or type of care. There are examples of EBPs across levels of an organization discussed in the following sections.

SERVICE IMPLEMENTATION: ORGANIZATION LEVEL

The way behavioral health and substance use intervention services are implemented affects the success or failure of an individual's treatment. How a clinical service is structured and presented to the public influences when an individual will begin, continue, and complete the course of treatment. This includes if the individual maintains recovery following the closure of active intervention/treatments. There are many research-based factors that describe best practice implementation of behavioral health services: i.e., practices that a system, organization, or department can implement in hopes of increasing client engagement and program completion.

Behavioral health services for veterans—much like mental health services for the civilian public—are most likely to be engaged if the services are accessible. Accessibility in the provision of behavioral health and substance use services include considerations such as:

1. Location[5,6]
    a. What is the drive time for the potential client to access the service?
    b. Are the services within walkable distance of the individual's home or public transportation?
    c. Is the location confidential, or even located in a non-clinical environment?
2. Ease of Engagement[5,6]
    a. Are there options for telehealth services or phone support?
    b. Is there a chance for the client to receive behavioral health services through collaborative partnerships with services they are already engaged with (such as primary care or case management)?
    c. Is the location a one-stop-shop for comprehensive health services?
        i. If not, does the office engage in warm hand-offs of the client for referral services?

d. Does the office have an open-door policy for new patients?
e. Is there a streamlined, straightforward pathway for service engagement?

Behavioral health treatment that is driven by the veteran under the guiding support of a mental health professional is called person-centered care (*Figure 2)*. Not only is person-centered care one of the primary EBP service implementation methods, but it also allows a behavioral health service organization to implement additional best practice elements that encourage veteran engagement and adherence in treatment.[6] These additional elements include providing services that are:

- Equipped to handle crisis situations safely and with respect for the client.[4]
- Situated in a location that pursues Trauma-Informed Care.[5]
    - Trauma-Informed Care (TIC) is the purposeful effort of an organization to train all professional, administrative, and support staff—across all levels of the organization—on the impact of trauma in order to create an organization that is empathetic, knowledgeable, and driven to provide trauma clients with a caring, warm, and understanding environment in which they can work through identified needs.
- Knowledgeable of the Veteran Population.[4,5]
    - Including the specific needs of the growing aging veteran population and how these may differ from Post-9/11 Veterans.
    - Including the impact of trauma.
    - Including the effect of Social Determinants of Health (SDoH)—such as housing, finances, family support, education, etc.—on behavioral health outcomes.
- Able to address co-occurring disorders, i.e., address behavioral health and substance use in one location.[5,6]

Figure 2: Best practice service implementation always includes person-centered care.

The implementation of EBP mental health services only happens in organizations where they also have intentional best-practice infrastructure. These procedural practices include elements such as considerations for employment and steps for obtaining treatment. For example, a best practice infrastructure procedure would encourage employing appropriate professionals who are trained across the behavioral health service spectrum. This means that the professional recruited and incentivized to stay in the organization would have knowledge of prescriptions, diagnoses, therapy, and case management. This professional could answer questions about medication, conduct therapy sessions, and oversee case management plans specifically so that clients of the organization have timely and adequate support from respective professionals the moment the intervention is needed. This professional may not be able to prescribe medication, nor have every answer necessary for the client, but they would be able

to assure the veteran, with confidence, that they knew where to find the answer, and act with expediency.

Best-practice service implementation for veterans often include the need for robust case management services.[4] Case management services link the client to appropriate community services, provide support through the referral and service navigation process, and use trained professionals to support the individual through the treatment, recovery, and maintenance phases of behavioral health care. Best practice behavioral health service implementation also includes engaging the client with a peer, or individual who has similar experiences as the client. This connection can be formal: within the organization through the practice of peer support services or group therapy; or informal: connecting the individual with community-based support groups such as substance groups or military service-related groups.

One primary case management model EBP where these elements are present is the patient navigation (PN) model.[7,8] Case management services that follow the PN model specifically:

1. Seeks to eliminate disconnect between discovery of disease and treatment implementation.
2. Implements the provision of individualized assessments for individual patients.
3. Addresses individual barriers to care for patients.
4. Engages in ongoing assessment both on the individual and programmatic levels to ensure best-practice level care is continuously implemented.

