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Veteran
Behavioral
Health
Literature
Review

CREATED BY



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The report was compiled by VitAL.

VitAL thanks the following individuals who created, drafted, and reviewed components in the *Alabama 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

PURPOSE

The purpose of the Veterans Mental Health Steering Committee is to maximize new and existing opportunities for veterans' access to behavioral healthcare.

The aim of the committee is holistic, meaning the committee sets out to maximize care for Alabama's veterans through all stages of behavioral healthcare: the prevention stage, the diagnosis and treatment stage, and in remission or the maintenance stage.

In order to maximize new and existing opportunities for veterans' access to behavioral healthcare, a baseline for the needs of veterans across cohort, age, and gender. Additionally, current best practices for clinical treatment of behavioral health diagnoses must be established. The *Veteran Behavioral Health Literature Review* provides insight for establishing a baseline on these topics in addition to framing the literature through insight on veterans within the State of Alabama.

In *Alabama Veteran Behavioral Health Literature Review*, the reader will find an account of the needs of veterans across age and gender and the current best practices in the provision of veteran behavioral healthcare. The *Review's* information is sorted across five sections.

The first section is dedicated to reviewing available needs assessments for Alabama veterans, specifically. The *Needs Assessments: Alabama Veterans* is followed by three *Best Practice* sections:

1. Best Practices: Service Implementation Overview
2. Best Practices: Veteran Populations
3. Best Practices: Across Diagnoses

The *Best Practices* sections explore the needs, traits, and best practices associated with veteran behavioral healthcare across (1) service implementation, (2) veteran populations, and (3) common mental health diagnoses. The final section, titled *Additional Considerations*, tackles important elements of veteran behavioral healthcare in Alabama that were not easily organized into the previous sections such as social supports, seasons of transitions, physical health, and invisible wounds.

The *Review* is intentionally organized. The organization of the report is intended to assist the reader in transversing the literature available on veteran mental health in a systemic way, beginning with the landscape of the assessed needs. In *Best Practices: Service Implementation Overview*, the exploration of best practices on a systems level attempts to answer the question: *What type of organization are veterans most likely to approach and engage with for mental health treatment or care?*

Following this, the *Review* sets up a concise picture of evidence-based practice care across the diverse population of the state's veterans. That is, the *Review* describes the overarching needs and approaches used for mental health treatment within different generations, genders, and underrepresented veteran populations.

Following the exploration of veteran populations, the *Review* approaches veteran mental healthcare from the perspective of diagnosis—exploring the common mental health and substance use diagnoses amongst veterans and the best evidence-based practices used within each. The report concludes by providing additional information regarding mental health and substance use considerations such as the role of case management and peer services in veteran behavioral health treatment, seasons of transition highlights, physical health insights, and the effect of invisible wounds on a veteran.

TABLE OF CONTENTS

1	NEEDS ASSESSMENTS: ALABAMA VETERANS
3	SOUTHWEST ALABAMA VETERANS NEEDS ASSESSMENT
3	Findings
3	<i>Interviews</i>
4	<i>Surveys</i>
5	<i>Findings from the Family Survey</i>
6	Discussion
7	AGING VETERANS IN THE STATE OF ALABAMA
7	Findings
8	Discussion
9	THE GREATER BIRMINGHAM AREA VETERANS NEEDS ASSESSMENT
9	Findings
10	Discussion
11	BARRIERS AND RESOURCES FOR VETERANS' POST-MILITARY TRANSITIONING IN SOUTH ALABAMA: A QUALITATIVE STUDY
11	Findings
12	Discussion
13	MILITARY CULTURE AND POST-MILITARY TRANSITIONING AMONG VETERANS: A QUALITATIVE STUDY
13	Findings
13	<i>Military Culture & Values</i>
13	<i>Conflict with Military Culture While Serving</i>
13	<i>Conflict with Military Culture After Serving</i>
14	Discussion
15	ADDITIONAL ASSESSMENTS
15	Alcohol Use
15	Drug Use
16	Behavioral Health
17	Discussion
18	BIBLIOGRAPHY
19	BEST PRACTICES: SERVICE IMPLEMENTATION OVERVIEW
21	SERVICE IMPLEMENTATION: ORGANIZATIONAL LEVEL
23	SERVICE IMPLEMENTATION: ONE-ON-ONE SERVICES
25	THERAPEUTIC SUPPORT SERVICES
25	Post-Traumatic Stress Disorder
25	Substance Use Disorder
25	Insomnia
26	Major Depressive Disorder
26	Suicidal Intent or Attempt
26	Social Support Services

26	BARRIERS TO CARE
26	Providers
27	Stigma
27	Transportation
27	Other Barriers
28	CONCLUSION
29	BIBLIOGRAPHY
31	BEST PRACTICES: VETERAN POPULATIONS
32	UNDERSERVED VETERANS
32	Women Veterans
34	<i>Military Sexual Trauma</i>
34	WORLD WAR II & KOREAN VETERANS
34	Post-Traumatic Stress Disorder + Aging
35	End of Life Care
35	VIETNAM VETERANS
37	GULF WAR VETERANS
38	POST-9/11 VETERANS
40	BIBLIOGRAPHY
44	BEST PRACTICES: ACROSS DIAGNOSES
44	OVERVIEW
44	SUICIDE
47	Risk & Protective Factors
47	POST-TRAUMATIC STRESS DISORDER
50	SUBSTANCE USE DISORDERS
52	DEPRESSIVE AND ANXIETY DISORDERS
52	Depression
53	Anxiety
53	Treatment
55	BIPOLAR AND SCHIZOPHRENIA
56	BIBLIOGRAPHY
58	ADDITIONAL CONSIDERATIONS
58	CASE MANAGEMENT SERVICES
59	PEER SUPPORT SERVICES
59	SEASONS OF TRANSITION
61	Veteran Transitions & Community
63	PHYSICAL HEALTH
64	Invisible Wounds of Service
67	BIBLIOGRAPHY

CHARTS

2	THEMES ACROSS ASSESSMENTS
20	COMMON, EBP-RELATED TERMS WITHIN THE REPORT
50	FACTS: SUBSTANCES AND VETERANS

FIGURES

21	LEVELS OF ORGANIZATIONAL STRUCTURE
22	BEST PRACTICE SERVICE IMPLEMENTATION: PERSON-CENTERED CARE
61	CONSIDERATIONS IN CIVILIAN TO MILITARY TO VETERAN TRANSITIONS

TABLES

6	SOUTHWEST ALABAMA VETERANS NEEDS ASSESSMENT: RECOMMENDATIONS & PROBLEMS
8	AGING VETERANS IN THE STATE OF ALABAMA: RECOMMENDATIONS & PROBLEMS
10	THE GREATER BIRMINGHAM AREA VETERANS NEEDS ASSESSMENT: RECOMMENDATIONS & PROBLEMS
12	BARRIERS AND RESOURCES FOR VETERANS' POST-MILITARY TRANSITIONING IN SOUTH ALABAMA: RECOMMENDATIONS & PROBLEMS
14	MILITARY CULTURE AND POST-MILITARY TRANSITIONING AMONG VETERANS: RECOMMENDATIONS & PROBLEMS
17	ADDITIONAL ARTICLES: PROBLEMS & RECOMMENDATIONS
28	MULTI-LEVEL EVIDENCE BASED BEST PRACTICES
46	EVIDENCE BASED PRACTICES FOR SUICIDE PREVENTION & INTERVENTION
49	EVIDENCE BASED PRACTICES FOR PTSD ASSESSMENT & TREATMENT
51	EVIDENCE BASED PRACTICES FOR TREATMENT OF SUBSTANCE USE DISORDERS
54	EVIDENCE BASED PRACTICES FOR TREATMENT OF DEPRESSIVE & ANXIETY DISORDERS
55	EVIDENCE BASED PRACTICES FOR TREATMENT OF BIPOLAR DISORDER & SCHIZOPHRENIA
58	EVIDENCE BASED PRACTICES FOR VETERAN CASE MANAGEMENT
59	EVIDENCE BASED PRACTICES FOR PEER SUPPORT SERVICES
62	EVIDENCE BASED PRACTICES FOR SEASONS OF TRANSITION

NEEDS ASSESSMENTS: Alabama Veterans

SOUTHWEST ALABAMA VETERAN NEEDS ASSESSMENT¹

Sought to identify the unmet needs and perceived gaps in available services of veterans and their families.

Quantitative and qualitative methods where research was conducted across eight Alabama counties: Mobile, Baldwin, Escambia, Conecuh, Monroe, Clarke, Choctaw, and Washington.

AGING VETERANS IN THE STATE OF ALABAMA²

Sought to specify target areas (health, healthcare, home stability, food stability, and caregiving status) for serving middle-aged and older military veterans in Alabama.

Quantitative methods that used existing data from the AARP to identify themes related to Alabama military veterans ($n = 556$) related to health issues, healthcare utilization, home stability, food stability, and caregiving status.

THE GREATER BIRMINGHAM AREA VETERAN NEEDS ASSESSMENT³

Sought to identify the unmet needs and perceived gaps in available services of veterans and their families.

A qualitative study designed to capture the experiences of military veterans and veteran service organizations in counties surrounding the Greater Birmingham area.

BARRIERS & RESOURCES FOR VETERANS' POST-MILITARY TRANSITIONING IN SOUTH ALABAMA⁴

Sought to provide an initial picture of the prominent barriers and resources for veterans in Alabama.

Qualitative methods that utilized both focus groups and expert interviews of veterans and families of veterans in a concentrated and rural southern area in the state.

MILITARY CULTURE AND POST-MILITARY TRANSITIONING AMONG VETERANS: A QUALITATIVE ANALYSIS⁵

Sought to describe existing military culture to help inform ongoing efforts to incorporate military culture into the provision of healthcare services for veterans.

Qualitative methods utilized focus groups to identify elements of military culture perceived by service members pre-discharge (while serving) and post-discharge (in the civilian community).

THEMES ACROSS ASSESSMENTS

<p>ACCESSIBILITY MATTERS</p>	<p>Accessibility of services was reported as a need in four assessments. Across the assessments, the two primary needs were noted as addressing barriers to care such as physical barriers (transportation, location, lack of remote access, lack of providers and/or services) and intrinsic barriers (walking into a <i>behavioral health</i> provider, dissatisfaction due to cultural incompetence, lack of education regarding available services).</p>
<p>THE IMPORTANCE OF INTEGRATED CARE</p>	<p>Integrated care is when mental healthcare and substance use treatment is folded into primary and/or specialty care organizations or services. Integrated care was reported as a need in three of the assessments to varying degrees: stressing the need for early screeners for mental illness and/or substance use diagnoses, up to complete treatment of all three—physical, behavioral, and substance diagnoses—under one roof.</p>
<p>THE WHOLE VETERAN: HOLISTIC APPROACHES</p>	<p>Person-centered care has been established as the best practice approach for both behavioral health and substance use services. Person-centered treatment not only fixes the veteran as a pilot of his/her treatment plan, but also considers needs that exist outside of diagnostic criteria that may be contributing to physical and mental illness. These needs—known as <i>Social Determinants of Health</i> (SDoH)—should be assessed in turn with standardized diagnostic assessments.</p>
<p>COMMUNITY SUPPORT</p>	<p>The need for increased community resources and/or community involvement was directly reported in three assessments and discussed in two additional assessments. These discussions took two approaches to recommendations. The first was community focused. It called for the veteran’s community to increase community resources focused on common veteran needs. The second was veteran focused, in that it called for veterans to increase exposure and involvement in the community in ways that are congruent with military culture (service, honor).</p>
<p>STIGMA REDUCTION IS CRUCIAL</p>	<p>Reducing stigma involving behavioral health and substance use treatment was noted as a need in five of the assessments. Recommendations for reducing stigma included, (1) increasing veteran presence in stigma-laden settings; (2) community education and exposure to services; and (3) increasing military cultural competence in the community so services are veteran-friendly and equipped to serve veterans in a satisfactory way.</p>
<p>PROVIDER EDUCATION IS IMPERATIVE</p>	<p>Two types of provider education were reported as needs across five assessments. Provider education was also incorporated into other needs—such as person-centered care and stigma reduction—in two assessments. Provider education included educating providers regarding military culture, so that the organization is culturally competent and approachable in veteran spheres. The second type of provider education stemmed from discussion around opioid prescription and the connections between prescribing opioids and opioid substance use disorder.</p>

Chart 1: Themes Across Assessments

In this exploration of needs assessments, eight individual works focused on Alabama’s veterans are discussed. The assessments included both qualitative and quantitative studies focused on veteran needs and/or gaps in services across varying population cohorts and regional groups of veterans in Alabama. Eight assessments total are addressed in the following pages: five discussed individually with separate headings and subsequent highlights following. The last three assessments are discussed in conjunction with one another at the end of the section.

SOUTHWEST ALABAMA VETERANS NEEDS ASSESSMENT

Published in 2017, the purpose of the *Southwest Alabama Veterans Needs Assessment* (SAVNA) was to identify the unmet needs and perceived gaps in available services of veterans and their families located in an eight-county area in southern Alabama: Mobile, Baldwin, Escambia, Conecuh, Monroe, Clarke, Choctaw, and Washington counties, in which approximately 64,000 veterans reside. The SAVNA was conducted in two phases: a qualitative phase and a quantitative phase. Phase one, the qualitative phase, included focus groups, individual interviews with Alabama Veterans and their family members, key informants, and relevant stakeholders about their unmet needs and perceived gaps in available services. Phase two, the quantitative phase, asked veteran participants to complete one survey and a close family member of the veteran—such as a parent, spouse, sibling, or child—to complete a second survey. Within the participant population, 68.2% of surveys were filled out by white veterans, 31.4% by non-White veterans, and 12.5% were female. Many of the veterans had some form of higher education, a majority having an associate’s degree or higher (53.8%), with a bachelor’s degree reported as the second most common response at 25.2%. Two-thirds of participating veterans were married.

FINDINGS

The findings of the SAVNA focused on transitioning from military to civilian life as a barrier reported within most groups. This was echoed within the quantitative surveys.

INTERVIEWS

Within the interviews, there were numerous themes identified as barriers to successful transitions between military and civilian life. The subjects within the groups that were reported as themes were those reported by at least half the participants. These included:

- financial difficulties and limited job opportunities;
- dissonance with civilian or post-military culture/life;
- negative perception of efficacy/competence of U.S. Department of Veterans Affairs’ (VA) services;
- family/marital conflict or divorce;
- stigmatizing attitudes/beliefs from public against military veterans;
- limited advertising/information about available resources;
- post-traumatic stress disorder (PTSD) and other mental health symptomatology;
- problems with alcohol/drug misuse;
- difficulties completing VA disability process and/or establishing care with VA; and
- generational differences between veterans of different military eras.

Veterans report difficulties transitioning to civilian life due to job shortages, cultural disconnections, and mental health issues. Female and non-White veterans face the greatest struggles.

These findings were compared to the results of the two quantitative surveys in the SAVNA.

SURVEYS

Across the surveys, more than one-third (40.7%) of veteran participants agreed that adjusting to civilian life was difficult for them. Both non-White veterans and female veterans were more likely to agree that adjustment was difficult for them (46.8% for non-White vets; 52.8% for female vets). Overall, female, and non-White veterans reported more difficulties with the military-to-civilian transition than men or white veterans.

When asked if they needed time to figure out what to do during their transition, 45% of all veterans agreed that they did. In that, non-White veterans were more likely to agree (58.9%) than white veterans (50.5%), and female veterans were the most likely to agree they needed time (77.8% vs. 46% for men).

Multiple categories regarding transitioning to civilian life were assessed in the report. One category was employment and finances. An important employment finding was the high numbers of veterans who were unemployed and seeking employment (pre-9/11 veterans 6.7%, post-9/11 veterans 8.7%). These percentages are higher than the State of Alabama's average unemployment rate of 3.9%. Among veterans who reported being unemployed and seeking employment, the highest rate was for female respondents at 9.7%.

According to the VA, Post-9/11 Veterans are veterans are the youngest cohort of veterans who have served after September 11, 2001. The cohort currently does not have an end date and thus continues to grow.⁹

Food security, housing, and income were discussed in the findings. These are all closely related to employment status. Across the three categories, 35.4% reported that within the past twelve months, they were sometimes or often worried that food would run out before they got money to buy more. This was slightly more likely to be reported by female (54.9%) or non-White (50%) veterans than other subgroups. In addition, 28.8% of veteran participants reported within the past 12 months, the food they bought did not last and that they did not have money to get more *sometimes* or *often*. This was also higher in female (32.3%) and non-White (45.1%) veterans.

These findings were different from the discussion regarding housing. Within housing, older veterans were reportedly less likely than younger veterans to find a permanent place to live, and in the past two months, 12.8% of veterans reported inconsistent or no housing. The highest rate was among non-White veterans (24.4%). Regarding housing, rates differed significantly between male and female veterans at 15.5% versus 6.5%, respectively.

There were five physical health, mental health, and alcohol use-related categories explored in the SAVNA. Across the five categories,

1. *Regarding physical health*, more than half (55.8%) of the veterans reported their health as *good* or *excellent*, while approximately one-third (37.5%) of veterans reported their health as either *fair* or *poor*. More than half (57%) of veterans reported receiving medical care for a physical need in the past 12 months.
 - a. Over one in ten (13.8%) post-9/11 veterans reported Traumatic Brain Injury (TBI) as compared to pre-9/11 veterans (3.3%).

2. *Regarding mental health*, nearly one-third (30.2%) of the veterans reported receiving some form of mental health service with both pre- and post-9/11 veterans having similar rates of mental health care (32.8% and 35.4%, respectively).
 - a. The two most common self-reported mental illnesses were anxiety (45.2% pre-9/11 and 42.4% of post-9/11 veterans) and PTSD (31.9% of pre-9/11 and 35.4% of post-9/11 veterans).
 - b. Despite these numbers, only 27.8% of veterans reported currently seeing a mental health professional and fewer, 17.7%, reported even wanting mental health care.
 - c. There are 36.4% reported veterans with some level of suicidal thought or attempt. No gender, race, or pre-post-9/11 difference was found in suicidal ideation and attempt among veterans.
3. *Regarding alcohol use*, 16.3% reported drinking alcohol 4 or more times a week, and male veterans were six times as likely to drink 4 or more times a week (20.1%) than female veterans (3.3%). Interestingly, 29.2% reported never drinking alcohol.
4. *Regarding veteran benefits*, only half (50.3%) of veterans in the study reported knowing at least some information about available education benefits. Similarly, only half of veterans reported knowing some or a lot about the health care benefits (49.7%), burial benefits (43.8%), or home loan benefits (46.2%) to which they are entitled.
 - a. Within this, half (51.4%) of veterans reported having filed a VA Disability claim, and of those who filed a claim, 34.4% were granted benefits. Reportedly, post-9/11 veterans were more likely to receive benefits than pre-9/11 veterans (78.6% versus 55.5%)

FINDINGS FROM FAMILY SURVEY

The results of the family survey reported that the greatest concerns of the participants included receiving/pursuing benefits (54.4% having challenges) and knowing where to go for services (48.1%). The least reported challenge was that of training or education for the parent. A higher percentage of non-White participants (33.3%) reported challenges with employment than white participants (16.5%) and non-White participants also reported a higher percentage of challenges with benefits, at a rate of 66.7% compared to whites at 50.6%.

54.4% of veterans reported issues obtaining guaranteed services post-transition to civilian life.

48.1% reported no knowledge of where to go to obtain rightful services.

DISCUSSION

The findings from this study also underscore the reality that veterans and their families have a range of needs that no one organization can address. Recommendations were discussed based on findings. These recommendations are reported in *Table 1*, below.

SOUTHWEST ALABAMA VETERANS NEEDS ASSESSMENT		
RECOMMENDATION	PROBLEM	DESCRIPTION
Ensure Service Availability/ Promote Accessible Services	Physical and intrinsic barriers to care exist.	<p>Recommendations include:</p> <ol style="list-style-type: none"> 1. Develop local transition support services and resources aimed at recently transitioned veterans, especially women and minority veterans, to assess individual needs and develop individual support plans. 2. Support regional public service announcements that normalize behavioral, mental, and physical health needs. 3. Strengthen access and connection to VA-based mental health services and support development of specialized, community-based programs outside of the VA system.
Increase Community and Professional Education	Lack of awareness of veteran experience, moral injury, and/or military culture.	<p>Recommendations include:</p> <ol style="list-style-type: none"> 1. Increase awareness of and services for the problem of moral injury among veterans, especially older veterans; capacity-building in this area should include spiritual advisors (e.g., chaplains, clergy, and local congregations). 2. Support regional public service announcements that normalize behavioral, mental, and physical health needs.
Increase Community Resources	Shortage of readily accessible community resources tailored to veteran-specific needs.	<p>Recommendations include:</p> <ol style="list-style-type: none"> 1. Support the development of community-based resources directed to develop and improve lives of veterans, specifically regarding: <ol style="list-style-type: none"> a. Financial literacy b. Employment 2. Continue support for veteran-focused homelessness services and support capacity to target minority veterans. 3. Strengthen access and connections to VA-based mental health services and support development of specialized, community-based programs outside of the VA system. 4. Provide veteran caregiver training on common conditions and local service availability, including the creation of community catalogues of services by county. 5. Support community-based professional and peer support services and activities.

Table 1: Southwest Alabama Veterans Needs Assessment: Recommendations & Problems

AGING VETERANS IN THE STATE OF ALABAMA

Aging Veterans in the State of Alabama (AVSA) was a study conducted in 2020. The AVSA was a cross-sectional study of middle-aged and older veterans living in Alabama which sought to determine specific areas of need within five life-course domains: health, healthcare utilization, home stability, food stability, and caregiving. These needs were further assessed within specific sociodemographic characteristics. There were 556 participants, ages 45+, who completed the study via phone interview in Alabama. The interviews were conducted by the American Association of Retired Persons (AARP).

FINDINGS

Within the AVSA, the most prevalent health issue reported, regardless of age, was high blood pressure (55.36%), followed by diabetes (30.88%), heart disease (16.49%), and cancer (14.27%). Cancer was more prevalent among (a) veterans aged ≥ 65 years than among veterans aged < 65 years ($p < .005$); and (b) white veterans than non-White veterans ($p < .005$). Heart disease was more prevalent among rural-dwelling veterans than among urban-dwelling veterans ($p < .005$), and lung disease was more common among white veterans than among non-White veterans ($p < .005$). Regarding mental health, 11.06% of Alabama Veterans reported using mental health services in the last twelve months.

In addition to mental health and substance use considerations, with aging veterans, physical health—such as high blood pressure and diabetes—and physical needs—such as housing and food securities—need to be assessed and addressed.

The AVSA also reported healthcare access and provider preference of participating veterans. Less than half (40.06%) sought healthcare from the VA. More than 63% of participating veterans in the State of Alabama reported using healthcare from a different source other than the VA or U.S. Department of Defense (DOD). Alabama Veterans aged 65 years and older were more likely to use some other healthcare source (other than the VA or DOD) than veterans under age 65 years ($p < .005$).

Regarding social determinants of health (SDoH), the AVSA cites that less than 5% of veteran participants reported hunger risk; however, hunger risk was more prevalent among non-White veterans than among white veterans. In addition, approximately 20% of Alabama Veterans reported having experienced housing instability in the last twelve months and just below 10% (9.94%) of Alabama Veterans reported providing care in an unpaid capacity for a loved one in the last twelve months.

DISCUSSION

Following the presentation of the research, the AVSA makes recommendations based on the findings discussed in the study. These recommendations are reported in *Table 2*, below.

AGING VETERANS IN THE STATE OF ALABAMA		
RECOMMENDATION	PROBLEM	DESCRIPTION
Community Engaged Approaches	Veterans have differing needs across age groups and home settings.	If services are to be tailored to the needs of the individual veteran, community engaged approaches are more likely to provide individualized care versus approaches tailored for larger demographic regions.
Increase Mental Health Service Utilization	Veterans are less likely than nonveterans to seek out mental health treatment.	<p>Intrinsic barriers to care include concerns regarding stigma, career impact, negative attitudes toward treatment, and lack of support.</p> <p>Solutions to these barriers of care may include “solutions that target de-stigmatization of mental illness within the military are pertinent, which may be accomplished through peer-to-peer support programs aiming to normalize mental illness, such as group counseling, mentoring, and support groups” (11).</p> <p>Increasing mental health service utilization can also be supported through community awareness and education programs centered around benefits available to veterans, specifically.</p>
Increase Peer Support Efforts	Lack of cultural compliance combined with “hero” imagery may yield intrinsic barriers to care for veterans.	Veterans are less likely to seek out and maintain compliance when there is little foreknowledge of military culture and/or experience. “With civilian opinion of veterans connected to media representations, veterans are more likely to be understood by their peers through the shared experience of ‘living’ the military life. Research also suggests that peer-to-peer engagement can be an effective way to address mental health” (12).
Increase Support for Identified Physical Needs	Veterans who experience food and housing insecurity lack interventions tailored to their compounded-need situations. This is also true for veteran caregivers.	<p>For both food and housing insecurity interventions, support for intergenerational living is recommended. Intergenerational living provides shelter for aging veterans, social support, and—in situations where there is a caregiver—can provide caregiver support.</p> <p>Financial support for veteran caregivers, food support, and housing support is also recommended.</p>

Table 2: Aging Veterans in the State of Alabama: Recommendations & Problems

THE GREATER BIRMINGHAM AREA VETERANS NEEDS ASSESSMENT

Published in January 2022, *The Greater Birmingham Area Veterans Needs Assessment* (GBVNA) was conducted to gain insight into the military veteran population in a selection of six counties centered around the City of Birmingham. The Central Alabama counties chosen for the GBVNA included Tuscaloosa, Bibb, Jefferson, Shelby, St. Clair, and Talladega counties. This research was unique in that the participants not only included area veterans, but also veteran service organizations that provide supportive services to the military veteran population. The research focused on multiple physical health, mental health, health access, SDoH, and substance use categories/experiences that are common issues for veterans, in addition to the COVID-19 Pandemic which was still at its height during the time GBVNA research was being conducted. The assessment was conducted via survey with a participant population of 135, in addition to an analysis of focus groups across select counties in the six-county catchment area. One limitation of the study is the small population size.

FINDINGS

Within the GBVNA survey, the following findings were reported:

1. 65% of respondents reported using their GI Bill educational benefits while 28% reported they had not used these benefits.
2. 21% of veterans reported using the Alabama GI Dependent Scholarship Program for a dependent and 73% had not.
3. Veterans reported using health care services through the VA (68%), while 32% stated they were not.
4. 28% stated they utilized healthcare services through Tricare and 65% stated they did not.
5. 71% of veterans also reported using another source for healthcare services, while 28% stated they did not.
6. 38% of veterans reported their disability, handicap, or chronic disease kept them from fully participating in work, school, housework, or other activities.
7. 28.83% had received mental health services within the past twelve months of data collection.

It was noted in the GBVNA findings that the survey should be considered in light of the small number of participants—a major limitation of the study.

Within the focus group work for the GBVNA, the findings state that participating veterans reported not utilizing veteran services at high volumes. The major findings from the focus groups also included:

1. Veterans reported alcoholism, depression, and suicide to be major problems in the veteran community.
2. There are gaps in awareness about veteran support organizations.
3. Focus group data revealed that veterans were unhappy with the wait time between the VA and a community care referral.

DISCUSSION

Following the presentation of the research, the GBVNA presented four primary recommendations for the issues identified through the study. Recommendations were discussed based on findings. These recommendations are reported in *Table 3*, below.

THE GREATER BIRMINGHAM AREA VETERANS NEEDS ASSESSMENT		
RECOMMENDATION	PROBLEM	DESCRIPTION
Encourage Service Utilization	Veterans in the area were not utilizing services at a high rate.	Increase area awareness of available services and/or community resources available to veterans, and engage stakeholder (veteran) buy-in.
Bolster Service Appeal to Male Veterans	Male veterans underutilize regional services.	Encourage organizations to work with existing programs such as Project Headstrong or Give-An-Hour to increase services' appeal to male veterans.
Reduce Wait Time for Community Care	VA community referrals were seen as "dragged out" and inefficient.	Increase networking between the VA and community resources through bolstering relationships between the two entities and placing VA representatives (best case) and/or providing VA-based education for resources (minimally) for referral agencies.
Integrate Technology into Service Provision	Traveling to services is a traditional, well-known barrier to services for veteran populations.	Plan and initiate integration of available technologies to increase awareness of resources, accessibility, and communication between the resource and the veteran.

Table 3: The Greater Birmingham Area Veterans Needs Assessment: Recommendations & Problems

BARRIERS AND RESOURCES FOR VETERANS' POST-MILITARY TRANSITIONING IN SOUTH ALABAMA: A QUALITATIVE ANALYSIS

Published in 2018, *Barriers and Resources for Veterans' Post-military Transitioning in South Alabama: A qualitative analysis* (BRSA) was conducted in an effort to allow veterans to report available resources and barriers that might prevent access to existing resources in their own words. The study was conducted with focus groups across eight counties in the southern portion of Alabama.

FINDINGS

Within the BRSA study, the findings state that data collected suggests that many veterans in South Alabama were not prepared for their military-to-civilian transition, especially female and minority veterans. There were two emergent themes discussed within the findings. The first included the importance of access to VA services during the military-to-civilian transition. Participants identified barriers to accessing care and emphasized a need for that care, specifically as it relates to mental health. This was the second emergent theme in the findings: mental health. Regarding transitioning to civilian life, outside of issues related to mental health, the participants reported that stress between home life and reintegration to non-military life was a barrier to successful transitions home. In addition, participants cited the importance of structural support services to include employment services and housing. The study's finding is important as it suggests prioritizing integrated programming to offer practical services with a focus on cultivating social support.

Regarding mental health, the participants in the BRSA reported a lack of access to culturally competent mental health care in the government and civic sectors. Participants reported the need for support for existing veterans support and/or mentor organizations.

Reported barriers for successful transitions to civilian life included:

- transitioning military skills and experience into civilian life employment or experience;
- access to benefits provided by the VA;
- barriers to mental health treatment, specifically;
- loss of relationships with other military personnel;
- frustration with paperwork associated with support services;
- lack of education regarding available supports and services; and
- lack of community and professional understanding of military experience.

In addition, the participants reported widespread issues that warranted support including:

- satisfactory employment;
- mental health distress;
- drug or alcohol addiction;
- familial conflict and/or instability; and
- dissonance with civilian or post-military culture/life.

Veterans struggle to adapt to civilian life and often feel disconnected from their communities.

DISCUSSION

Following the presentation of the research, the BRSA links the results of the research to other research, highlighting how they agree that access to care, financial and employment resources, mental health issues, and often co-occurring cultural adjustment problems challenge veterans reintegrating into civilian life. Recommendations were discussed based on the findings of the study. These recommendations are reported in *Table 4*, below.

BARRIERS AND RESOURCES FOR VETERANS' POST-MILITARY TRANSITIONING IN SOUTH ALABAMA		
RECOMMENDATION	PROBLEM	DESCRIPTION
Increase Community and Professional Education	Issues with stigma lead to lower mental health outcomes. Lack of military cultural competence leads to barriers for care.	"To improve mental health outcomes and combat stigma issues, counties should deliver targeted public service announcements that normalize behavioral, mental, and physical health needs while also sharing information for veterans on where they can go for and/or call for additional information on services" (244).
Increase Mental Health Service Accessibility	Services that are perceived as inaccessible due to intrinsic reasons or physically are inaccessible yield lower mental health service utilization.	Recommendations include: <ol style="list-style-type: none"> 1. Increase the number of mental health service professionals in rural Alabama communities. 2. Ensure that appropriate levels of military cultural competency exist. 3. Provide county-level services in nontraditional settings like churches and hardware stores (244).
Improve Current Mental Health Services	Cultural and physical barriers to care exist.	Recommendations include: <ol style="list-style-type: none"> 1. Staff VA-certified veterans service officers (VSO) whose mission it is to enable system access for veterans. 2. Ensure VSOs offer robust transportation-related resources to facilitate health-care access.
Provide Individualized Care	The veteran population of Alabama is comprised of many sub-groups, all who present with specific needs.	Recommendations include: <ol style="list-style-type: none"> 1. Promote a culture of competence among veterans' service personnel working at the state, county, and community levels. 2. Emphasize staff education on military culture and the inherent diversity in how service members and veterans experienced and contextualize their military experiences. 3. Promote socially supportive environments (244).

Table 4: Barriers and Resources for Veterans' Post-military Transitioning in South Alabama: Recommendations & Problems

MILITARY CULTURE AND POST-MILITARY TRANSITIONING AMONG VETERANS: A QUALITATIVE ANALYSIS

Published in 2019, the *Military Culture and Post-military Transitioning Among Veterans: A Qualitative Analysis* (MCTAV) used focus groups in an effort to answer the questions: (1) How do veterans, as primary stakeholders, define military culture? and (2) how might military culture affect individuals over time? The study was focused in an eight-county region in Southwest Alabama.

FINDINGS

Within the MCTAV study, themes were organized into broad categories that were discussed within the report:

1. the participants' perceptions of the culture of the military while he/she served;
2. conflict the participant may/may not have had while serving; and
3. conflicts with military culture following discharge from service.

MILITARY CULTURE & VALUES

Here, there were three sub-themes discussed. The first was the sub-theme of individual character. Within the study, *individual character* was primarily described as patriotism and being willing to serve one's country. Other prominent points within individual character included emphasis in the areas of honor, integrity, discipline and hard work, and pride.

A second sub-theme of military culture and values was relational character in the form of *camaraderie*—which was described in the report as the element that captures the essence of relational character within the military. Within this sub-theme, there was also an emphasis on developing camaraderie, trust, and respect. This led into discussion of the final sub-theme of military culture and values which was systemic character. *Systemic character* included elements of order, structure, and training.

CONFLICT WITH MILITARY CULTURE WHILE SERVING

The MCTAV described both conflicts that occurred during service between veteran's individual values and beliefs before moving to similar conflicts that occurred following military service. The first—conflicts during service—were largely denied, with participants stating that they did not experience conflicts of character or with their values or beliefs because they were doing what was necessary to accomplish the mission. The most common reports of possible conflicts here were captured in the sub-themes of transgressions and discussions around killing. The MCTAV highlighted how these reports of transgressions and conflict in killing were not always perceived as conflicts of character and may be how veterans safely organized character conflict to successfully cope with incongruences.

CONFLICT WITH MILITARY CULTURE AFTER SERVING

The MCTAV describes two primary difficulties encountered by veterans following discharge from service. The most prolific theme, *Disparate from Civilian Culture*, captured how civilian society was perceived by the participants who possess different values, character, and ways of living from military life and culture. Other themes here included the interrelated categories of *Interpersonal Difficulties* and *Divorce*. These themes captured how veterans may struggle to reintegrate into their families and communities after military service, becoming socially isolated and struggling without the camaraderie they enjoyed in the military.

Mental health was also a common theme. Specifically, the MCTAV highlighted the reported barriers and expectations veterans had surrounding mental health services and seeking help. First, the MCTAV reported on *ambivalence toward help-seeking* which exposed barriers perceived by veterans in seeking help or sharing experiences with professionals without similar experiences and/or with little-to-no military cultural competence. Though strengths of *personal growth* and *continuity of military culture* were discussed in the MCTAV, the needs of limited communication, isolation in civilian communities, and perception of limited health resources were discussed as needs.

DISCUSSION

Following the presentation of the research, the BRSA links the results of the research to other research, highlighting how they agree that access to care, financial and employment resources, mental health issues, and often co-occurring cultural adjustment problems challenge veterans reintegrating into civilian life. Recommendations were discussed based on the findings. These recommendations are reported in *Table 5*, below.

MILITARY CULTURE AND POST-MILITARY TRANSITIONING AMONG VETERANS: A QUALITATIVE ANALYSIS		
RECOMMENDATION	PROBLEM	DESCRIPTION
Increase Veteran Peer Support	Veterans who do not perceive a degree of connectedness to treatment are less likely to engage with treatment and/or remain compliant.	As “veteran peer contact is associated with higher attendance and lower dropout during psychotherapy” thus, “using peer supports within the context of a value-directed treatment approach may be a key for cultivating a community of recovery” (292).
Increase Service Provider Knowledge of “Moral Injury”	Moral injury has been shown to be a primary cultural reason veterans do not engage with mental health treatment.	When professionals are aware of the intrapersonal and interpersonal struggles veterans may face due to moral injury, services can be altered to yield higher customer satisfaction and customer service, higher outreach outcomes, and individual treatment buy-in and/or compliance.
Promote Veteran Community Involvement	Most perceptions of veterans stem from sources of mass media.	High rates of community integration are beneficial in multiple ways. Community integration promotes self-worth and purpose through volunteerism, decreases isolation, and increases community awareness of veteran experience and military culture.

Table 5: Military Culture and Post-military Transitioning Among Veterans: Recommendations & Problems

ADDITIONAL ASSESSMENTS

Published in 2019, 2019, and 2020 respectively, the SAES, VNVAD, and BXHVA described above explore and discuss varying needs and resources of Alabama's veterans across substance use and behavioral health categories. Highlights of the three assessments are noted and synthesized in the following pages.

Small Area Estimation and Hotspot Identification of Opioid Use Disorders Among Military Veterans Living in the Southern United States⁶ (SAES)

The SAES sought to estimate opioid use disorder prevalence rates at the county level among veterans in Alabama and to determine hotspots of said rates. The study utilized existing national-level data to model probabilities of mental health and substance use categories across Alabama counties.

Veteran-nonveteran Differences in Alcohol and Drug Misuse by Tobacco Use Status in Alabama SBIRT⁷ (VNVAD)

The VNVAD sought to determine whether tobacco use modified the relationship between veteran status and substance misuse, by collecting self-reported wellness data regarding substance, alcohol, or tobacco consumption. Risk levels for alcohol and drug use were measured using standard assessment and screening tools.

Behavioral Health Outcomes in Veterans Compared to Nonveterans by Rural and Urban Areas in Alabama, 2015-2018⁸ (BXHVA)

The BXHVA sought to evaluate behavioral health outcomes and other impacting factors for military veterans and nonveterans living in rural and urban areas of Alabama. The study was conducted using existing national data.

ALCOHOL USE

Each assessment speaks to veteran alcohol use. The BXHVA states the research showed that heavy use of alcohol was more likely to be reported by veterans in Alabama than nonveterans (4.54% to 7.92% vs. 4.59% to 8.41% respectively). In the VNVAD, results showed that (1) alcohol use is increasing in rural Alabama, and (2) that alcohol use may be higher across veteran populations compared to nonveteran populations. In the SAES, there was discussion of alcohol use and opioid use among veterans.

DRUG USE

Each assessment speaks to drug use. Drug use is the primary focus of the SAES. In the study, researchers found:

1. The highest prevalence of opioid use was in the Appalachian Region—a “federally designated region of economic distress and rurality”.⁶
2. The highest prevalence of opioid use was in the highest opioid prescribing area in Alabama.

The SAES also uses existing literature and data to emphasize the frequency of co-occurring disorders such as substance use disorder and PTSD. The VNVAD states that according to the results of the study, drug use was more prevalent in veterans than nonveterans in Alabama. The VNVAD went on to explain that the difference was greater in rural areas across the state. This is echoed in the BXHVA where similar data was used to craft the picture of behavioral health status of Alabama's veterans—which includes both mental health and substance use diagnoses, specifically when the diagnoses are co-occurring. The BXHVA reported that illicit

drug use increased for veterans between 2015 and 2018 in Alabama, and that veterans in urban Alabama were more likely to have co-occurring heavy alcohol consumption and illicit drug use than those in rural areas.

BEHAVIORAL HEALTH

Each assessment spoke to the landscape of Alabama's veterans. Behavioral health was the primary focus in the BXVHA. In the study, there was emphasis on the prevalence of veteran substance use disorders, illicit drug use, and suicidal ideation/planning across rural Alabama—where the likelihood of each of the three issues were more prevalent than in urban or suburban settings. The study also connected behavioral health and substance use prevalence to SDoH such as chronic pain, social pressure, employment status, access to healthcare, and social isolation. The study also emphasized the importance of considering counties within their appropriate context, asking *why* rates are/may be higher than surrounding areas and addressing the individualized needs of each area rather than attempting a blanket solution for behavioral health needs across the state.