PN models of care are utilized across multiple care settings including primary care, specialty care such as cancer treatment, and have been assessed for use specifically in rural settings. Veterans in rural health settings are most likely to report barriers to care such as care scarcity, distance and transportation issues including high travel costs, perceptions of poor customer service, and frustrations with bureaucratic processes.[9] According to Jervis et al. (2024),[8] PN case management addresses these barriers through assessment and implementation of person-, solution-focused care, where the navigation of these services is—in part—places on the navigator versus the veteran.[9]

Patient navigation **is an EBP case management model utilized across multiple treatment settings including rural health healthcare.**

SERVICE IMPLEMENTATION: ONE-ON-ONE SERVICES

When working with an individual, the specific, unique circumstances and history of that person should be the foundation on which treatment occurs. This means, though the care of any individual is driven by that person's identification of their own needs, the lens through which the professional carries out an intervention is influenced by his or her knowledge of the individual's circumstance and history. Professional behavioral health providers who work with the veteran population should always be competent in understanding the relationship between a veteran's mental well-being and their military service.[5,6]

This understanding starts with establishing veteran status.[5,10] Over the last two decades, there has been a push in medical and behavioral health settings to identify and explore an individual's veteran status in a way that is non-invasive and conducive to treatment. Establishing veteran status should be a common part of physical and behavioral health histories. In addition, screening for commonly veteran-associated behavioral health diagnoses—such as

substance use disorder, depression, and/or post-traumatic stress disorder—or suicidal ideation should be also an intentional part of gathering a patient's history.[11] In order to accurately capture the needs of veterans an organization is serving, a specific, intentional line of exploratory questions needs to be integrated into intake processes. Such a line of questioning includes those provided by the *Have You Ever Served in the Military?*[12,13] initiatives and assists healthcare providers in establishing a foundation of treatment that a veteran is more likely to participate in and complete.[7,9]

While some veterans express a preference for providers with military experience, research shows that non-veteran healthcare providers are equally capable of delivering high-quality, veteran-centered care when equipped with proper cultural competency. Effective care for veterans is not dependent on the provider's military background but rather on their ability to understand and address the unique health challenges and experiences of veterans. This reinforces the need for comprehensive training in military cultural competency across all healthcare settings, ensuring that veterans receive person-centered, high-quality care regardless of the provider's service history.

Healthcare services for veterans are only person-centered if they are veteran-centered; and they cannot be veteran-centered without the organization hiring and equipping healthcare professionals who trained in military culture.

In addition to establishing a rich history that includes the individual's history as a veteran, veterans are more likely to comply with treatment when they perceive their experiences with treatment as favorable.[6,10] Veterans are more likely to identify their treatment experience as favorable when the services provided are person-centered and team-based with strong leadership.[9] Overall, positive veteran experiences can be attributed to:

1. The degree of person-centered care[5,6,7,11]
    a. To what degree is the care personalized specifically to that veteran?
    b. To what degree is the veteran being equipped to direct his or her own care or treatment?
2. Cross-sectional service provision[5,11]
    a. Can the veteran receive both behavioral health and primary care in the same setting?
    b. The more referrals, locations, and/or organizations involved in treatment will lower the likelihood of engagement and adherence with treatment.
3. High frequency case management services[5]
    a. Organizations have adequate staffing and available services for each individual.
4. Culturally competent veteran care[5,10,14]

a. Are the multi-level providers within the organization trained in military culture so that they can provide services in a way veterans feel comfortable, understood, and equipped to participate in veteran-centered care?