In the SAES, though opioid use disorder was the primary focus, the disorder also falls under the criteria for a behavioral health diagnosis, or substance use disorder (SUD). Though the discussion within the SAES incorporates all veteran populations in Alabama, there is specific focus peppered throughout the article pertaining to the high rates of SUD among veterans of the Iraq and Afghanistan wars. The study also poses that military cultural competence across professionals—both medical and behavioral health providers—may prevent SUD amongst veterans before it starts. SAES specifically states:

1. Chronic opioid receipt, with attendant risks, applies to veterans of these conflicts, and to veterans of prior eras as well. Chronic pain and mental health disorders are more typical among veterans who ultimately receive opioids at high dosages (p. 116).
2. A previous study showed that veterans with a mental health diagnosis, such as post-traumatic stress disorder (PTSD), were more likely to receive opioids for chronic pain, were at a higher risk of misusing opioids, and were more likely to have adverse medical events related to opioids (p. 116).

The study further describes that opioid use disorder is a problem beyond veteran populations; however, there are routes to best practice treatment that are specific to veteran versus nonveteran populations. Recommendations from SAES included physician education, integrated primary/mental healthcare, and culturally competent professionals.

In the VNVAD, the researchers' focus is the relationship between tobacco use and alcohol and/or drug use in veterans versus nonveterans across Alabama. Though the study's focus is substance use in relationship to tobacco use, the discussion of the study lends itself to discussion of behavioral health. For example, in the VNVAD, the study states that SUD is not a siloed incident, but instead is an interconnected issue:

Both individual and community-level risk factors such as low education, poverty, isolation, and unemployment loom as key contributing factors for substance use. (p. 46)

The VNVAD highlights that almost half of Alabama's veterans live in rural areas, that military service is a known risk factor for SUD, and that there is a strong likelihood that the substance of choice is opioids.

DISCUSSION

Following the presentation of the respective research, the three studies provide recommendations regarding the findings and identified issues within the research. Some of these recommendations are touched on in the previous discussion of the articles; however, the primary recommendations and their corresponding problems are reported in *Table 6*, below.

ADDITIONAL ARTICLES: PROBLEMS & RECOMMENDATIONS		
RECOMMENDATION	PROBLEM	DESCRIPTION
Provider Education: Opioid Prescribing	Prescribing of opioids has been proven to relate to the misuse of opioids.	Educate providers on opioid prescription and the relationship between prescribing opioids and SUD. The SAES recommends connecting or requiring prescribers to undergo training such as that provided in the Opioid Safety Initiative Toolkit provided by the VA.
Provider Education: Military Culture	Veterans are less likely to engage with treatment not provided by a veteran and/or a professional with no proof of military experience, knowledge, and/or cultural competence.	Training veterans for work in behavioral health settings, and/or engaging in training and education regarding the values, culture, and experience of veterans would be considered best practice care for all behavioral health organizations.
Integrated Care	Veterans may not seek out behavioral health treatment until later stages in severity of symptoms.	Many SUD and mental health diagnoses are more successfully managed when intervention begins in the early stages of care. If veterans are more likely to seek out treatment for physical needs, screeners for common SUD and mental health diagnoses should be standard parts of office visits.

Table 6: Additional Articles: Problems & Recommendations

BIBLIOGRAPHY

Needs Assessments: Alabama Veterans

- ¹ Albright, D. L., Hamner, K., and Currier, J. (2017). Southwest Alabama Veterans Needs Assessment. *Community Foundation of South Alabama*.
- ² Albright, D. L., McDaniel, J., Suntai, Z., Laha-Walsh, K., and Williams, C. (2021). Aging Veterans in the State of Alabama. *Journal of Evidence-Based Social Work, 19*(1), 1-18. <https://doi.org/10.1080/26408066.2021.1948939>.
- ³ Laha-Walsh, K., and Albright, D. L. (2022). The Greater Birmingham Area Veterans Needs Assessment. *Office for Military Families and Veterans*.
- ⁴ Albright, D. L., McCormick, W. H., Carroll, T. D., Currier, J. M., Thomas, K. H., Hamner, K., Slagel, B. A., Womack, B., Sims, B. M., & Deiss, J. (2018). Barriers and resources for veterans' post-military transitioning in south Alabama: A qualitative analysis. *Traumatology, 24*(3), 236-245. <https://doi.org/10.1037/trm0000147>
- ⁵ McCormick, W. H., Currier, J. M., Isaak, S. L., Sims, B. M., Slagel, B. A., Carroll, T. D., Hamner, K., and Albright, D. L. (2019). Military Culture and Post-Military Transitioning Among Veterans: A qualitative analysis. *Journal of Veteran Studies, 4*(2).
- ⁶ Albright, D. L., McDaniel, J., Kertesz, S., Seal, D., Prather, K., English, T., and Laha-Walsh, K. (2019). Small Area Estimation and Hotspot Identification of Opioid Use Disorders Among Military Veterans Living in the Southern United States. *Substance Abuse, 42*(1). <https://doi.org/10.1080/08897077.2019.1703066>
- ⁷ Albright, D. L., Holmes, L., Lawson, M., McDaniel, J., Laha-Walsh, K., and McIntosh, S. (2019). Veteran-nonveteran Differences in Alcohol and Drug Misuse by Tobacco Use Status in Alabama SBIRT. *Journal of Social Work Practice in the Addictions, 20*(1). <https://doi.org/10.1080/1533256X.2020.1705109>.
- ⁸ Albright, D. L., Fletcher, K. L., Thomas, K. H., McDaniel, J. T., Laha-Walsh, K., Null, D., Vohra, S. (2020). Behavioural Health Outcomes in Veterans Compared to Nonveterans by Rural and Urban Areas in Alabama, 2015-2018. *Health and Social Care in the Community, 2022*(20). DOI: 10.1111/hsc.13392.
- ⁹ U.S. Department of Veterans Affairs. (2018). *Profile of Post-9/11 Veterans: 2016*. National Center for Veterans Analysis and Statistics. https://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2016.pdf

BEST PRACTICES: Service Implementation Overview

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: tailored to each veteran's needs;
4. EBPs consider and prioritize each veteran's priorities and values; and
5. EBPs 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 2: Common, EBP-related Terms 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

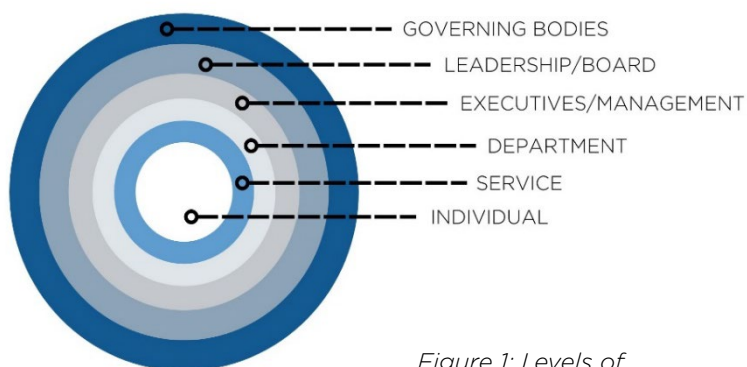


Figure 1: Levels of organizational structure

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
- That are 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.
- That have veteran-informed providers and programs.^{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; and
 - Are 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:

- seeks to eliminate disconnect between discovery of disease and treatment implementation;
- implements the provision of individualized assessments for individual patients;
- addresses individual barriers to care for patients; and
- 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

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

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

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 civilian healthcare providers are equally capable of delivering high-quality, veteran-centered care when equipped with proper cultural competency.¹⁴ 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.¹⁴ 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 are 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, attributes of positive veteran care experiences,

1. Can be linked to 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. Typically include 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. Involve high frequency case management services;⁵ and

- a. Organizations have adequate staffing and available services for each individual.
4. Provide 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.¹⁵ What follows are quick reference summaries of best practice treatment with common behavioral health diagnoses and services across veteran populations.

POST-TRAUMATIC STRESS DISORDER^{12,16,17,18,19}

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^{19,20}

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.

INSOMNIA²¹

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^{22,23}

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^{19,24}

Best practices for intervention and treatment of suicidal intent or attempts include, 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.²⁵ 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.”²⁶ 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.

PROVIDERS²⁷

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^{28,29}

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.

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

TRANSPORTATION^{26,30}

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 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.

OTHER BARRIERS^{27,28,31}

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 and/or time commitment associated with behavioral health treatment;
- stigma; and/or
- 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 7*, 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 7: Multi-level Evidence-based Best Practices

BIBLIOGRAPHY

Best Practices: Service Implementation Overview

- ¹ American Psychological Association. (2021). APA Guidelines on Evidence-based Psychological Practice in Healthcare.
- ² U.S. Department of Veterans Affairs. (2024). Mental Health. <https://www.mentalhealth.va.gov/get/help/treatment/ebt.asp>.
- ³ The Maryland Child & Adolescent Innovations Institute. (2008). Evidence-based Practice, Promising Practice, & Practice-Based Evidence: What's the difference? *The University of Maryland Baltimore, School of Medicine*. <https://theinstituteofcf.umaryland.edu/topics/ebpp/docs/GeneralImplementationDocs/Other%20Resources/Evidenced%20Based%20Promising%20Practices%20Differences.pdf>
- ⁴ Veterans Affairs. (2018). VA Office of Mental Health and Suicide Prevention Guidebook. <https://www.mentalhealth.va.gov/docs/VA-Office-of-Mental-Health-and-Suicide-Prevention-Guidebook- June-2018-FINAL-508.pdf>
- ⁵ Veterans Affairs. (2021a). Trauma-informed care fact sheet. <https://www.va.gov/homeless/nchav/docs/Trauma-Informed-Care-Fact-Sheet.pdf>
- ⁶ University of Wisconsin. (2024). Mental Health Providers. County Health Rankings & Roadmaps. <https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care/mentalhealth-providers?year=2024>
- ⁷ Freeman, H. P., & Rodriguez, R. L. (2011). History and principles of patient navigation. *Cancer*, 117(15 Suppl), 3539–3542. <https://doi.org/10.1002/cncr.26262>
- ⁸ Pratt-Chapman, M.L., Silber, R., Tang, J. *et al.* Implementation factors for patient navigation program success: a qualitative study. *Implement Sci Commun* 2, 141 (2021). <https://doi.org/10.1186/s43058-021-00248-0>
- ⁹ Jervis, L.L., Kleszynski, K., TallBull, G. *et al.* Rural Native Veterans' Perceptions of Care in the Context of Navigator Program Development. *J. Racial and Ethnic Health Disparities* (2024). <https://doi.org/10.1007/s40615-024-01955-9>
- ¹⁰ National Center for Healthcare Workforce Analysis. (2023). Behavioral Health Workforce. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf>
- ¹¹ Moore M.J., Shawler E., Jordan C., et al. (2023). Veteran and Military Mental Health Issues. StatPearls. Treasure Island (FL): StatPearls Publishing; 2024. Online.
- ¹² Mohler K.M., Sankey-Deemer C., (2017). Primary Care Providers and Screening for Military Service and PTSD. *American Journal of Nursing*. 117(11):22-28. doi: 10.1097/01.NAJ.0000526720.34516.4b. PMID: 29035900
- ¹³ American Academy of Nursing. (2023). Intake questions. Have You Ever Served in the Military? <https://www.haveyoueverserved.com/intake-questions.html>
- ¹⁴ Samuelson, K. W., Koenig, C. J., McCamish, N., Choucroun, G., Tarasovsky, G., Bertenthal, D., & Seal, K. H. (2014). Web-based PTSD training for primary care providers: A pilot study. *Psychological Services*, 11(2), 153–161. <https://doi.org/10.1037/a0034855>
- ¹⁵ U.S. Department of Veterans Affairs and U.S. Department of Defense. (2024a). VA/DoD Clinical Practice Guidelines: Assessment and management of patients at risk for suicide. https://www.healthquality.va.gov/guidelines/MH/srb/VADoD-CPG-Suicide-Risk-Provider-Summary-2024_Final_508.pdf.
- ¹⁶ Kertesz, S.G., deRussy, A.J., Hoge, A.E., et al. Organizational and patient factors associated with positive primary care experiences for veterans with current or recent homelessness. *Health Serv Res*. 2024; 1-12. doi:10.1111/1475-6773.14359
- ¹⁷ Deployment Psychology. (2023). Cognitive Behavioral Therapy for Depression. Center for Deployment Psychology. <http://deploymentpsych.org/content/cognitive-behavioral-therapy-depression-cbt-d-0>
- ¹⁸ Deployment Psychology. (2023). Cognitive Therapy for Suicidal Patients. Center for Deployment Psychology. <http://deploymentpsych.org/treatments/Cognitve-Therapy-for-Suicidal-Patients-CT-SP>

-
- ¹⁹ Veteran Affairs. (2023). Management of Posttraumatic Stress Disorder and Acute Stress Disorder. (2023, June 3). <https://www.healthquality.va.gov/guidelines/MH/ptsd/>.
- ²⁰ Veteran Affairs. (2023). Management of Substance Use Disorder. (2023, June 3). [hquality.va.gov/guidelines/MH/sud/VADoDSUDCPGProviderSummary.pdf](https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGProviderSummary.pdf)
- ²¹ Deployment Psychology. (2023). Prolonged exposure therapy for PTSD (PE). Center for Deployment Psychology. <http://deploymentpsych.org/treatments/prolonged-exposure-therapy-ptsd-pe>.
- ²² Deployment Psychology. (2023). Cognitive Processing Therapy. Center for Deployment Psychology. <http://deploymentpsych.org/treatments/cognitive-processing-therapy-cpt>
- ²³ Hurley, E. C. (2018, August 24). Effective treatment of veterans with PTSD: Comparison between intensive daily and weekly EMDR approaches. *Frontiers in Psychology*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6117416/>
- ²⁴ Deployment Psychology. (2023). Cognitive Behavioral Therapy for Insomnia. Center for Deployment Psychology. <http://deploymentpsych.org/treatments/cognitive-behavioral-therapy-insomnia-cbt-i>
- ²⁵ Perla, L. Y., Beck, L. B., Grunberg, N. E. (2023). Assessment of Veterans Affairs Case Management Leadership. *Professional Case Management*, 28(3). Doi: 10.1097/NCM.0000000000000615.
- ²⁶ Mercier, J. M., Hosseiny, F., Rodrigues, S., Friio, A., Brémault-Phillips, S., Shields, D. M., & Dupuis, G. (2023). Peer Support Activities for Veterans, Serving Members, and Their Families: Results of a Scoping Review. *International journal of environmental research and public health*, 20(4), 3628. <https://doi.org/10.3390/ijerph20043628>
- ²⁷ Steigerwald, V. L., Bagley, J. M., Parrish, M. S., Van Horn, R., & Held, P. (2022). A qualitative investigation of barriers to initiating a 3-week intensive posttraumatic stress disorder treatment program for veterans. *Traumatology*.
- ²⁸ Pietrzak, R. H., Johnson, D. C., Goldstein, M. B., Malley, J. C., & Southwick, S. M. (2009). Perceived stigma and barriers to mental health care utilization among OEF-OIF veterans. *Psychiatric services*, 60(8), 1118-1122.
- ²⁹ U.S. Department of Veterans Affairs. (2024). VA/DoD Clinical Practice Guidelines. Assessment and Management of Patients at Risk for Suicide. <https://www.healthquality.va.gov/guidelines/mh/srb/index.asp>
- ³⁰ Poleshuck, E., Johnson, E., Boykin, D., Davis, A., Funderburk, J. S., Hundt, N., ... & Possemato, K. (2024). Barriers to accessing care among rural women veterans: A qualitative study with veterans, peer specialists, and primary care professionals. *Psychological Services*.
- ³¹ Pyne, J. M., Kelly, P. A., Fischer, E. P., Owen, R. R., Cucciare, M. A., Miller, C. J., ... & Fortney, J. C. (2023). Trust and perceived mental health access: Exploring the relationship between perceived access barriers and veteran-reported trust. *Psychological services*.

BEST PRACTICES: Veteran Populations

VETERAN POPULATIONS^{1,2}

Across the United States:

- There are over 18.2 million veterans.
- Veterans comprise roughly 6% of the nation's population.
- By race:
 - White: 76%
 - Black: 13%
 - Hispanic: 9%
 - Other: 2%
- By gender:
 - Male: 16,180,913
 - Female: 2,086,057

ALABAMA VETERANS^{1,2}

- Total number: 316,473
- Over three-fourths (80%) of Alabama Veterans are Wartime Veterans.
- By race:
 - White: 76%
 - Black: 13%
 - Hispanic: 9%
 - Other: 2%
- By generation:
 - World War II: 0.2%
 - Korea: 2%
 - Vietnam: 28%
 - Gulf War: 50%
 - Post-9/11: 22%
- By gender:
 - Male: 87%
 - Female: 13%

**These numbers may include veterans who served in more than one theatre.*

VETERAN NUMBERS^{1,2}

- Veteran numbers vary across sources due to differing definitions of the term “veteran.”
- Veteran numbers do not always include those who served in the National Guard or Reserves.

In 2023, veterans represented about 6% of the nation's population and 8% of the population of Alabama.^{1,2} The population of veterans across the nation are diverse—composed of multiple generations, genders, races, and ethnicities. If the State of Alabama is to provide excellent behavioral health and substance use services to veterans through the platform of person-centered care, a foundation of knowledge needs to be established. This foundation includes informed care where organizations and individual providers are knowledgeable of both best practice implementation of services to veterans as a singular group and best practices across veteran sub-populations.

UNDERSERVED VETERANS

Over the last fifty years, the number of non-majority, or underrepresented, military service members has grown that as of 2020, one-third of active-duty military personnel identified as an underrepresented population.³ The specific needs of underrepresented groups is not well understood.¹ Therefore, underrepresented groups are also referred to as underserved groups, as most healthcare implementation was created, practiced, and assessed with White male military service members or veterans in mind.¹ Veterans who belong to underserved populations are more likely to face minority stress and social isolation when compared to active military and veterans of majority populations:¹

- Women are more likely than men to:
 - suffer from depression and PTSD;
 - experience suicidal ideation and attempt suicide;
 - experience domestic violence;
 - experience military sexual trauma;³ and
 - experience reproductive issues associated with physical and/or mental health.
- Non-White veteran populations are more likely than their White counterparts to:
 - engage in suicide attempts (veterans of multiple races, American Indian or Alaska Native veterans, non-Hispanic Black and non-Hispanic Asian populations);
 - engage in heavy drinking (those who identified as *other race*); and
 - smoke tobacco or vape (Hispanics and non-Hispanic Asians).

The specific needs of underrepresented groups must be understood and integrated into behavioral health service organizations and practice in order to provide all veterans with appropriate, person-centered care. Due to the nature of service experience, underrepresented groups are also reported as having more difficult times with integration than majority-population peers.⁴ In the following pages, best practices for underrepresented populations and common experiences across the populations are explored.

WOMEN VETERANS

Women veterans comprise 9.4% of the total veteran population across all generations, and the population is growing.^{5,6} The largest cohort of women veterans are those who served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).⁵ As such, this population grows, their health concerns will grow with them.

Women veterans are more likely than their male counterparts to have endured not only the trauma associated with active duty service, but also military sexual trauma, intimate partner violence, and social stress associated with parental duties. Similar to their male counterparts, women veterans are more likely than civilians to engage in high-risk activities, including reckless driving. Women veterans also have a higher likelihood of being diagnosed with PTSD than the general veteran population (20% versus 12-14%).⁵

Women veterans are more likely to utilize services provided by the VA, however, they are more likely than male counterparts to express dissatisfaction with services they receive through the VA.⁵ According to the VA Office of Research and Development (ORD), women veterans

reported dissatisfaction with services related to the lack of:

1. the presence of female providers;
2. the availability of female-only treatment groups; and
3. gender-related comfort.^{6,7}

The ORD reported that women veterans who were involved in treatment with these traits were more likely to perceive care as accessible.^{5,6} In addition, it was reportedly important to women veterans populations to be included in the decisions made in their care. Positive perceptions of shared decision-making also contributed to overall satisfaction and compliance with treatment.⁷ Women veterans who perceived care as accessible and supportive of females were more likely to engage with treatment regularly.⁶

Women veterans have specific needs beyond those of their male counterparts including higher likelihood of PTSD diagnoses, the need for parental care support, caregiver support, and women’s reproductive services.

Within the women veteran population, under-represented populations (URP) such as the Hispanic population and non-White populations, were more likely to report dissatisfaction with services than other sub-groups of the women veteran population.^{5,6} The VA ORD (2023) also reported that rural women veterans were less likely to access services—specifically women’s services—through the VA than their more urban counterparts.^{5,6,8} This is true for both women and men veterans across generational cohorts.⁶

Just as there are specific needs across specific veteran populations, there are also specific needs and/or considerations for women veterans across specific veteran generations. For example, women veterans who served in Vietnam are more likely than other women veterans to develop PTSD—20% versus 11%^{6,9}—and more likely than comparable women veteran populations to have children born with birth defects and/or spina bifida than women veterans who were not deployed to Vietnam.^{6,8,10} Magruder et al., (2015)⁹ posed that PTSD in women veterans could be linked to chronic physical illness including heart disease. This hypothesis was reinforced by further studies, which cited Magruder et al. (2015). This intersection of mental and physical health ailments further reinforces the case for cross-sectional care approaches.

When working with women veterans in a behavioral health setting, there are specific best practices that have been found to yield high satisfaction across women veteran populations. EBPs specific to women veterans include groups facilitated by other women that were strength-based and women-only have been reported as beneficial to behavioral health outcomes for women veterans.^{11,12} Other EBP interventions included preventative health initiatives, specifically those associated with reproductive health, those that involved physical health elements, and those that involved alternative treatments such as yoga, meditation, and/or creative elements.^{11,12}

MILITARY SEXUAL TRAUMA

Military sexual trauma (MST) is the term used by both the VA and larger provider community that refers to sexual assault or threatened sexual assault experienced while in the military.¹³ Women service members are most likely to experience MST, though it is thought to be underreported across military cohorts and also by women service members (approximately 20-40% of women while in service). Amongst men, the VA reports that MST is frequently justified and/or referred to as *hazing*.^{14,13} Overall, the rates of reported MST indicate that non-White, non-male, and non-married service members are more likely to experience MST while in service. MST should be assessed and addressed in behavioral health settings as a psychological trauma. Veterans who report MST are three times more likely to also be diagnosed with a mental health and/or substance use diagnosis.¹⁵

There are assessment and treatment tools available for veterans who report or have suspected MST, including the Universal MST Screener utilized by the VA.¹³ According to Doucette et al. (2022), the first step in treating a veteran with MST experience is to identify the MST. The second is to obtain a significant history for the veteran, including possible trauma or adverse childhood experiences that pre-date military tenure. This history then should inform the treatment sessions and goals of the treatment plan.¹²

Reports of Military Sexual Trauma should influence the trajectory of treatment through all phases: assessment through recovery.

WORLD WAR II & KOREAN VETERANS

In 2020, approximately 6% of veterans in each state were veterans of the Korean War, with that number dropping to a projected 3.3% by 2025.¹⁶ The Korean War Veteran population is the next oldest population numbering of veterans in the United States with a median age of 88 in 2020.¹⁸ In Alabama in 2020, it was estimated that approximately 15,000 of the total veteran population had served in Korea.¹⁷ That is 9.5% of Alabama's veteran population.

The oldest veteran population in the United States are those who served in World War II. Although World War II was a widespread war with one of the largest veteran cohorts in history,¹⁸ there was an estimated 1,000 World War II Veterans in Alabama in 2023.¹⁹ The average age of veterans from both the World War II and Korean War cohorts face mental health issues that are more likely to be associated with health issues related to advanced aging, but still may be affected by their service experiences.

POST-TRAUMATIC STRESS DISORDER + AGING

Post-traumatic stress disorder (PTSD) was not an official diagnosis until 1980, thirty and forty years following the experiences of Korean and World War II Veterans respectively.²⁰ As such, veterans who presented with symptoms of present-day PTSD were usually diagnosed with *shell shock* or *combat fatigue*, which was viewed as a temporary condition.²² Though too late in the life course to support this population in the acute onset of PTSD or other combat-related mental health distress, there is evidence that demonstrates ongoing PTSD and/or other combat-related mental health issues can impact veterans as they reach the end-of-life stages.^{22,21,22}

It is true for most all veteran cohorts that the cost of service is rendered not only mentally, but physically as well.²⁴ One consideration for aging World War II and Korean War Veterans is to ensure that all ailments are being treated in a way that considers the likelihood that the veteran has experienced a traumatic brain injury (TBI) as approximately 14% of Korean War Veterans have been reported to have sustained TBI during combat.²⁴ Both TBI and PTSD are common contributors to cognitive decline.²⁵ In addition to accelerated physical and/or

cognitive decline, veterans diagnosed with PTSD also commonly experience feelings of detachment.¹¹ Loneliness—a risk factor for all aging populations—may be a greater risk for those of this population with PTSD or other anxiety-related symptoms that decrease social interaction.²² Research promotes screening for veteran status in all healthcare settings and educating providers on the veteran-related needs such as the impact of combat-related PTSD and TBI in Korean and World War II veteran populations.

END OF LIFE CARE

A real life consideration within Korean War and World War II veteran populations is end of life care. Conard (2023) and others state that caring for veterans as they transition from this life should be considered “supporting them in their last deployment.”²³ Both Conard (2023) and the National Center for PTSD (Larsen, 2023)²⁴ encourage consideration for the implications that PTSD may play a role in end of life (EOL) care. Larsen (2023) states,

For patients with pre-existing PTSD, some may have had chronic symptoms, and others may experience a flare of symptoms during EOL, either of which can complicate the dying process for patients and their loved ones. (1)

The majority of veterans experience EOL stages in a civilian medical setting, outside of services provided by the VA.²³ As such, it is imperative that civilian medical providers are well-versed in not only the implications and influence of military culture, but also common diagnoses—such as TBI and PTSD—that are likely to impact EOL care and the veteran’s transition.²³ When specifically working with Korean War and/or World War II Veterans in EOL stages, all providers should be educated on the impact of combat-related health issues and address them within the context and culture that the veteran and the veteran’s loved ones are most comfortable with. Additional EOL considerations for veteran populations include those associated with having a good death. Research shows the concept of a *good death* is influenced by a person’s background, culture, values, spirituality, beliefs, and other influential identity factors.²⁵

“Military culture is a complex and multifaceted concept that has significant implications for veterans, particularly in terms of their health and well-being.”¹⁸

As previously stated, the military cultural competence of providers and the organizations in which they are situated is an important factor when treating veteran populations. According to Suntai et al. (2023)²⁷ one of the most distinct factors of military culture is how the culture and the individuals within it emphasize self-sufficiency and stoicism. Suntai et al. (2023) found that not only was this the case for veterans, but also for veterans when considering EOL care. The majority of veterans within the study reported a desire for fighting death with all tools available and maintaining a sense of pride during EOL stages.²⁷ In order to support veterans from all cohorts in their last deployment,¹⁷ EOL care providers must be culturally competent regarding the values, beliefs, and experiences of veteran populations.²⁷

VIETNAM VETERANS

Vietnam Veterans make up the second largest and oldest veteran population, as there are approximately 6 million Vietnam Veterans in the United States, second only to the cohort of Gulf War veterans.⁵ Reportedly, approximately 30% of Vietnam veterans—around 1.8 million—

have experienced PTSD as compared to 20% of veterans from Iraq and Afghanistan wars, and 10% of the veterans from the Gulf War Era.⁶ For women Vietnam Veterans, specifically, the likelihood of long-term PTSD symptoms and diagnoses was high. In addition to mental health diagnoses, Vietnam Veterans face a host of health risks associated with their military service that other veteran cohorts do not face.²⁶ These health risks include exposure to Agent Orange, an increased risk of Hepatitis C, and exposure to open air burn pits—which can lead to severe respiratory illnesses and an increased risk for leukemia—in addition to Vietnam Marines’ possible exposure to the Camp Lejune Water Contamination between 1957 and 1987.²⁷ According to the VA, “Vietnam Veterans with PTSD have diminished health functioning and increased disability today compared with those who did not develop PTSD.”²⁷

As little as ten years ago, the VA Palo Alto Health Care System found that even though older veterans were less likely than the general population to report elevated anxiety (11% versus 12.6%) the opposite was true for Vietnam veteran populations.^{10,28} Vietnam Veterans were twice as likely to report anxiety as Korean and World War II counterparts.^{10,28}

In 2024, the median age for Vietnam Veterans is approximately 70 years old and range in age from 60 to 99 years old.²⁹ An overwhelming 97% of Vietnam Veterans are male, and of those, 82% are white males.²⁹ According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2020),³⁰ suicide rates are “particularly high among older men, with men ages 86 and older having the highest rate of any group in the country.” Because of this, specific attention should be paid to older, male Vietnam Veterans when discussing suicide intent and/or ideation.

Some suicide prevention methods for Vietnam Veteran populations could include:

- social connectedness;^{30,31}
- access to physical and mental health treatment;^{30,31}
- limiting access to lethal means, including weapons;³¹ and
- recognizing warning signs of depression, anxiety, and/or suicide early.³¹

Much like the other veteran cohorts, Vietnam Veterans face a specific set of documented issues that are isolated to this generation of veterans. As many of the service-related issues for Vietnam Veterans are physical ailments, in addition to the high-prevalence of PTSD and depression among Vietnam veteran populations, and the aging demographic, Vietnam Veterans would best be served through integrated care and programs that work to increase protective factors within the Vietnam veteran cohort. Integrated care includes accessible mental and physical health services under one roof, and early screening and detection of SUD, suicidal intent or ideation. Programs that promote increasing protective factors in this veteran population have also been found to have a mitigating effect on the impact of mental illnesses such as PTSD and depression. Nearing et al. (2022) found that veterans who were able to “share wisdom” with both individuals and organizations yielded more positive outcomes both with the veterans as individuals but also within the organizations and individuals the older veteran had the opportunity to share with.³²

Strong case management services led by a social worker is a best practice mental health service for Vietnam Veterans.

In order to serve aging veteran populations well, the VA recommends working with a social worker to help navigate the host of available services in order to find those that the individual veteran is both eligible for and are appropriate for the veteran's needs.³³ In addition to navigating mental and physical health services and supports, older Veterans have higher health outcomes when they feel connected to the community and to others.³³ This promotion of health service connection in addition to establishing connections within the community is considered a type of case management service and is most often carried out by social work professionals.^{33,34} Bloeser and Bausman (2019)³⁴ state

that social workers are most likely to assist veterans with mental health service navigation and commonly produce practice-related research related to veterans, service navigation, marginalized populations, and PTSD symptoms present/that impact service navigation and marginalized populations. Koufacos et al. (2021)³⁵ report that social worker-led care across older veteran populations is likely to improve patient compliance with treatment, including carrying through with all treatment recommendations in the most appropriate treatment setting.

Overall, when considering the Vietnam Veteran cohort, it is important to remember the demographics of the cohort and common mental and/or physical health concerns associated with this generation. Comparing the factors of age, connectedness, and risk of suicidality can drive positive evidence-based founded care. Research shows that the strongest foundations of evidence-based care for Vietnam Veterans includes early screening for and promoting protective factors against suicide, promotion of community connectedness, and assistance/support in service navigation by a social worker.

GULF WAR VETERANS

Gulf War Veterans comprise the largest veteran population as there are approximately 7 million Gulf War veterans in the United States.⁵ The majority of the Gulf War veterans served in active duty in the early 1990s, from 1990-1991.³⁶ Approximately 10% of Gulf War Veterans are cited to have a diagnosis of PTSD.¹⁸

In addition to mental health concerns, Gulf War Veterans are also more likely to experience physical health diagnoses related to deployment including Gulf War Syndrome—a syndrome characterized by a host of neurological and gastro-intestinal concerns such as brain and testicular cancers, and neurodegenerative diseases—and heavy metal toxicity in addition to higher risks for respiratory and kidney diseases.³⁷ Gulf War Syndrome can also be referred to as Gulf War Illness (GWI) and is largely categorized by unexplained illnesses most commonly attributed to Gulf War Veterans who served closest to combat zones during the conflict.²⁸ According to the VA (2022), approximately 200,000 to 250,000 Gulf War Veterans are affected—nearly 36% of the total Gulf War Veteran population.²⁸

Symptoms of GWI can also include common exacerbators of mental illness symptoms such as: insomnia, chronic pain, fatigue, and impaired mood.³⁸ Chao et al. (2021) produced research that was driven by the nature of these closely related behavioral health symptoms of GWI. Her team piloted Cognitive Behavioral Therapy for Insomnia (CBT-I) for patients who had been diagnosed with GWI to reduce symptoms. When compared to a group of Gulf War Veterans who did not receive the intervention, those who engaged in CBT-I reported reductions across all symptoms related to behavioral health and GWI and even maintained those results six months post-intervention.³⁰

In 2023, Gromatsky et al.³⁹ produced research regarding nonsuicidal self-injury (NSSI) in veterans and military personnel. Overall, Gromatsky et al. (2023) state that NSSI, though not a direct indicator of suicidal intent or ideation, is frequently cited in the history of veterans who become suicidal.⁶¹ The VA (2023) cites the work of Gromatsky et al., and additional studies before making the claim that self-harm (NSSI) is underrecognized in Gulf War veterans.⁴⁰ One study cited was produced by Halverson et al. (2023).⁴¹ In it, the researchers stated,

Symptoms of physical conditions such as Gulf War Illness should be considered in mental health treatment for Gulf War Veterans.

The high prevalence of non-suicidal self-injury among Veterans is alarming, because it is one of the strongest predictors of a suicide attempt identified to date, and Veterans are much more likely to die by suicide compared to civilians.

Both Halverson et al. (2023) and Gromatsky et al. (2023) stress the importance of exploring NSSI in patient histories, specifically when veteran status is confirmed. This screening is best performed at initial assessments across healthcare settings rather than being isolated to intakes for behavioral health services.

Overall, Gulf War Veterans are more likely than their other veteran population counterparts to report unexplained

medical symptoms such as those associated with GWI, and the behavioral health symptoms associated with GWI.^{28,35} Moreover, Gulf War Veterans are more likely to engage in NSSI than other veteran cohorts.^{35,42} Best practice recommendations for both these families of concern—Gulf War Illness and non-suicidal self-injury—begin with early screening for problems or needs—with an emphasis on screening outside of behavioral health provider settings.^{28,35,40}

POST-9/11 VETERANS

Veteran populations from Post-9/11 are the youngest cohort of veterans currently in the United States.⁴³ Veterans from the Post-9/11 cohort include those most recently discharged from service and those to be discharged in the foreseeable future as there is not an end date for the cohort.⁴⁵ Even though there are over 4 million Post-9/11 Veterans, just under 3 million of these cohort members saw combat in OIF and/or OEF.⁴² Post-9/11 Veterans are more likely to have been deployed, serve in a combat zone, experience emotionally traumatic events, seek help for emotional issues, and suffer post-traumatic stress compared to veterans from the pre-9/11 cohorts.⁴⁴

The post-9/11 veteran population is unique in its diversity. An increasing number of women, Black, and Hispanic Americans served in the Armed Forces. More than 30% of post-9/11 veterans are women.⁴⁵ This population of veterans is also more likely than previous cohorts to be single, non-White, uninsured, and from a low socioeconomic background.³⁷ Beyond demographic characteristics, post-9/11 veterans were less likely to die from combat wounds compared to previous cohorts as amputations and severe brain injuries were more common than previous veteran combat encounters.⁴³ This population of veterans often redeploy into combat, which introduces the potential for multiple and more complex health needs.⁴³ In terms of mental and behavioral health, experts recommend consideration of Post-9/11 Veterans' experiences before, during, and after service.⁴³ For example, providers should consider a veteran's exposure to trauma before service and their attitudes toward their behavior during service (e.g., moral injury, social support, etc.).

People who served post-9/11 may experience PTSD, traumatic brain injury, dementia, and misuse of substances in addition to unique physical conditions that also affect mental health, such as hearing loss and respiratory problems.³⁷ This combination of mental and physical health conditions—including disabilities such as loss of a limb or reduced level of functioning—should be considered when treating the mental health of a Post-9/11 Veteran. A study of post-9/11 Veterans who experienced traumatic brain injury (TBI) reported they were more likely to experience long-term health-related outcomes compared to those with no TBI.⁴⁶ Veterans who served during the Post-9/11 period experienced exposure to unique health risks, including burn pits and other toxic materials.⁴⁷ Veterans who self-reported greater exposure to toxic substances during service also reported poorer mental and physical health. Researchers considered the results evidence that post-9/11 veterans who experienced toxic exposure will have greater health demands in the future.³⁹

Post-9/11 Veterans are more likely to utilize services at the VA than their older cohort counterparts, have the highest female demographic of all cohorts, and the highest non-White demographic of all veteran cohorts.⁴³

In all, to serve Post-9/11 Veterans best in the mental health sector, the following considerations need to be made:

- Post-9/11 Veterans have strengths that coincide with military culture such as self-discipline and prioritizing physical wellbeing/health.⁴⁸
- Post-9/11 Veterans who have been deployed are likely to have been deployed multiple times.³⁶
- Post-9/11 Veterans are currently working through the stress of transition. Veterans with stronger social supports are more likely to navigate this stage with greater success than those without strong social supports.^{49,50}
- Post-9/11 Veterans are more likely than other veteran cohorts to face complex issues due to the nature of their military service.³⁹

Post-9/11 Veterans exposed to the elements of combat zones (such as burn pits), multiple deployments, and the typical stressors of life after service—transitions to civilian life, employment, family life, mental and physical health history—are complex in need. Thus, best practice treatment would be care that is tailored to the unique needs of the individual veteran.