THERAPEUTIC SUPPORT SERVICES

In addition to how services are structured and the organizations' provision of those services, there is evidence that certain types of therapeutic modalities and supports may make a veteran more successful in seeking out, completing, and maintaining desired levels of behavioral health functioning. The first are clinical behavioral health therapeutic modalities that may aid a veteran in exploring and addressing behavioral health needs. There are common, evidence-based treatments for common veteran behavioral health concerns such as post-traumatic stress disorder (PTSD), substance use disorder (SUD), insomnia, Major Depressive Disorder (MDD), and/or suicidal ideation/intent. These evidence-based services include psychotherapy, psychotropic medication interventions, and even group and/or peer support. Across the board, combined behavioral and pharmacology interventions work best for most conditions. These evidence-based practices for therapeutic care fall into one of three categories: (1) pharmacology; (2) psychotherapy; and (3) social support and service navigation. Pharmacology services are performed by medical doctors across medical settings (primary care, psychiatry, etc.). Psychotherapy can be performed by doctoral-level professionals such as psychiatrists or psychologists but is more often performed by master's-level practitioners such as licensed professional counselors (LPC) or licensed clinical social workers (LCSW). The final category, social supportive services, can be performed by a variety of persons from doctoral to master's- to bachelor's-level, or even in the community. In areas where there is a workforce shortage amongst helping professionals, it is likely that there will be gaps in the number and types of services available to veterans across the state. This is true for Alabama where labor shortages continue to rise.[14] What follows are quick reference summaries of best practice treatment with common behavioral health diagnoses and services across veteran populations.

POST-TRAUMATIC STRESS DISORDER[12,15,16,17,18]

Post-traumatic stress disorder (PTSD) is best addressed through trauma-focused psychotherapies such as Eye Movement Desensitization and Reprocessing (EMDR), Cognitive Processing, and Prolonged Exposure. There is no defined difference between treatment that is delivered in-person or using telehealth-based technology. When the symptoms are moderate to severe, and/or the symptoms include sleep disturbances—which can exacerbate symptoms of PTSD—the use of selective serotonin reuptake inhibitors (SSRIs)—also known as anti-depressant or anti-anxiety medications, and/or the prescription of the hypertensive medication, prazosin, have been shown to be effective treatment pathways.

SUBSTANCE USE DISORDER[187,19]

Substance issues should primarily be screened for often and early across sections of medical care, including primary care and specialty settings. Best practice treatment of SUD depends largely on the substance and the severity of use. Overall, the best practice treatment includes: medication treatment during withdrawal, especially in the case of opioid use; cognitive based psychotherapies; and peer support and groups for maintaining recovery status such as a 12-step program.

INSOMNIA[20]

When insomnia is diagnosed, best practice treatment has proven to include cognitive based psychotherapies such as Cognitive Behavioral Therapy for Insomnia (CBT-I). Depending on the frequency and severity of the insomnia, psychotropic medication paired with CBT-I has been found to be helpful in symptom reduction.

MAJOR DEPRESSIVE DISORDER[21,22]

In the case of a diagnosis of Major Depressive Disorder (MDD), best practice treatment typically occurs in a location where behavioral health care can be integrated with primary care, or other regular physical health services. Within treatment, pharmacology and/or psychotherapy treatment yields the best results, and the type/dosage depends on the frequency and severity of the MDD symptoms. At times, when MDD is paired with severe mental illness, including psychosis or suicidality, electroconvulsive therapy (ECT) is recommended.

SUICIDAL INTENT OR ATTEMPT[188,23]

Best practices for intervention and treatment of suicidal intent or attempts includes, first, a full assessment of the individual's current status, supports, strengths, and needs followed by collaboration with the individual's social support network. Within individual treatment, there is an emphasis on shared decision making, especially treatment planning. Optimal health outcomes and quality of life in individuals who are suicidal or have attempted suicide are usually reported at the highest level in treatment where health, behavioral health, and case management services intersect.

When considering behavioral health supports and treatment for veterans, *moral injury* and *traumatic brain injury* (TBI) should be considered, assessed, and addressed.

SOCIAL SUPPORT SERVICES

Social support services include case management services, community resource linkage, and peer support services. Case management services for veterans include professionals supporting veterans in navigating health and social systems both within medical settings and in the community.[24] The number of veterans receiving veteran-specific services has risen since the 2018 MISSION Act; and so has the need for robust case management and community resource-linking services.[25]

In addition to case management services, social support services include peer support programs. *Peer support* can be defined as "support between individuals with shared lived experiences."[25] Peer support services have been shown to potentially support veterans and their families in a holistic, multi-dimensional way.[26]

BARRIERS TO CARE

It is important that established care services are accessible in a holistic way: both physically and culturally. At times, behavioral health services are not perceived as accessible to veterans; or the services may not be physically accessible to veterans with mobility or transportation issues.

PROVIDERS[26]

One of the most fundamental barriers to behavioral health treatment is the lack of available providers and/or the lack of consistent providers—meaning providers who are available for extended periods of time, versus a "revolving door" of providers due to turnover. An additional provider-related barrier to care for veterans is the lack of a publicly accessible database or tool to find providers who are eligible to serve veterans through insurance certification, training, etc.