BIBLIOGRAPHY

Best Practices: Veteran Populations

- ¹ Schaeffer, K. (2023, November 8). *The changing face of America's veteran population*. Pew Research Short Reads. <https://www.pewresearch.org/short-reads/2023/11/08/the-changing-face-of-americas-veteran-population/>
- ² U.S. Department of Veterans Affairs. (2010, November 24). *Veteran Populations*. Office of Policy and Planning. https://www.va.gov/vetdata/veteran_population.asp
- ³ Wong, E. C., Meadows, S. O., Schell, T. L. ... & Roth, E. (2021). The Behavioral Health of Minority Active-Duty Service Members. *Rand Corporation*. Santa Monica, CA. https://www.rand.org/pubs/research_reports/RR4247.html
- ⁴ Thomas, K. H., McDaniel, J. T., Haring, E., Albright, D. L., & Gletcher, K. L. (2017). Mental Health Needs of Military and Veteran Women: An assessment conducted by the Service Women's Action Network. *Traumatology*, 24(2). P. 104-112. https://psycnet.apa.org/fulltext/2017-44050-001.pdf?auth_token=39786cfed45dede08c757c97726820fc2faab97c
- ⁵ National Center for Veterans Analysis and Statistics. (2016). *Veteran Population Projections 2017-2037*. Vet Data. https://www.va.gov/vetdata/docs/demographics/new_vetpop_model/vetpop_infographic_final31.pdf
- ⁶ U.S. Department of Veterans Affairs. (2024). Women Veterans. VA Research. https://www.research.va.gov/topics/womens_health.cfm
- ⁷ Kimerling, R., Pavao, J., Greene, L., Karpenko, J., Rodriguez, A., Saweikis, M., & Washington, D. L. (2015). Access to mental health care among women Veterans: is VA meeting women's needs?. *Medical care*, 53(4 Suppl 1), S97-S104. <https://doi.org/10.1097/MLR.0000000000000272>
- ⁸ Brooks, E., Dailey, N., Bair, B., & Shore, J. (2014). Rural women veterans demographic report: defining VA users' health and health care access in rural areas. *The Journal of rural health : official journal of the American Rural Health Association and the National Rural Health Care Association*, 30(2), 146-152. <https://doi.org/10.1111/jrh.12037>
- ⁹ Magruder K, Serpi T, Kimerling R, Kilbourne AM, Collins JF, Cypel Y, Frayne SM, Furey J, Huang GD, Gleason T, Reinhard MJ, Spiro A, Kang H. Prevalence of Posttraumatic Stress Disorder in Vietnam-Era women veterans: The Health of Vietnam-Era Women's Study (HealthVIEWS). *JAMA Psychiatry*. 2015 Nov;72(11):1127-34. doi: 10.1001/jamapsychiatry.2015.1786. PMID: 26445103; PMCID: PMC7529477.
- ¹⁰ Gould CE, Rideaux T, Spira AP, Beaudreau SA. Depression and anxiety symptoms in male veterans and civilians: the Health and Retirement Study. *Int J Geriatr Psychiatry*. 2015 Jun;30(6):623-30. doi: 10.1002/gps.4193. Epub 2014 Aug 22. PMID: 25145943; PMCID: PMC4336840
- ¹¹ Lawn S, Waddell E, Roberts L, et al. Women veteran transition mental health and well-being support group programs: A scoping review. *Women's Health*. 2024;20. doi:10.1177/17455057241275441
- ¹² Hamilton, A. (2022). Engaging Women Veterans in Evidence-based Care: VA Empower Query 2.0. VA Health Systems Research: Women's Health. <https://www.hsrd.research.va.gov/publications/forum/fall22/default.cfm?ForumMenu=fall22-6>
- ¹³ U.S. Department of Veterans Affairs. (2024). Military Sexual Trauma: Effects & veteran resources. *Mental Health*. <https://www.mentalhealth.va.gov/msthome/index.asp#:~:text=VA%20uses%20the%20term%20%E2%80%9Cmilitary,when%20unable%20to%20say%20no.>
- ¹⁴ U.S. Department of Veterans Affairs. (2020). Strength and Recovery: Men overcoming military sexual trauma. Mental Health: MST. https://www.mentalhealth.va.gov/docs/Men_Overcoming_MST.pdf
- ¹⁵ Doucette, C. E., Morgan, N. R., Aronson, K. R., Bleser, J. A., McCarthy, K. J., & Perkins, D. F. (2023). The Effects of Adverse Childhood Experiences and Warfare Exposure on Military Sexual Trauma Among Veterans. *Journal of Interpersonal Violence*, 38(3-4), 3777-3805. <https://doi.org/10.1177/08862605221109494>
- ¹⁶ U.S. Department of Veterans Affairs. (2018). *Veterans of the Korean War: Projections 2020-2040*. Vet Data.

https://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/Veterans_of_Korean_War.pdf

- 17 U.S. Department of Veterans Affairs. (2018a). *Korean War Veterans*. Vet Data. <https://www.data.va.gov/stories/s/Korean-War-Veterans/7wja-85c3/>
- 18 U.S. Department of Veterans Affairs. (2024). *World War II Veterans*. Benefits. https://www.benefits.va.gov/persona/veteran-world_war_II.asp
- 19 U.S. Department of Veterans Affairs. (2024). *Map of WWII Veterans by State, FY2023*. Department of Veterans Affairs Open Data Portal. <https://www.data.va.gov/dataset/Map-of-WWII-Veterans-by-State-FY2023/bqtu-2n2h>
- 20 Palmer, B. W., Friend, S., Huege, S., Mulvaney, M., Badawood, A., Almaghraby, A., & Lohr, J. B. (2019). Aging and Trauma: Post traumatic stress disorder among Korean War Veterans. *Federal Practitioner: For the Health Care Professionals of the VA, DoD, and PHS*, 36(12), 554-562.
- 21 Palmer, B. W., Hussain, M. A., & Lohr, J. B. (2022). Loneliness in Posttraumatic Stress Disorder: A Neglected Factor in Accelerated Aging? *Journal of Ageing and Longevity*, 2(4), 326-339. <https://doi.org/10.3390/jal2040027>
- 22 Hassan, A. (2024). (dissertation). *Cognitive Aging in Marginalized Populations*. University of California Los Angeles, Los Angeles.
- 23 Conard, P. L., Keller, M. J., & Armstrong, M. L. (2023). Military veterans' end of life. *Home Healthcare Now*, 41(1), 28-35. <https://doi.org/10.1097/nhh.0000000000001138>
- 24 Larsen, S. (2023). *PTSD and End of Life: Clinical Considerations for PTSD in Palliative or Hospice Care*. https://www.ptsd.va.gov/professional/treat/specific/ptsd_end_of_life.asp
- 25 Suntai, Z., Laha-Walsh, K., & Albright, D. L. (2023). Perspectives on a good death: A comparative study of veterans and civilians. *Death Studies*, 48(3), 276-285. <https://doi.org/10.1080/07481187.2023.2219641>
- 26 U.S. Department of Veterans Affairs, (2018). *VA Office of Mental Health and Suicide Prevention Guidebook*. U.S. Department of Veterans Affairs. <https://www.mentalhealth.va.gov/docs/VA-Office-of-Mental-Health-and-Suicide-Prevention-Guidebook-June-2018-FINAL-508.pdf>.
- 27 U.S. Department of Veterans Affairs. (2024a). *Vietnam Veterans*. VA Research. https://www.research.va.gov/pubs/docs/va_factsheets/VietnamVeterans.pdf
- 28 U.S. Department of Veterans Affairs. (2024). *Mental Health*. VA Research. https://www.research.va.gov/topics/mental_health.cfm
- 29 U.S. Department of Veterans Affairs. (2024). *Vietnam Veterans*. Vet Data. https://www.va.gov/vetdata/docs/SpecialReports/Vietnam_Vet_Profile_Final.pdf
- 30 Substance Abuse and Mental Health Services Administration. (2023). *Older adults*. Suicide Prevention Resource Center. <https://sprc.org/populations/older-adults/>
- 31 Substance Abuse and Mental Health Services Administration. (2023). *Suicide Prevention in Older Adults Toolkit*. Suicide Prevention Resource Center. <https://store.samhsa.gov/sites/default/files/sma15-4416.pdf>
- 32 Nearing, K. A., Adams, H. M., Alsphaugh, J., Douglas, S. E., Feller, T. R., Fleak, R., Moore, V., Martin-Sanders, S., Schultz, T. M., Stratton, K., Sullivan, J. P., Van Sickle, L., Yates, J. D., Yates, T. A., & Matlock, D. D. (2022). Engaging the wisdom of older veterans to enhance VA Healthcare, research, and Services. *Journal of General Internal Medicine*, 37(S1), 22-32. <https://doi.org/10.1007/s11606-021-07076-x>
- 33 Tolstyka, S. M. (2024, May 1). *Promoting Healthy Aging for Older Adults*. VA News. <https://news.va.gov/130889/promoting-healthy-aging-for-older-adults/>
- 34 Bloeser, K. J., & Bausman, M. (2020). A Scoping Review of Contemporary Social Work Practice with Veterans. *Research on Social Work Practice*, 30(1), 40-53. <https://doi.org/10.1177/1049731519837355>
- 35 Koufacos, N. S., May, J., Judon, K. M., Franzosa, E., Dixon, B. E., Schubert, C. C., Boockvar, K. S. (2021). Improving Patient Activation among Older Veterans: Results from a Social Worker-Led Care Transitions Intervention. *Journal of Gerontological Social Work*, 65(1), 63-77. <https://doi.org/10.1080/01634372.2021.1932003>

-
- ³⁶ U.S. Department of Veterans Affairs. (2024). *Gulf War Veterans*. VA Research. <https://www.research.va.gov/topics/GulfWarVeterans.cfm>
- ³⁷ American Academy of Nursing. (2023). *Intake questions*. Have You Ever Served in the Military? <https://www.haveyoueverserved.com/intake-questions.html>
- ³⁸ Chao, L. L., Kanady, J. C., Crocker, N., Straus, L. D., Hlavin, J., Metzler, T. J., Maguen, S., & Neylan, T. C. (2021). Cognitive Behavioral Therapy for Insomnia in Veterans with Gulf War Illness: Results from a randomized controlled trial. *Life Sciences*, 279, 1-10. <https://doi.org/10.1016/j.lfs.2021.119147>
- ³⁹ Gromatsky, M., Halverson, T. F., Dillon, K. H., Wilson, L. C., LoSavio, S. T., Walsh, S., Mellows, C., Mann, A. J., Goodman, M., & Kimbrel, N. A. (2022). The prevalence of nonsuicidal self-injury in military personnel: A systematic review and meta-analysis. *Trauma, Violence, & Abuse*, 24(5), 2936-2952. <https://doi.org/10.1177/15248380221119513>
- ⁴⁰ U.S. Department of Veterans Affairs. (2023, September 12). *Self-harm is Underrecognized in Gulf War Veterans*. Research Currents. <https://www.research.va.gov/currents/0923-Self-harm-is-underrecognized-in-Gulf-War-Veterans.cfm>
- ⁴¹ Halverson, T. F., Calhoun, P. S., Elbogen, E. B., Andover, M. S., Beckham, J. C., Pugh, M. J., & Kimbrel, N. A. (2023). Nonsuicidal self-injury among veterans is associated with psychosocial impairment, suicidal thoughts and behaviors, and underutilization of mental health services. *Death Studies*, 48(3), 238-249. <https://doi.org/10.1080/07481187.2023.2216169>
- ⁴² Danan, E.R., Krebs, E.E., Ensrud, K. et al. An Evidence Map of the women veterans' Health Research Literature (2008-2015). *J GEN INTERN MED* 32, 1359-1376 (2017). <https://doi.org/10.1007/s11606-017-4152-5>
- ⁴³ U.S. Department of Veterans Affairs. (2018). *Profile of Post-9/11 Veterans: 2016*. National Center for Veterans Analysis and Statistics. https://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2016.pdf
- ⁴⁴ Parker, K., Igielnik, R., Barroso, A., & Cilluffo, A. (2019). The American veteran experience and the post-9/11 generation. Pew Research Center, 419, 4372.
- ⁴⁵ Waszak, D. L., & Holmes, A. M. (2017). The unique health needs of post-9/11 US veterans. *Workplace Health & Safety*, 65(9), 430-444.
- ⁴⁶ Swan, A. A., Amuan, M. E., Morissette, S. B., Finley, E. P., Eapen, B. C., Jaramillo, C. A., & Pugh, M. J. (2018). Long-term physical and mental health outcomes associated with traumatic brain injury severity in post-9/11 veterans: A retrospective cohort study. *Brain injury*, 32(13-14), 1637-1650.
- ⁴⁷ Bourassa, K. J., Wagner, H. R., Halverson, T. F., Ashley-Koch, A. E., Beckham, J., Garrett, M. E., ... & Naylor, J. C. (2024). Deployment-related toxic exposures are associated with worsening mental and physical health after military service: Results from a self-report screening of veterans deployed after 9/11. *Journal of Psychiatric Research*, 174, 283-288.
- ⁴⁸ Vogt, D., Borowski, S., Maguen, S., Blosnich, J. R., Hoffmire, C. A., Bernhard, P. A., ... & Schneiderman, A. (2022). Strengths and vulnerabilities: Comparing post-9/11 US veterans' and non-veterans' perceptions of health and broader well-being. *SSM-Population Health*, 19, 101201.
- ⁴⁹ Morgan, N. R., Aronson, K. R., Perkins, D. F., Bleser, J. A., Davenport, K., Vogt, D., ... & Gilman, C. L. (2020). Reducing barriers to post-9/11 veterans' use of programs and services as they transition to civilian life. *BMC health services research*, 20, 1-14.
- ⁵⁰ Kamdar, N., Khan, S., Brostow, D. P., Spencer, L., Roy, S., Sisson, A., & Hundt, N. E. (2023). Association between modifiable social determinants and mental health among post-9/11 Veterans: A systematic review. *Journal of military, veteran and family health*, 9(3), 8-26.
- ⁵¹ Ramsey, C., Dziura, J., Justice, A. C., Altalib, H. H., Bathulapalli, H., Burg, M., Decker, S., Driscoll, M., Goulet, J., Haskell, S., Kulas, J., Wang, K. H., Mattocks, K., & Brandt, C. (2017). Incidence of Mental Health Diagnoses in Veterans of Operations Iraqi Freedom, Enduring Freedom, and New Dawn, 2001-2014. *American journal of public health*, 107(2), 329-335. <https://doi.org/10.2105/AJPH.2016.303574>

BEST PRACTICES: Across Diagnoses

According to the U.S. Department of Veterans Affairs (VA), mental health diagnoses are common across the United States; however, veteran populations may be predisposed to certain or more acute diagnoses depending on time of service and type of service. The most common mental health diagnoses in both veteran and civilian populations include mood disorders, PTSD, anxiety, and substance use disorders (SUD).¹ Sometimes an individual is diagnosed with both a mental health disorder and an SUD. In this case, the diagnosis would be referred to as a *co-occurring* diagnosis as the mental health disorder and SUD are occurring simultaneously. In the following sections, the best practices associated with these common diagnoses and co-occurring disorders are discussed.

OVERVIEW

When working with any mental health, SUD, or co-occurring disorder, evidence-based practices (EBP) for working with veterans include similar elements. These common traits of veteran EBP include involving support systems—such as family²—in treatment, and a professional staff well-established in military cultural competence^{2,3} and Trauma-Informed Care (TIC).⁴ According to the research put forth by academic research and organizations that typically serve veterans in a behavioral health capacity, mental health, SUD, and co-occurring disorder interventions for a veteran should be delivered with:

- professional skill to integrate military experience into treatment planning;¹
- cultural awareness that includes how military experience impacts individual identity—especially values and ideals;¹
- the support of technology including phone, web, or app-based modalities;¹
- within trauma-informed settings;^{2,3,4} and
- within primary care and specialty settings.²

Considering that many veterans, especially veterans who have engaged in combat, have experienced a traumatic event, intake questions for all health assessments should not only include questions regarding veteran status, but also trauma experience.⁵ Both the VA and the American Academy of Nursing encourage that if intake questions central to veteran status are answered in the affirmative, then follow-up questions should include exploration of common behavioral health diagnoses, of possible traumatic brain injury (TBI), and military-related sexual trauma.^{2,5}

Across diagnoses and treatment modalities, EBPs should be consistently monitored and assessed for efficacy and program fidelity.² The VA recommends regularly engaging in a cycle of *collect—share—act* program evaluation. In this type of program evaluation, information on the program is collected in addition to outcomes for participants. The information is then shared with stakeholders, including providers and administration. The results derived from data analysis and stakeholder feedback is acted upon—i.e., the information is used to adjust, change, or redirect the trajectory of planned programs and/or interventions.² Through this program evaluation, the VA states it is able to deliver better, more accessible services to veterans.

SUICIDE

There is no single cause for suicide in veteran or civilian populations,⁶ and prevention of suicide is possible. EBP interventions for addressing suicidality in a veteran include considerations for accessibility.^{2,7} Crisis services must be accessible and crisis response must

be immediate.^{2,7} In order to be accessible, EBPs for interventions with suicidal persons include interventions based across a host of technology modalities including—but not limited to—text messaging, phone calls, personal device applications, web-based services, video conferencing services, and face-to-face walk-in services for crisis intervention.^{2,8} It is important that the support for veterans who may be suicidal extends to loved ones, coworkers, and/or additional members of the veteran’s regular support network as a support person may recognize warning signs of a mental health crisis or suicide before the individual veteran.^{2,8}

Resiliency is a protective factor against veteran suicide. Resiliency can be assessed, evaluated, and supported within therapeutic settings. One common assessment for resiliency is the *Connor-Davidson Resilience Scale-10*—a brief scale of ten items.

Within medical settings, part of being a culturally competent military healthcare organizations is ensuring that the medical provider is well-versed on the statistics and precipitating factors of veteran suicide so that the treatment is informed and able to perform early intervention if needed.² According to the *2024 National Veteran Suicide Prevention Annual Report* the VA *Office of Mental Health and Suicide Prevention Guidebook*, veteran suicide is less likely to occur when a veteran;

- is connected with primary care and specialty services such as those provided by the VA;
- belongs to a veteran community; and/or
- has family or other close support.

The same VA publications state that veteran suicide is more likely to occur when a veteran;

- has easy access to firearms, as approximately 67% of veteran suicides were due to firearm injury in 2014² and 75% in 2022;⁸
- is aged 50 or older;
- is female; and/or
- feels isolated in his/her community.

There are EBP and clinical guidelines for working with veterans experiencing suicidal thoughts, ideation, and/or plans.^{8,9} These EBPs for patients at risk for suicide are outlined in *Table 8* on the following page. The table organizes EBPs across the severity of the need of the patient and by the practice type. The three types of practice described in the table include therapeutic services—such as psychotherapy or mental health education—medication, and SDoH, or *Social Determinants of Health*. SDoHs are the factors external of the individual veteran that may assist in treatment completion/success or may be attributing to the decline/suicidality of the patient.

EVIDENCE BASED PRACTICES FOR SUICIDE PREVENTION & INTERVENTION

PRACTICE TYPE	DESCRIPTION
ALL LEVELS: Screening	Utilize screening tools such as the Columbia Suicide Severity Rating Scale Screener, Suicide Cognition Scale, or the Patient Health Questionnaire-9.
ALL LEVELS: Assessment	Consider the following factors while collecting information: <ul style="list-style-type: none"> • Self-directed violence, thoughts, and behaviors. • Current psychiatric conditions and current or past mental/behavioral health treatment. • Psychiatric symptoms. • Social determinants of health and adverse life events. • Availability/access of lethal means, including firearms. • Physical health conditions. • Demographic characteristics.
ALL LEVELS: Interventions	Utilize therapies such as: cognitive behavioral therapy–psychotherapy focused on suicide prevention and solution-focused therapies.
ALL LEVELS: Risk Management	Risk should be managed with the support of a professional. This may include medication, spontaneous communication efforts and communication of support from a professional, and robust targeted case management services focused on linking the individual with community support (including other veterans/veteran groups) and/or community resources to meet resource needs.
HIGH ACUTE RISK: Safety & Next Steps	Psychiatric hospitalization to maintain safety. Therapeutic interventions should include brief, solution-focused therapies with a focus on precipitating factors, current status, and future safety. There should be an exploration of current exacerbated mental health symptoms.
HIGH ACUTE RISK: Medication	Medication should address psychiatric symptoms and should be strongly considered/addressed during hospitalization.
HIGH ACUTE RISK: SDoH	A robust assessment of current external factors and barriers to consistent care should be conducted. Screenings here should be conducted regularly through the use of assessment tools such as the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences tool (PRAPARE); The American Academy of Family Physicians SDoH tool; and/or the Health-Related Social Needs Screening Tool (AHC-HRSN).
LOW ACUTE RISK: Therapeutic & Medication	For patients with suicidal ideation but no plan and robust supports should be engaged in therapies that address dysfunctional thought processes, undesirable feelings, and appropriate coping skills. Risk should be regularly assessed. Medication can be managed in an outpatient setting.
LOW ACUTE RISK: SDoH	An assessment should be conducted to determine what—if any—negative SDoHs are present in the life of the veteran. If possible, preemptively engage the veteran in promotive SDoH activities such as financial education and relationship enhancement courses.
CHRONIC RISK: Therapeutic	Patients with chronic risk of suicidality typically require interventions such as: a well-developed safety plan, talk therapy, focus on building coping skills, and therapeutic interventions that focus on the management of co-occurring symptoms (if present). With patients at chronic risk of suicide, practitioners should conduct routine suicide risk assessments.
CHRONIC RISK: Medication	Medication treatment should be routine, accessible, and focus on optimizing the psychiatric condition of the patient, and/or managing co-occurring symptoms if present. Low chronic risk patients may be able to have medication managed in a primary care or other typical outpatient setting.
CHRONIC RISK: SDoH	Psychosocial status should be routinely assessed. SDoH needs should be targeted in a way that links the individual to solution-focused resources; and SDoH strengths can be utilized to further leverage treatment compliance/success.

Table 8: Evidence Based Practices for Suicide Prevention & Intervention

RISK & PROTECTIVE FACTORS

One buffer against suicide risk was social connectedness.^{2,10,11} According to Isaac et. al (2016), *social connectedness* is the ability and opportunity to establish secure attachments in one's life. Social connectedness was reported as a strength of older veterans with low psychological distress and/or suicidality across the two-year longitudinal study.¹¹ Many other protective factors against suicide are community or relationship-related, such as having a spouse or partner,¹¹ and robust social support.¹² An additional protective factor against suicidality was *greater protective psychosocial characteristics*.¹² This *characteristic* include resiliency, dispositional gratitude, community integration, dispositional optimism, curiosity, and active lifestyles.¹²

Risk factors for suicidality include absence or a lack of the protective factors listed above in addition to lack of mental health treatment, higher psychological distress usually associated with a mood disorder, physical health difficulties including chronic pain¹² and the presence of a co-occurring disorder such as a mood disorder and SUD.^{11,12} All explored literature recommend screening for both suicidality and risk/protective factors—specifically targeting known risk factors—of suicide across healthcare settings, including primary care settings.^{11,12}

POST-TRAUMATIC STRESS DISORDER

In the United States, the prevalence of post-traumatic stress disorder (PTSD) for the general population is approximately 6% and slightly higher for the general population of veterans, 7%.¹² When regarding the prevalence and likelihood of PTSD diagnoses, female veterans are more likely than male counterparts to be diagnosed with PTSD (13% versus 7% respectively), and is more likely in veterans younger than 65 than those older than 65 (9% to 15% for populations under 65 and 4% in veterans older than 65).¹³

Age demographic regarding PTSD is important as veterans from older war eras—pre-Gulf War—are less likely to have a diagnosis of PTSD than veterans who served in the Gulf War and post-9/11 era.¹³ The prevalence rates for each cohort as of 2024 are reported in the box to the right. Overall, the risk factors and symptoms of PTSD should be regularly evaluated in patients across healthcare settings when the patient is identified as a veteran.^{2,5,11,12,13}

Diagnoses of PTSD can impact many other facets of the life of a veteran including other elements of mental health, physical health, and psychosocial factors such as relational health. According to Schnurr (2024), a diagnosis of PTSD was not only linked with a higher prevalence of co-occurring disorders (SUD) but also other mood disorders, anxiety disorders, and/or personality disorders. Schnurr goes on to explain that PTSD diagnoses are also linked with:

- greater impairment of functioning;
- increased risks of co-occurring depression;
- increased risks of co-occurring SUD;
- poorer perceived physical health;
- greater health care utilization for physical problems; and
- overall mortality and mortality due to accidental causes.¹³

The DSM-5 criteria for PTSD includes *exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence* via firsthand experience

PTSD Prevalence Rates

WWII/Korean Veterans
Current: 2% Lifetime: 3%

Vietnam Veterans
Current: 5% Lifetime: 10%

Gulf War Veterans
Current: 14% Lifetime: 21%

Post-9/11 Veterans
Current: 15% Lifetime: 29%

(directly), an eyewitness account, hearsay of the trauma directed towards a relative or friend, or indirect exposure to a traumatic event through professional duties.¹³ The DSM-5 then provides three criterion options where one to two of each category is required to be present in order for a diagnosis to be rendered, in addition to time requirements for the duration of the symptoms.¹⁴ Within military service, though combat veterans are more likely to experience PTSD symptoms/be diagnosed with PTSD,¹³ there are other common types of trauma veterans may experience that can lead to symptoms and a diagnosis of PTSD including: sexual trauma and trauma associated with indirect exposure due to carrying out job duties such as working in warzones or natural disaster sites.¹⁴ Since the exposure to traumatic events is widespread and likely as a military personnel, assessment for PTSD should be routinely performed for all patients identified as veterans through the use of a validated instrument.¹⁴ There are many standardized assessments for PTSD with various data collection methods.¹⁵ Specific assessment tools for PTSD are further discussed in *Table 9: Evidence Based Practices for PTSD Treatment*.

The framework for PTSD treatment is similar to the framework for most mental health diagnoses. It includes assessing the patient's condition before then collaborating and building support for the patient through person-centered and shared decision-making. Treatment modalities for PTSD should minimize preventable complications and morbidity; and optimize individual health outcomes and quality of life (QoL)¹⁵—much like other mental illness treatment frameworks.

Key Points for EBP PTSD Treatment

- PTSD psychotherapies work well in person or via telehealth services.^{14,16}
- One psychotherapy, *Cognitive Processing Therapy (CPT)* can be conducted in individual or group settings. This may be beneficial in also encouraging social support for a veteran.¹⁷
- Holistic/whole body approaches to the treatment of PTSD can decrease patient anxiety and improve trust in providers.¹⁶
- *Prolonged Exposure (PE)* has been shown to reduce comorbid symptoms of PTSD such as depression, anger, and anxiety.¹⁸

There are EBP and clinical guidelines for working with veterans experiencing PTSD.^{14,16} These EBPs for patients with PTSD are outlined in *Table 9* on the following page. The table organizes EBPs across the various stages of treatment, from assessment, through treatment, and onto recover—or *maintenance*. These recommendations were taken from the VA/Department of Defense's (DoD) *Clinical Practice Guidelines for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder*.¹⁶ Additional key points for the treatment of PTSD are included in the box above. Overall, there are specific, evidence-based interventions cited by the VA and DoD that have undergone evaluation in clinical practice environments over the course of years and have been published as clinical practice guideline recommendations since 2019. Within the *Clinical Practice Guidelines*, the VA and DoD specifically cite previously recommended or not recommended interventions and report if the evidence for the intervention is still recommended or not recommended. This is an example of assessment and measurement at work, specifically for the identification of EBPs across veteran care.

EVIDENCE BASED PRACTICES FOR PTSD ASSESSMENT & TREATMENT¹⁶

TREATMENT STAGE	DESCRIPTION
Assessment	<p>As with all assessments, a positive screen does not mean that the patient has a diagnosis of PTSD; however, a positive screen does indicate a high likelihood of trauma-related problems. Therefore, a positive screen is an indication that a more thorough history and assessment needs to be conducted. Common PTSD screening assessments include:</p> <ol style="list-style-type: none"> 1. The Primary Care Screen for PTSD (PC-PTSD-5) <ul style="list-style-type: none"> • Self-report; twenty items 2. The Clinically-Administered PTSD Scale for DSM-5 (CAPS-5) <ul style="list-style-type: none"> • Administered by a clinician; thirty items • Can be used to make current diagnoses or assess the severity of symptoms over a post period of time (week, month). 3. The PTSD Checklist for DSM-5 (PCL-5) <ul style="list-style-type: none"> • Self-report; twenty items • Can be used for screening or monitoring symptoms. • Is a self-report versus the CAPS-5 which is administered by a clinician. 4. The SPAN Self-Report Screen <ul style="list-style-type: none"> • Derived from the Davidson Trauma Scale • Can be used to monitor symptoms over a select period of time 5. The Short post-traumatic stress disorder Rating Interview (SPRINT) <ul style="list-style-type: none"> • Self-report; eight items • Can be used for diagnoses assessment or symptom monitoring over time 6. The Trauma Screening Questionnaire (TSQ) <ul style="list-style-type: none"> • Self-report, ten items • Designed to be used with all survivors of all types of traumatic stress
Therapy	<p>The VA/DOD recommends psychotherapy for the treatment of PTSD.¹⁵ Strongly recommended EBP therapy modalities included:</p> <ul style="list-style-type: none"> - Cognitive Processing Therapy (CPT). - Eye Movement Desensitization and Reprocessing (EMDR). - or Prolonged Exposure (PE). <p>There was also sufficient evidence for delivering these psychotherapies over e-based modalities such as teleconferencing.</p>
Social Support & Case Management	<p>EBP care for PTSD regarding social support and case management includes recommendations such as:</p> <ol style="list-style-type: none"> 1. Assessment of psychosocial status including assessment of housing, relationships, finances, and external stressors. 2. Ensuring care is patient-centered and integrates both shared decision making and the support/regular involvement of close friends and/or family members. 3. Diagnosis education for both the patient and involved friends/family members. 4. Diagnosis education specifically for sleep health.
Medication	<p>EBPs for treatment for PTSD include a combination of psychotherapy and pharmacology. The VA/DOD recommends specific pharmacological treatments for PTSD. Strongly recommended pharmacological interventions included: Paroxetine, Sertraline, or Venlafaxine.</p> <p>There was no evidence for/evidence included treating PTSD with: benzodiazepines, cannabis, and cannabis derivatives. There was weak evidence against using psilocybin, ayahuasca, dimethyltryptamine, ibogaine, or lysergic acid diethylamide for the treatment of PTSD.</p>
Maintenance	<p>Maintenance of PTSD diagnoses includes:¹⁵</p> <ol style="list-style-type: none"> 1. Normalizing fluctuations in emotions and symptoms. 2. Patient education regarding self-monitoring symptoms and reinitiating interventions. 3. Continuation or tapering off medication under the care of a clinician. 4. Referrals to other resources to support the patient in continuing holistic care.

Table 9: Evidence Based Practices for PTSD Assessment & Treatment

SUBSTANCE USE DISORDERS

The term *substance use disorder* (SUD) includes disorders associated with a broad range of substances—alcohol use disorder, cannabis use disorder, opioid use disorder, and stimulant use disorder among others.¹⁹ According to the Substance Abuse and Mental Health Services Administration (SAMHSA), *there is a dramatic lack of consistency in services available to adults in need of specialty SUD treatment.*²⁰ In *Chart 3*, below, facts regarding substance use and veterans are explored.

FACTS: SUBSTANCES AND VETERANS	
ILLICIT DRUG USE	<ul style="list-style-type: none"> Veterans are more likely than active-duty personnel to engage in illicit drug use.¹⁸
OPIOID AND PRESCRIPTION DRUG MISUSE	<ul style="list-style-type: none"> Two-thirds of veterans' report pain-related issues.²¹ Opioid use disorders and prescription drug misuse among veterans is most likely to begin with opioid pain prescription or prescription of another drug that then gets misused.²¹
ALCOHOL USE	<ul style="list-style-type: none"> Alcohol use disorder is the most prevalent SUD among active-duty military and veterans.²¹ The likelihood of alcohol use disorders goes up with the amount of exposure to combat a veteran has experienced.²¹ Two-thirds of veterans who receive SUD treatment report alcohol as the substance most frequently misused.²¹
TOBACCO USE	<ul style="list-style-type: none"> Though rates have decreased recently, veteran and active-duty tobacco use is more likely if an individual has experienced combat.²¹ Veterans are more likely to use tobacco—cigarettes, tobacco products, e-cigarettes, vapes—than their nonveteran counterparts.

Chart 3: Facts: Substances and Veterans

Across research regarding veterans and SUDs, there is support for specific focus regarding SUD and veteran populations due to the unique experience of veterans—especially veterans who have experienced combat, were deployed, and/or have reintegrated into civilian society.²¹ The connection between trauma and SUDs is strong as veterans who have an SUD diagnosis are three to four times more likely than their veteran peers to have a comorbid diagnosis of PTSD or depression.²¹ Additional risk factors for veteran SUD and other mental disorders include:

- reintegration stresses
- sleep disturbances
- traumatic brain injury (TBI)
- violence in relationships²¹

Recovery from SUDs is possible. EBP for treatment of SUDs are further described in *Table 10* on the following page. There is an emphasis on early screening, assessment, and intervention

as the likelihood of recovery from an SUD is more likely when the SUD treatment is engaged early in the disorder’s progress. EBPs taken from the VA/DoD’s *Clinical Guidelines for the Management of Substance Use Disorders*.²¹

EVIDENCE BASED PRACTICES FOR TREATMENT OF SUBSTANCE USE DISORDERS	
DIAGNOSIS	TREATMENT
Screening/ Assessment	<ul style="list-style-type: none"> • Brief screenings are recommended across all healthcare settings for new patients or at annual visits/wellness screeners. • Brief screeners are recommended if there is any indication of substance use at a visit across healthcare settings. • If substance misuse is indicated, it is recommended that next step treatment or intervention is handled through a warm hand-off or referral, if not treated in the healthcare facility where the indication was made.
Withdrawal	<p>Across all SUDs, when withdrawal symptoms are present, there is recommendation of medication assisted withdrawal.</p> <ul style="list-style-type: none"> • Alcohol Use Disorder: benzodiazepines with adequate monitoring. • Opioid Use Disorder: medication-assisted treatment such as methadone, buprenorphine/naloxone, or extended-release naltrexone. • Sedative Hypnotic Use Disorder: gradual tapering off the medication.
Medication Assisted Treatment	<p>At times, medication assisted treatment is recommended depending on the severity and/or the type of SUD.</p> <ul style="list-style-type: none"> • Alcohol Use Disorder: For patients with moderate-severe alcohol use disorder, naltrexone (oral or extended-release) or topiramate are recommended. • Opioid Use Disorder: Buprenorphine/naloxone in any setting; or methadone or buprenorphine/naloxone provided through an accredited opioid treatment center.
Psychosocial Interventions	<p>Each SUD has common psychosocial and therapeutic intervention EBPs. Common interventions include:</p> <ul style="list-style-type: none"> • Behavioral couples therapy (AUD). • Cognitive behavioral therapy (AUD, Cannabis Use Disorder, Stimulant Use Disorder). • Community reinforcement approach (AUD). • Motivational enhancement therapy (AUD, Cannabis Use Disorder). • 12-step facilitation (AUD and other drug use disorders). • Recovery-focused behavioral therapy—individual drug counseling and community reinforcement approach (Stimulant Use Disorder). • Peer linkage (AUD and other drug use disorders).

Table 10: Evidence Based Practices for Treatment of Substance Use Disorders

DEPRESSIVE AND ANXIETY DISORDERS

The terms *depression* and *anxiety* refer to various DSM-5 group classifications of similar disorders.^{22,23} SAMHSA reports six types of depressive disorders²³ and five types of anxiety disorders,²⁴ respectively. Both depressive and anxiety are treatable disorders that—when left untreated—can sometimes lead to greater severity of symptoms and/or co-morbid diagnoses.²⁴ Common considerations, including symptoms and risk factors, of depression and anxiety among veteran populations are described below.

Depression and PTSD are the two most commonly diagnosed mental illnesses across veteran cohorts.

DEPRESSION

Depressive disorders are common across both the civilian and veteran populations. Common symptoms of depressive disorders include:²⁵

- excessive feelings of sadness or hopelessness
- loss of interest in normal activities or activities the person once felt pleasure in
- insomnia or hypersomnia
- increased or decreased appetite

There are six depression diagnoses²³: major depressive disorder (MDD), persistent depressive disorder—where depressive symptoms last two years or more in adults (formerly called dysthymia)—postpartum depression, psychotic depression, seasonal affective disorder, and bipolar disorder. Bipolar disorder is a mood disorder that includes seasons/cycling in and out of MDD episodes. In addition to the typical symptoms of depression, other symptoms specific to individual depressive disorders include:²³

- Has the individual had sudden change in depressive symptoms congruent with seasonal and/or weather changes?
- Have the depressive symptoms that have lasted more than two years, or less than six months?
- Are there co-morbid symptoms including psychosis or mood disorder symptoms?

Depression is one of the two most commonly diagnosed mental illnesses across veteran cohorts.²⁵ Within the Post-9/11 Veteran cohort, 14-16% have been diagnosed with PTSD or a depressive disorder.²⁵ Research also shows that Vietnam Veterans are twice as likely to have depressive symptoms than older veteran cohorts.²⁶

ANXIETY

Risk factors for depressive and anxiety symptoms are prevalent in active military and veteran lives due to the nature of the service and transitions involved in military to civilian transitions.²⁵ Common symptoms of anxiety disorders include:²⁷

- excessive feelings of restlessness or worry;
- the feeling of specific physical symptoms;
 - racing heart, the need to fidget, difficulties catching one's breath, lightheadedness, feeling dizzy, and/or trembling.
- difficulty focusing;
- hyperactivity; and/or
- insomnia or poor sleep.

Anxiety disorders include generalized anxiety disorder (GAD), panic disorder, specific phobias, obsessive-compulsive disorder (OCD), and social anxiety. Additional other symptoms specific to individual anxiety disorders include:²⁴

- frequent and/or unexpected panic attacks;
- chills or hot flashes;
- fear of specific things or circumstances;
- obsessions or compulsions; and/or
- heart palpitations.

Though PTSD and trauma-related disorders may share symptoms, PTSD is not considered an anxiety disorder due to the diagnosis' requirement for experiencing a traumatic event. A good assessment and history would be required to ensure that a veteran who presented with anxiety symptoms was diagnosed with the correct mental illness. However, many of the therapies utilized for the treatment of PTSD can also be used for the treatment of anxiety disorders.

TREATMENT

The treatment for depressive and anxiety disorders varies depending on the symptom severity, the patient's goals, if there is a co-morbid diagnosis, and/or the types of treatment that have succeeded or failed in the past (if applicable). According to the VA,²⁸ there are five EBP therapies for the treatment of depression, and one EBP for the treatment of anxiety.²⁹ Though the VA has only one therapy technique listed for the treatment of anxiety, remembering that other diagnoses—such as PTSD—have similar symptoms to these diagnoses, it is possible that the scope of therapies for the treatment of anxiety is larger. The therapeutic technique selected for use, again, should be selected through the process of shared decision making—where the veteran provides the information on his/her symptoms, experience, and goals; the provider informs the veteran of the benefits of each type of treatment; and treatment decisions are made from there.³⁰

Many depressive and anxiety diagnoses can be treated within primary care settings through the use of medication such as antidepressants.^{23,24,29,30,31} Typically, the best course of treatment for these diagnoses is a combination of talk therapy and psychotropic medication.³¹ The EBPs for the treatment of depressive and anxiety disorders are outlined in *Table 11* on the following page.

EVIDENCE BASED PRACTICES FOR TREATMENT OF DEPRESSIVE AND ANXIETY DISORDERS

THERAPY	DESCRIPTION
Cognitive Behavioral Therapy^{29,30}	<p>Cognitive Behavioral Therapy (CBT) is a short-term talk therapy that helps the veteran identify disruptive and/or distressful thoughts and feelings in an effort to reduce the discomfort in future situations. CBT assists the veteran in addressing anxiety-based fears and build coping skills quickly.</p> <p>CBT for Depression (CBT-D) shifts the focus to identification of modification of depressive thought patterns in an effort to reduce symptom severity. CBT-D is also structured to build positive coping skills quickly.</p> <p>Both CBT and CBT-D are usually time-limited programs; however, elements of both therapy modalities can be integrated alongside others to supplement and reinforce the identification of dysfunctional thought processes and build coping skills.</p>
Acceptance and Commitment Therapy for Depression^{29,32}	<p>Acceptance and Commitment Therapy (ACT) attempts to guide the veteran through the acceptance of distressful feelings or emotions and building skills that enable the veteran to focus on goal-directed behaviors. ACT is largely founded on the veteran’s individual values. The acceptance aspect of ACT has historically decreased symptom severity.</p>
Behavioral Therapy and Behavioral Activation^{29,32}	<p>Behavioral therapy (BT) is a behaviorism-based therapy that teaches individuals with depression to increase rewarding activities, specifically in times when depressive symptoms are high or may become high. Behavioral activation (BA) is a type of BT where the link between avoidant behaviors and depressive symptoms is a larger focus.</p> <p>Both BT and BA engage the veteran in problem-solving, reflection, mood tracking and emotional intelligence, and interpersonal skills practice.</p>
Interpersonal Psychotherapy^{29,32}	<p>Interpersonal Psychotherapy (IPT) and interpersonal psychotherapy for depression (IPT-D) engage the veteran in an exploration of interpersonal relationships and problem-solving identified issues within those relationships. IPT targets four interpersonal relationship areas; (1) interpersonal loss; (2) role conflict; (3) role change; (4) interpersonal skills.</p>
Problem-Solving Therapy^{29,32}	<p>In Problem-Solving Therapy (PST), the veteran and practitioner work together to identify problematic areas in the life of the veteran, break the problems down into manageable steps, and develop appropriate coping skills for each identified problem. PST works well when there is a short window available for therapy as it is a short-term approach to symptoms. It may be useful to utilize PST in conjunction with a more detailed and lengthy therapy technique, especially when motivation/compliance for and with therapy may be an issue.</p>
Non-directive Supportive Psychotherapy³²	<p>Non-Directive Supportive Psychotherapy (NDSP) utilizes various therapeutic techniques; however, symptom reduction and change is dependent largely on the strength of the therapeutic relationship (between the veteran and the practitioner). Typically, successful NDSP is dependent on the veteran’s perception of the strength of the support, listening, and reflection of the practitioner.</p>
Short-term Psychodynamic Psychotherapy (STPP)³²	<p>A 10-20 week therapeutic program where the therapeutic focus is on building insight for the veteran into identified symptoms and problems—especially unconscious challenges or thoughts. These are identified by the practitioner then explored by the veteran with the support of the practitioner. STPP and IPT overlap in their techniques; however, whereas IPT’s sole focus is relationships, STPP’s focus is broader.</p>

Table 11: Evidence Based Practices for Treatment of Depressive and Anxiety Disorders

BIPOLAR AND SCHIZOPHRENIA

In veteran populations, the diagnosis of bipolar disorder is higher in women, and the diagnosis of schizophrenia is higher in men.³² With both diagnoses, the prevalence is higher in Medicaid and low-socioeconomic status patients than populations with greater access to primary care and early intervention screenings.³³ Considerations for EBP treatment for bipolar disorder and schizophrenia are described in *Table 12*, below. All information was taken from the VA/DoD Clinical Practice Guidelines for both disorders.^{34,35}

EVIDENCE BASED PRACTICES FOR TREATMENT OF BIPOLAR DISORDER & SCHIZOPHRENIA

PHASE	DESCRIPTION
Assessment	<p>Assessments for both bipolar disorder and schizophrenia include initial and regular assessments for safety using a validated suicide safety screening tool. If suicidality is identified, steps should be taken to ensure the safety of the veteran such as enabling a crisis safety plan and/or hospitalization.</p> <p>For bipolar disorder, information should be gathered regarding family history of bipolar disorder and specific questions asked regarding the type, duration, and distress experienced during both depressive and manic episodes. An assessment for SUD should be done in the initial assessment and as needed throughout treatment. For schizophrenia, the utilization of EBP screening tools when schizophrenia is suspected is recommended, even if there is no history of a first episode. Assess to rule out differential diagnosis such as substance use or substance withdrawal.</p>
Medication	<p>For bipolar disorder, the prescription of both an antidepressant and mood stabilizer are most recommended as the highest result-yielding line of treatment. For schizophrenia, the choice of antipsychotic medication should be based on the needs and wants of the individual veteran. Antipsychotic medication is strongly recommended for both first-episodes psychosis and the prevention of relapse. Clozapine is not recommended for first-time psychosis.</p>
Therapeutic Interventions	<p>For both bipolar disorder and schizophrenia, non-pharmacological interventions such as the following have been proven to decrease symptoms and distress:</p> <ul style="list-style-type: none"> • psychosocial interventions; incorporating familial and friend support into treatment; • pharmacotherapy and primary care coordination; • case management services/support; • psychoeducation; • team-based care; • patient-centered care; • shared decision making; and • planning monitoring of moods, symptoms, and treatment adherence including identifying early warning signs of possible recurrences and reporting them to providers <p>Specifically for bipolar disorder, other EBP interventions include psychotherapy intervention to build coping skills; and access to peer support in the treatment organization or community.</p> <p>Specifically for schizophrenia, other EBP interventions include:</p> <ul style="list-style-type: none"> • service models based on the Assertive Community Treatment model; • service models for employment based on the Individual Placement and Support model; and • face-to-face intervention for smoking cessation.
Maintenance	<p>For both bipolar disorder and schizophrenia, support in the maintenance phase of treatment includes:</p> <ul style="list-style-type: none"> • addressing specific SDoH issues including access to housing, employment, and healthcare; • education regarding warning signs of symptoms and symptom decline; • education regarding reconvening acute care/treatment, including access; and • linkage and ongoing support towards social connection, peer support, and community integration/support.