STIGMA[27,28]

Perhaps the most cited barrier to behavioral health treatment is stigma. *Stigma* is the fear of being labeled, thought about differently, and/or treated differently by friends, family, colleagues, and other people due to a behavioral health diagnosis or being involved with behavioral health treatment. Stigma oftentimes discourages people from seeking help for psychological distress. For example, a study of military veterans serving after the September 11th terrorist attacks examined stigma and barriers-to-care among veterans seeking help for a psychiatric disorder. Veterans worried about embarrassment, being perceived as weak, not knowing where they could find help, and encountering difficulty when scheduling appointments (Pietrzak et al., 2009). Another study (Short et al., 2024) found an association between suicidal behavior among veterans and the endorsement of stigma concerning mental illness.

TRANSPORTATION[25,29]

One common barrier to accessible care is transportation—especially in more rural areas. The distance between the home of the veteran and the office where help is available can exacerbate the severity of the barrier as the further away the services are, the less likely there will be readily available transportation to the services. In addition to distance, transportation is also costly. If an individual does have a vehicle, there are ongoing costs for upkeep, maintenance, and gasoline the individual must keep up with in order to maintain their source of transportation. In addition to distance and cost, the veteran seeking help may find transportation to be a barrier in that they are unable to drive the distance between themselves and the appointment location, or unable to drive at all. When this is the case, the veteran may find themselves in the first category of transportation barriers: no access to a vehicle they can use in order to get to the appointment. Transportation is a specific issue for access to care in Alabama.

Veteran-centered care and individualized assessments help identify the specific barriers to care that each veteran perceives or experiences.

OTHER BARRIERS[26,27,30]

Additional barriers to care are largely related to the system of the veteran. The system of the veteran are the individual and collective entities that the veteran interacts with on a regular basis. The veteran's system is influenced by where he lives, his financial or socio-economic status, and the community and state in which he lives. Availability of providers, accessibility of services, transportation, and stigma are all systems-related barriers. Other systems-related barriers can include both realities and/or perceptions of:

- The financial commitment associated with behavioral health treatment.
- The time commitment associated with behavioral health treatment.
- Stigma.
- Access to technology.

Other considerations include tailored care and doubts concerning care. Though mostly White and male, as the larger veteran population becomes more diverse, care considerations for non-White and non-male populations need to be addressed.

CONCLUSION

Before exploring, implementing, or modifying micro-level EBPs, it is important to ensure that the services provided to individuals are situated in settings where organizational-level EBPs are being executed. This is specifically true in veteran behavioral health and substance use treatment environments. EBPs for organizations include efforts that attempt to ensure services are accessible, holistic, and person-centered. In *Table 1,* below, specific practices reported in research produced by federal and state behavioral health organizations and associations are highlighted.

MULTI-LEVEL EVIDENCE-BASED BEST PRACTICES

EBP EFFORT	LEVEL	DESCRIPTION
Person-Centered Care	All Levels	Care that is tailored to the desires, needs, and initiatives of the veteran/individual. Care where the veteran/individual is a primary member of the care team.
Accessible Care	Organizational Level	Services must be accessible in both physical location and ease of engagement. This includes considerations such as operating hours, telehealth, collaborative care, intake documents, cost, and customer service.
Accessible Care	Micro Level	Services for an individual must be appropriate, i.e., they must be the most appropriate type of intervention for the diagnosis and/or situation of the veteran or individual, provided by the appropriate professional.
Trauma-Informed Care	All Levels	All staff within the organization works within a trauma-informed context. This not only contributes to the culture of the organization as a whole but is also a result of intentional efforts of the organization's leadership.
Culturally Competent with Veteran Cultures	All Levels	Multi-level staff are trained and therefore knowledgeable of veteran populations including cohort traits, common diagnoses, engagement methods, culture, and the provision of team-based services. This does not mean the organization hires only veterans, as some veterans prefer nonveteran healthcare providers; but that all providers are competent working through a lens of military culture.
Diverse Practice Methods	Organizational Level	Provision of services includes cross-sectional service provision and early screening and referrals for treatment/treatment on site.

Table 1: Multi-level Evidence-based Best Practices

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