Table 12: Evidence Based Practices for Treatment of Bipolar Disorder and Schizophrenia

BIBLIOGRAPHY

Best Practices: According to Diagnoses

- ¹ U.S. Department of Veterans Affairs. (2021). *Mental Health*. Office of Research and Development. https://www.research.va.gov/topics/mental_health.cfm.
- ² U.S. Department of Veterans Affairs. (2018). VA Office of Mental Health and Suicide Prevention Guidebook. <https://www.mentalhealth.va.gov/docs/VA-Office-of-Mental-Health-and-Suicide-Prevention-Guidebook-June-2018-FINAL-508.pdf>
- ³ U.S. Department of Veterans Affairs. (2024a). *Support for Healthcare Providers*. Health Care: Mental Health. <https://www.mentalhealth.va.gov/healthcare-providers/index.asp>
- ⁴ U.S. Department of Veterans Affairs. (2024b). *Trauma-informed Care Fact Sheet*. VA National Center on Homelessness Among Veterans. <https://www.va.gov/homeless/nchav/docs/Trauma-Informed-Care-Fact-Sheet.pdf>
- ⁵ American Academy of Nursing. (2023). Intake questions. Have You Ever Served in the Military? <https://www.haveyoueverserved.com/intake-questions.html>
- ⁶ U.S. Department of Veterans Affairs. (2024d). *Mental Health: Suicide Prevention*. Mental Health. https://www.mentalhealth.va.gov/suicide_prevention/index.asp
- ⁷ U.S. Department of Veterans Affairs. (2024e). *Veterans Crisis Line: for veterans and their loved ones*. <https://www.veteranscrisisline.net/>.
- ⁸ U.S. Department of Veterans Affairs and U.S. Department of Defense. (2024a). *VA/DoD Clinical Practice Guidelines: Assessment and management of patients at risk for suicide*. https://www.healthquality.va.gov/guidelines/MH/srb/VADoD-CPG-Suicide-Risk-Provider-Summary-2024_Final_508.pdf.
- ⁹ U.S. Department of Veterans Affairs and U.S. Department of Defense. (2020). *Suicide Prevention: Risk factors and warning signs for family members and caregivers*. Veterans Crisis Line.
- ¹⁰ Isaacs, K., Mota, N. P., Tsai, J., Harpaz-Rotem, I., Cook, J. M., Kirwin, P. D., Krystal, J. H., Southwick, S. M., & Pietrzak, R. H. (2017). Psychological resilience in U.S. military veterans: A 2-year, nationally representative prospective cohort study. *Journal of psychiatric research*, 84, 301-309. <https://doi.org/10.1016/j.jpsychires.2016.10.017>
- ¹¹ Smith, N. B., Mota, N., Tsai, J., Monteith, L., Harpaz-Rotem, I., Southwick, S. M., Pietrzak, R.H. (2016). Nature and Determinants of Suicidal Ideation Among U.S. Veterans: Results from the national health and resilience in veterans study. *Journal of Affective Disorders*, 197(June 2016). Pp. 66-73. <https://doi.org/10.1016/j.jad.2016.02.069>.
- ¹² Schnurr, P. P. (2022). Epidemiology and Impact of PTSD. U.S. Department of Veterans Affairs National Center for PTSD. <https://www.ptsd.va.gov/professional/treat/essentials/epidemiology.asp>.
- ¹³ U.S. Department of Veterans Affairs. (2022). Treatment Essentials. PTSD: National Center for PTSD. <https://www.ptsd.va.gov/professional/txessentials/index.asp>.
- ¹⁴ U.S. Department of Veterans Affairs. (2022). Assessment Overview. PTSD: National Center for PTSD. <https://www.ptsd.va.gov/professional/assessment/overview/index.asp>.
- ¹⁵ U.S. Department of Veterans Affairs and U.S. Department of Defense. (2023a). *VA/DoD Clinical Practice Guidelines: Management of posttraumatic stress disorder and acute stress disorder*. <https://www.healthquality.va.gov/guidelines/MH/ptsd/VA-DOD-CPG-PTSD-Provider-Summary.pdf>.
- ¹⁶ Uniformed Services University of the Health Sciences. (2024). *Cognitive Processing Therapy (CPT)*. Center for Deployment Psychology. <https://deploymentpsych.org/treatments/cognitive-processing-therapy-cpt>.
- ¹⁷ Uniformed Services University of the Health Sciences. (2024). *Prolonged Exposure (PE)*. Center for Deployment Psychology. <https://deploymentpsych.org/treatments/prolonged-exposure-pe>.
- ¹⁸ U.S. Department of Health and Human Services National Institutes of Health. (2024). *General risk of substance use disorders*. Substance Use and Military Life DrugFacts. <https://nida.nih.gov/publications/drugfacts/substance-use-military-life>

-
- ¹⁹ U.S. Department of Veterans Affairs. (2024f). *Mental Health: Substance use*. Office of Research and Development. <https://www.mentalhealth.va.gov/substance-use/index.asp>.
- ²⁰ SAMHSA. (2005). Substance Abuse and Mental Health Services Administration: National Guidance on Essential Specialty Substance Use Disorder (SUD) Care. *Publication No. PEP25-04-003, Substance Abuse and Mental Health Services Administration, 2025*.
- ²¹ U.S. Department of Veterans Affairs and U.S. Department of Defense. (2023a). *VA/DoD Clinical Practice Guidelines for the Management of Substance Use Disorders*. <https://www.healthquality.va.gov/guidelines/MH/sud/VADODSUDCPGProviderSummary.pdf>
- ²² Substance Abuse and Mental Health Services Administration. (2023). *Mental Health Conditions: Depression*. What is Mental Health? <https://www.samhsa.gov/mental-health/what-is-mental-health/conditions/depression>
- ²³ Substance Abuse and Mental Health Services Administration. (2023). *Mental Health Conditions: Anxiety*. What is Mental Health? <https://www.samhsa.gov/mental-health/what-is-mental-health/conditions/anxiety>
- ²⁴ Moore, M. J., Shawler, E., Jordan, C. H., & Jackson, C. A. (2023). Veteran and Military Mental Health Issues. In *StatPearls*. StatPearls Publishing.
- ²⁵ U.S. Department of Veterans Affairs. (2025). *Depression Symptoms, Screening, & Veteran Resources*. Mental Health: Depression. <https://www.mentalhealth.va.gov/depression/index.asp>
- ²⁶ Gould, C. E., Rideaux, T., Spira, A. P., & Beaudreau, S. A. (2015). Depression and anxiety symptoms in male veterans and civilians: the Health and Retirement Study. *International journal of geriatric psychiatry*, 30(6), 623–630. <https://doi.org/10.1002/gps.4193>
- ²⁷ U.S. Department of Veterans Affairs. (2025). *Anxiety Symptoms, Screening, & Veteran Resources*. Mental Health: Anxiety. <https://www.mentalhealth.va.gov/anxiety/index.asp>
- ²⁸ U.S. Department of Veterans Affairs. (2025). *Depression Treatments & Therapies for Veterans*. Mental Health: Depression. <https://www.mentalhealth.va.gov/depression/treatment.asp>
- ²⁹ U.S. Department of Veterans Affairs. (2025). *Anxiety Treatments & Therapies for Veterans*. Mental Health: Depression. <https://www.mentalhealth.va.gov/anxiety/treatment.asp>
- ³⁰ U.S. Department of Veterans Affairs. (2025). *Choosing a Treatment*. PTSD: National Center for PTSD. https://www.ptsd.va.gov/understand_tx/choose_tx.asp
- ³¹ U.S. Department of Veterans Affairs and U.S. Department of Defense. (2023a). *VA/DoD Clinical Practice Guidelines: Management of major depressive disorder*. https://www.healthquality.va.gov/guidelines/MH/mdd/VADODMDDCPG_ProviderSummary_Final_508_updated.pdf.
- ³² Ramsey, C., Dziura, J., Justice, A. C., Altalib, H. H., Bathulapalli, H., Burg, M., Decker, S., Driscoll, M., Goulet, J., Haskell, S., Kulas, J., Wang, K. H., Mattocks, K., & Brandt, C. (2017). Incidence of Mental Health Diagnoses in Veterans of Operations Iraqi Freedom, Enduring Freedom, and New Dawn, 2001-2014. *American journal of public health*, 107(2), 329–335. <https://doi.org/10.2105/AJPH.2016.303574>
- ³³ Hoeft, T. J., Hall, J. D., Solberg, L. I., Takamine, L. H., Danna, M. N., Fortney, J. C., Shushan, S., & Cohen, D. J. (2023). Clinician Experiences With Telepsychiatry Collaborative Care for Posttraumatic Stress Disorder and Bipolar Disorder. *Psychiatric services (Washington, D.C.)*, 74(6), 596–603. <https://doi.org/10.1176/appi.ps.202100595>
- ³⁴ U.S. Department of Veterans Affairs and U.S. Department of Defense. (2023a). *VA/DoD Clinical Practice Guidelines: Management of bipolar disorder*. <https://www.healthquality.va.gov/guidelines/MH/bd/VA-DOD-CPG-BD-Provider-SummaryFinal508.pdf>
- ³⁵ U.S. Department of Veterans Affairs and U.S. Department of Defense. (2023a). *VA/DoD Clinical Practice Guidelines: Management of first-episode psychosis and schizophrenia*. https://www.healthquality.va.gov/guidelines/MH/scz/VA-DOD-CPG-Schizophrenia-Provider-Summary_finalv231924.pdf

ADDITIONAL CONSIDERATIONS

Barriers to care exist at all levels for veterans.¹ Interventions such as case management, peer support, and linkage to community resources can assist veterans in navigating healthcare systems, completing treatment, maintaining recovery, and feeling more highly integrated into post-military communities and life.^{2,3}

CASE MANAGEMENT SERVICES

Case management services for veterans include professionals supporting veterans in navigating health and social systems both within medical settings and in the community.² Case management services can be integrated into any healthcare setting, and are regularly present within behavioral health treatment, especially when the individual veteran has identified SDoH as a precipitating factor of or an additional stressor to mental health symptoms/distress. Case management care models take the focus off the individual and expand it to include the individual veteran’s family, friends, organizational supports, setting, and situation.⁴ Veteran case management services can be rendered across any medical or behavioral health setting in which the veteran solicits treatment.² In *Table 13*, below, elements of EBP case management services are described.

EVIDENCE BASED PRACTICES FOR VETERAN CASE MANAGEMENT	
INTERVENTION	DESCRIPTION
Social Work Case Management ⁵	<p>The goal within social work case management is to assist veterans, their families, and/or their caregivers in addressing and resolving SDoH challenges. The challenges can be to mental health, physical health, and/or overall well-being. Some specific challenges addressed through social work case management include:</p> <ul style="list-style-type: none"> • resource navigation • crisis intervention • client/family advocacy • SUD Treatment • housing support • homelessness intervention • psychoeducation • relational education • access to care • transition case management
Transition Case Management ⁶	<p>One specific best practice within veteran support and case management is case management support during transitioning from active duty to civilian life. Case management services during times of transition help bridge the gaps that may cause stress for the veteran, including gaps between available services provided through agencies such as the VA and Department of Defense (DoD).</p>
Mental Health Case Management	<p>Case management services provided during the treatment of mental illness or SUD are intended to assist veterans in navigating the healthcare system (including prescriptions), ensuring services align, ensuring services needed are also services rendered, leading team-based care under the premise of veteran-centric care, and filling service gaps as they are identified.²</p>

Table 13: Evidence Based Practices for Veteran Case Management

PEER SUPPORT SERVICES

Peer support services are a type of social service that can be delivered across behavioral health settings. *Peer support* can be defined as “support between individuals with shared lived experiences.”⁷ Peer support services have been shown to potentially support veterans and their families in a holistic, multi-dimensional way.⁷ In *Table 14*, below, EBPs for peer support services are described.

EVIDENCE BASED PRACTICES FOR PEER SUPPORT SERVICES	
INTERVENTION	DESCRIPTION
Peer Specialists ⁸ Interventions	<p>Peer specialists exist to:</p> <ul style="list-style-type: none"> • draw upon lived experiences; • share relatable emotions and perceptions of common experiences; • serve as role models; • promote hope; • engage veterans in treatment; and • assist veterans in accessing support in the community. <p>Though there are common reported issues in workforce development and retention of peer specialists traditionally, the services provided by peer specialists have been positively recorded:</p> <ol style="list-style-type: none"> 1. Peer specialists have been found to help in decreasing social isolation and increasing hope. 2. Peer specialists can assist in increasing engagement in services. 3. Peer specialists can contribute to decreasing re-hospitalizations <p>Support provided by peer specialists services are considered an EBP for behavioral healthcare within and outside of the veteran population.</p>

Table 14: Evidence Based Practices for Peer Support Services

Overall, both case management and peer support services should be considered a standard element of behavioral health programs versus being framed as an add-on service. Case management services support veterans in ensuring treatment remains patient-centered and that shared-decision making is not overlooked while supporting veterans, veteran families, and caregivers in addressing any issue that may arise outside the specific course of treatment for the veteran. Peer services assist the veteran by offering a mode of education, support, and hope where shared experience and culture are present. Both case management and peer support services aid veterans in addressing barriers present in traditional healthcare settings.

SEASONS OF TRANSITION

Times of transition are notable times of increased stress for all individuals, and the transition from military to civilian life is a particularly vulnerable time for veterans.⁹ According to Derefinko et. al,⁹ many veterans transitioning from active duty to civilian life report worsening issues such as:

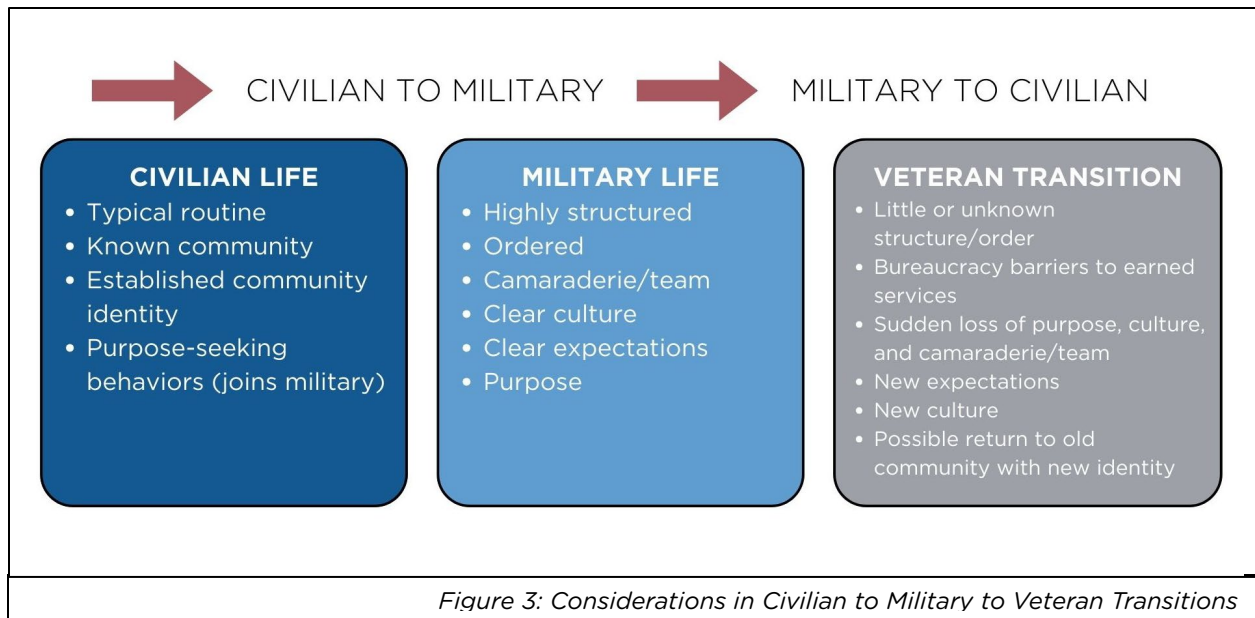
- anger outbursts
- PTSD
- sustained substance use
- strained family relationships

This is congruent with the findings of two Alabama Veteran needs assessments explored earlier in the literature review: *Barriers and Resources for Veterans' Post-military Transitioning*

*in South Alabama: A qualitative analysis (BRSA)*¹⁰ published in 2018, and *Military Culture and Post-military Transitioning Among Veterans: A Qualitative Analysis (MCTAV)*¹¹ published in 2019. The findings of these papers reported that veterans in transition communicated issues with the following categories:

1. Employment
 - a. transitioning military skills and experience into civilian life employment or experience;
 - b. lack of community and professional understanding of military experience;
 - c. satisfactory employment opportunities; and
 - d. familial conflict and/or instability.
2. Healthcare
 - a. lack of access to benefits provided by the VA;
 - b. barriers to mental health treatment, specifically;
 - c. frustration with paperwork associated with support services;
 - d. ambivalence towards help-seeking;
 - e. lack of education regarding available supports and services; and
 - f. lack of community and professional understanding of military experience.
3. Behavioral health distress
 - a. ambivalence towards help-seeking;
 - b. frustration with lack of military cultural competence;
 - c. mental health distress;
 - d. drug or alcohol addiction;
 - e. familial conflict and/or instability; and
 - f. dissonance with civilian or post-military culture/life.
4. Interpersonal issues
 - a. familial conflict and/or instability;
 - b. divorce and family integration issues;
 - c. social isolation; and
 - d. loss of military camaraderie.

In 2019, almost half of veterans transitioning to civilian life reported difficulties with readjusting to non-military life.⁹ While in the military, soldiers live daily in highly structured environments with a strong presence of well-defined culture and camaraderie.¹² Overall, when transitioning back to civilian life, veterans may have difficulties establishing purpose and place within their communities.¹² Some research cites that transition stress is a greater risk to veterans than PTSD as it is more prevalent and can lead to serious mental health problems.¹³ In *Figure 3* on the following page, the elements of the civilian to military to civilian transition are illustrated.



Though still very much a current and developing topic of veteran research, there are EBPs suggested for supporting veterans during transitioning back to civilian life. Some of these recommendations are described in *Table 15* on the following page.

VETERAN TRANSITIONS & COMMUNITY

Many sources cite social isolation and loss of camaraderie as a source of stress for veterans during the season of transition back into civilian life. Across the studies, there are many recommendations for increasing accessibility to and encouraging veterans to get involved in not only in veteran specific community organizations, but also in the larger community. This serves to provide the individual veteran with support, purpose, and place while also exposing the civilian community at-large to experience what/how veteran add value to the community. In this, there are specific community-based practices that have shown to make the transition experience of veterans less stressful:

1. Encourage communities to be knowledgeable of resources available to veterans, especially those that include peer and community-based elements.⁹
2. Encourage veterans to get involved in a spiritual community.
 - a. According to the Pew Research Center,¹⁴ veterans who regularly attended religious services were less likely to report transition stress than those who did not (43% versus 67%).
 - b. Spiritual practices can assist veterans in establishing meaning for past experiences and current situations.¹⁵

EVIDENCE BASED PRACTICES FOR SEASONS OF TRANSITION

Practice	DESCRIPTION
Ensure Veteran Services are Available, Accessible, & Well-Known	<ol style="list-style-type: none"> 1. Available <ol style="list-style-type: none"> a. Services in all spaces in which a veteran will transition to. This includes both a literal place and typical spaces such as employment and community spaces.¹⁶ b. Integrate telehealth and other technologies into interventions and services to increase the catchment area for available services.¹⁶ 2. Accessible <ol style="list-style-type: none"> a. Support development of specialized, community-based programs outside of the VA system.¹⁶ b. Reduce paperwork and wait times for initial and follow-up appointments for veterans engaged in healthcare systems.¹⁷ c. Decrease barriers between veterans and available services through, <ol style="list-style-type: none"> i. Increasing available alternative transportation options. ii. Increasing online and call options for services.¹⁶ iii. Increasing the access points for all levels of veteran support services. iv. Centralize veteran case management services that specifically address and are trained in veteran service navigation. 3. Well-Known <ol style="list-style-type: none"> a. Support regional public service announcements that normalize behavioral, mental, and physical health needs.¹⁶ b. Provide training for community professionals, veterans, and veteran caregivers on common conditions and local service availability, including the creation of community catalogues of services by county.¹⁶ c. Increase awareness of and services for the problem of moral injury among veterans, especially older veterans.¹⁶ d. Increase knowledge of veteran resources across veteran stakeholders, including healthcare services, behavioral health services, community resources, veteran groups, and community-specific veteran organizations.¹⁷
Individualized Transition Services	<ol style="list-style-type: none"> 1. For each veteran, individual support plans should be created through the identification of individual needs.¹⁶ <ol style="list-style-type: none"> a. Special attention paid to ensuring non-White and women veterans' transition support is individualized¹⁶ and based on assessed need—not a model created for majority veteran populations.¹⁷
Support in Healthcare Venues	<p>All healthcare venues should,</p> <ol style="list-style-type: none"> 1. Actively work towards decreasing military stereotypes and increasing competence of military culture^{10,18} 2. Engage in the provision of Trauma-Informed Care.^{19,20} 3. Ask questions regarding veteran status during history/assessments. <ol style="list-style-type: none"> a. Have clear, outlined, informed processes for positive veteran status responses including screeners for common behavioral health and SDoH issues such as SUD, PTSD, interpersonal relationship issues, and/or employment issues.

Table 15: Evidence Based Practices for Seasons of Transition

3. Encourage and provide marriage & interpersonal relationship support.
 - a. Stress is almost guaranteed in marriage during re-entry. In one study,¹⁴ veterans in marriages during transition were more likely to report stress than those who were not married (63% versus 48%). Support that is targeted to marriage relationships would be beneficial to veterans transitioning out of active military status.
 - b. Engage veterans, veteran partners/spouses, and veteran dependents on effective communication methods to ease or lower stress associated with communication frustrations/lack of understanding of the veteran's experience.⁹
 - c. Services such as those provided by the DoD's *Military Family Readiness System* should be universal and centralized to equip veterans and their immediate interpersonal relationships (spouse/partner, caregiver, children, family) for the possible stresses of transitioning back to civilian life and ways to navigate the season.²¹
4. Link veterans transitioning to peer support.
 - a. Veteran peer contact is associated with lower transition stress outside of healthcare venues⁹ and higher treatment engagement/treatment rates¹¹ than veterans not engaged in peer relationships.
 - b. Veteran to veteran networking can not only assist in lowering transition stress, but also increase the likelihood of veterans engaging in meaningful employment.¹²

Many supports during seasons of transitions include strengthening relationships and understanding within relationships outside of the military.

PHYSICAL HEALTH

One primary concern for the delivery of behavioral health services to veteran populations is the status of the veteran's physical health and the possible implications of physical health status on veteran behavioral health. One example of this is the existence of traumatic brain injury (TBI). According to the VA, a TBI is an injury that results from any blow to the head from an external object, the head striking an external object or force (such as a blast or explosion).²² TBI can not only increase veterans' chances of being diagnosed with a mental illness such as depression, PTSD, anxiety, or SUD,²³ but it can also impact how a veteran perceives both the world around them and their own thoughts or situation²². The VA/DoD *Clinical Practice Guidelines: Management and rehabilitation of post-acute mild traumatic brain injury* recommend that if a veteran presents with symptoms of TBI, he/she should be referred to a specialist where an appropriate battery of tests to confirm the diagnosis can be ran.²⁴

When treating behavioral health issues in veterans with TBI, practitioners should be mindful of TBI symptoms and impact while following best practice guidelines for the specific behavioral health diagnosis.²⁴ Since specific behavioral health diagnoses are more prevalent across veterans with TBIs, providers on both the behavioral health and primary care/specialist sides of care should both be aware of the impact of the other in order to connect and provide the best possible and most appropriate care for the veteran.

Other specific physical health considerations for the treatment of behavioral health diagnoses across veteran populations are explored in other sections of the report. This includes:

1. reproductive health concerns and family stress associated with motherhood in women veteran populations;²⁵
2. the impact of PTSD on aging and memory in older veterans;²⁶
3. the symptoms of Gulf War Syndrome or Gulf War Illness (GWI) and its impact on veteran physical and mental health;^{27,28}
4. connections between reports of pain across veteran populations, the prescription of pain medication, and pain reliever addictions;²⁹ and
5. the connection between chronic illness and/or chronic pain and suicidality.³⁰

Physical and mental health are connected, and the presence of mental illness or substance use disorders can often be linked to poorer physical health outcomes.³¹ Poor health or ongoing health problems can also become a stressor for individuals, leading to increased symptoms of mental illness or substance use.^{27,28,31} Best practices for overall behavioral health care would include overlap between behavioral health, specialty care, and primary care where early identification of mental illness and/or substance use disorders can happen early, and seamless treatment can follow.

INVISIBLE WOUNDS OF SERVICE

Within treatment of physical and behavioral health for veterans comes the need for providers to be aware of the frequency of invisible wounds of service, including traumatic brain injury (TBI) and moral injury. Both TBI and moral injury are often precipitating or overlapping factors of mental health diagnoses and/or SUD.³²

TBI occurs when an external force injures the head.¹⁹ TBIs can injure any or all parts of the brain and can cause changes in a person's physical, behavioral, and/or cognitive health.¹⁸ Some behavioral changes that can occur with TBI include,

- Depression;
- Anxiety;
- Impulsivity/risk taking;
- Social inappropriateness;
- Isolation/inability to get along with others;
- Irritability or frustration;
- Increased self-focus; and
- Grief due to before/after contrasts.

Individuals with TBI are more likely than those who are not to experience diagnosis of mental illness or distressing symptoms such as anxiety, depression, attention-deficit issues, and anger

in addition to limited problem solving and increased impulsive behaviors. One of three veterans experience a mental health diagnosis after TBI.¹⁸ Of these, one-half are diagnosed with SUD—either alcohol or illicit drug use--and one-third have suicidal ideation while just shy of one-fifth attempt suicide.¹⁸ TBI is common among veterans, even veterans who are not engaged in combat.¹⁸

TBI is an *invisible wound* of military service, affecting up to one-fifth of OEF and OIF veterans. Though TBI is a large-scale issue, according to SAMHSA,¹⁸ there are procedural solutions for ensuring that TBI is addressed across veteran populations:

1. Train all professionals on TBI and the frequency of TBI across veteran populations;
2. Screen for TBI when symptoms indicate possible TBI and/or when veteran status is confirmed;
3. If TBI is confirmed, screen for TBI-related impairments;
4. Adjust treatment and supports to address TBI-related impairments; and
5. Refer the veteran to appropriate community supports for TBI-related issues.

Treating a TBI may first be assumed to be a medical issue versus a behavioral health issue; however, research shows that TBIs typically produce behavioral health concerns, symptoms, and/or distress following the injury. Through veteran-centered care, both the medical and behavioral health concerns associated with TBI can be addressed in tandem with one another, through integrated care—an EBP healthcare model.

TBI is not the only invisible wound for veterans. An additional wound that impacts many military service members is moral injury. Moral injury is hurt or harm that occurs mentally following a transgression that contradicts a personal or deeply held belief. Moral injury can be the result of one's own actions or an act of perceived betrayal conducted by a position of power. Though as many as one-in-two military service members report engaging in or witnessing an decision of a position of power that they believed to be morally wrong, approximately 10% of these screen positively for moral injury as *moral injury* is a cycle of shame, guilt, and loss that impacts the functionality of a veteran regularly.¹⁸

Traumatic brain injury and moral injury are two common invisible wounds of active duty that directly impact behavioral health diagnoses and treatment.

Moral injury can be assessed using the Moral Injury and Distress Scale (MIDS).¹⁸ Though Moral injury is frequently cooccurring with other event-related diagnoses, such as PTSD, providers for veterans who score within range for moral injury on MIDS should approach treatment differently than those who treat veterans with solely PTSD. Where PTSD responds best to treatment modalities such as prolonged exposure, moral injury requires more than exposure

to be successfully navigated through. Instead, veterans with indicated moral injury should be walked through one of the following, or a hybrid of these therapeutic modalities:¹⁸

1. Adaptive Disclosure
 - a. 12 sessions, individual
2. Impact of Killing
 - a. 10 sessions, individual
3. Trauma Informed Guilt Reduction (TrIGR) therapy
 - a. 4-7 sessions, individual
4. Building Spiritual Strength
 - a. 8 sessions, group
5. ACT-MI
 - a. 12 sessions, group
6. Moral Injury Group (MIG)
 - a. 12- week group + community involvement

Much like TBI, moral injury is best treated when it is considered as part of the whole picture of the veteran versus being treated in a silo. This means that with veterans where moral injury is indicated, there is a need for not only integrated care, but also community integration and involvement.

BIBLIOGRAPHY

Additional Considerations

- ¹ RAND Health Care. (2025). *Veterans' barriers to care*. Navigating mental health care for veterans. <https://www.rand.org/health-care/projects/navigating-mental-health-care-for-veterans/barriers-to-care.html>
- ² Perla, L. Y., Beck, L. B., Grunberg, N. E. (2023). Assessment of Veterans Affairs Case Management Leadership. *Professional Case Management*, 28(3). Doi: 10.1097/NCM.0000000000000615.
- ³ Mercier, J. M., Hosseiny, F., Rodrigues, S., Friio, A., Brémault-Phillips, S., Shields, D. M., & Dupuis, G. (2023). Peer Support Activities for Veterans, Serving Members, and Their Families: Results of a Scoping Review. *International journal of environmental research and public health*, 20(4), 3628. <https://doi.org/10.3390/ijerph20043628>
- ⁴ U.S. Department of Veterans Affairs. (2024). *Patient care services*. Care Management and Social Work. <https://www.patientcare.va.gov/caremanagement.asp#:~:text=Severely%20ill%20and/or%20injured,reintegration%20back%20into%20the%20community.>
- ⁵ U.S. Department of Veterans Affairs. (2024b). *VHA Social Work*. Care Management and Social Work. <https://www.patientcare.va.gov/caremanagement.asp>
- ⁶ U.S. Department of Veterans Affairs. (2024c). *Post-9/11 Transition and Case Management*. Post-9/11. <https://www.va.gov/POST911VETERANS/index.asp>
- ⁷ Mercier, J. M., Hosseiny, F., Rodrigues, S., Friio, A., Brémault-Phillips, S., Shields, D. M., & Dupuis, G. (2023). Peer Support Activities for Veterans, Serving Members, and Their Families: Results of a Scoping Review. *International journal of environmental research and public health*, 20(4), 3628. <https://doi.org/10.3390/ijerph20043628>
- ⁸ Chinman, M., Salzer, M., & O'Brien-Mazza, D. (2012). National survey on implementation of peer specialists in the VA: implications for training and facilitation. *Psychiatric rehabilitation journal*, 35(6), 470–473. <https://doi.org/10.1037/h0094582>
- ⁹ Derefinko, K.J., Hallsell, T.A., Isaacs, M.B. *et al.* Perceived Needs of Veterans Transitioning from the Military to Civilian Life. *J Behav Health Serv Res* 46, 384–398 (2019). <https://doi.org/10.1007/s11414-018-9633-8>
- ¹⁰ Albright, D. L., McCormick, W. H., Carroll, T. D., Currier, J. M., Thomas, K. H., Hamner, K., Slagel, B. A., Womack, B., Sims, B. M., & Deiss, J. (2018). Barriers and resources for veterans' post-military transitioning in south Alabama: A qualitative analysis. *Traumatology*, 24(3), 236–245. <https://doi.org/10.1037/trm0000147>
- ¹¹ McCormick, W. H., Currier, J. M., Isaak, S. L., Sims, B. M., Slagel, B. A., Carroll, T. D., Hamner, K., and Albright, D. L. (2019). Military Culture and Post-Military Transitioning Among Veterans: A qualitative analysis. *Journal of Veteran Studies*, 4(2).
- ¹² Shue, S., Matthias, M. S., Watson, D. P., Miller, K. K., & Munk, N. (2021). The career transition experiences of military Veterans: A qualitative study. *Military Psychology*, 33(6), 359–371. <https://doi.org/10.1080/08995605.2021.1962175>
- ¹³ Mobbs, M. C., & Bonanno, G. A., (2018). Beyond War and PTSD: The crucial role of transition stress in the lives of military veterans. *Clinical Psychology Review*, 59(February 2018), p. 137-144. <https://doi.org/10.1016/j.cpr.2017.11.007>
- ¹⁴ Morin, R. (2023). The Difficult Transition from Military to Civilian Life. *Pew Social & Demographic Trends*. <https://www.pewresearch.org/wp-content/uploads/sites/20/2011/12/The-Difficult-Transition-from-Military-to-Civilian-Life.pdf>.
- ¹⁵ Gubkin, R. (2016). An Exploration of Spirituality and the Traumatizing Experiences of Combat. *Journal of Humanistic Psychology*, 56(4), p. 311-330. <https://journals.sagepub.com/doi/pdf/10.1177/0022167814563142>
- ¹⁶ Albright, D. L., Hamner, K., and Currier, J. (2017). Southwest Alabama Veterans Needs Assessment. *Community Foundation of South Alabama*.

-
- ¹⁷ Laha-Walsh, K., and Albright, D. L. (2022). The Greater Birmingham Area Veterans Needs Assessment. *Office for Military Families and Veterans*.
- ¹⁸ Shepherd, S., Sherman, D. K., MacLean, A., & Kay, A. C. (2021). The Challenges of Military Veterans in Their Transition to the Workplace: A Call for Integrating Basic and Applied Psychological Science. *Perspectives on Psychological Science*, 16(3), 590-613. <https://doi.org/10.1177/1745691620953096>
- ¹⁹ U.S. Department of Veterans Affairs. (2018). VA Office of Mental Health and Suicide Prevention Guidebook. <https://www.mentalhealth.va.gov/docs/VA-Office-of-Mental-Health-and-Suicide-Prevention-Guidebook- June-2018-FINAL-508.pdf>
- ²⁰ U.S. Department of Veterans Affairs. (2021a). Trauma-informed care fact sheet. <https://www.va.gov/homeless/nchav/docs/Trauma-Informed-Care-Fact-Sheet.pdf>
- ²¹ Mohatt, Beehler, & Thompson. (2019). The Military Family Readiness System: Present and future. In *Strengthening the Military Family Readiness System for a Changing American Society* (pp. 233-272). essay, The National Academies of Sciences, Engineering, and Medicine.
- ²² U.S. Department of Veterans Affairs. (2024). *TBI Effects*. TBI Symptoms, Effects & Veteran Support. <https://www.mentalhealth.va.gov/tbi/index.asp>
- ²³ Greer, N., Sayer, N. A., Spooont, M., Taylor, B. C., Ackland, P. E., MacDonald, R., McKenzie, L., Rosebush, C., & Wilt, T. J. (2020). Prevalence and Severity of Psychiatric Disorders and Suicidal Behavior in Service Members and Veterans With and Without Traumatic Brain Injury: Systematic Review. *The Journal of head trauma rehabilitation*, 35(1), 1-13. <https://doi.org/10.1097/HTR.0000000000000478>
- ²⁴ U.S. Department of Veterans Affairs and U.S. Department of Defense. (2023a). *VA/DoD Clinical Practice Guidelines: Management and rehabilitation of post-acute mild traumatic brain injury*. <https://www.healthquality.va.gov/guidelines/Rehab/mtbi/VADODmTBICPGProviderSummaryFinal 508.pdf>.
- ²⁵ U.S. Department of Veterans Affairs. (2024). Women Veterans. VA Research. https://www.research.va.gov/topics/womens_health.cfm
- ²⁶ Palmer, B. W., Friend, S., Huege, S., Mulvaney, M., Badawood, A., Almaghraby, A., & Lohr, J. B. (2019). Aging and Trauma: Post traumatic stress disorder among Korean War Veterans. *Federal Practitioner: For the Health Care Professionals of the VA, DoD, and PHS*, 36(12), 554-562.
- ²⁷ U.S. Department of Veterans Affairs. (2024). *Gulf War Veterans*. VA Research. <https://www.research.va.gov/topics/GulfWarVeterans.cfm>
- ²⁸ Chao, L. L., Kanady, J. C., Crocker, N., Straus, L. D., Hlavin, J., Metzler, T. J., Maguen, S., & Neylan, T. C. (2021). Cognitive Behavioral Therapy for Insomnia in Veterans with Gulf War Illness: Results from a randomized controlled trial. *Life Sciences*, 279, 1-10. <https://doi.org/10.1016/j.lfs.2021.119147>
- ²⁹ U.S. Department of Health and Human Services National Institutes of Health. (2024). *General risk of substance use disorders*. Substance Use and Military Life DrugFacts. <https://nida.nih.gov/publications/drugfacts/substance-use-military-life>
- ³⁰ Smith, N. B., Mota, N., Tsai, J., Monteith, L., Harpaz-Rotem, I., Southwick, S. M., Pietrzak, R.H. (2016). Nature and Determinants of Suicidal Ideation Among U.S. Veterans: Results from the national health and resilience in veterans study. *Journal of Affective Disorders*, 197(June 2016). Pp. 66-73. <https://doi.org/10.1016/j.jad.2016.02.069>.
- ³¹ U.S. Department of Veterans Affairs. (2024). PTSD and Physical Health. *PTSD: National Center for PTSD*. https://www.ptsd.va.gov/professional/treat/cooccurring/ptsd_physical_health.asp#two
- ³² McCaslin-Rodrigo, S., Crowley, M., & Maguen, S. (2024). Invisible Wounds of Service: PTSD, TBI, and Moral Injury. *SAMHSA*. Webinar.