ALABAMA

2024-2025

Veterans Mental Health Steering Committee Comprehensive Report

Created by:

The *VMHSC Comprehensive Plan* was created by the Alabama Veterans Mental Health Steering Committee:

ADMH Commissioner Kimberly G. Boswell, Chair
Major General (Ret.) Paulette Risher, Vice Chair

Doryan Carlton
Jess Skaggs
Representative Ed Oliver
Senator Keith Kelley
Representative Neil Rafferty
Senator Bobby Singleton
Representative Chip Brown
Senator Andrew Jones
Helena Young, LICSW-S, CADAC

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The *Alabama Veteran Behavioral Health Landscape* and *Alabama Veteran Behavioral Health Literature Review* reports were compiled by VitAL. VitAL thanks the following individuals who created, drafted, and reviewed components in both reports:

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TABLE OF CONTENTS

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TABLE OF CONTENTS

VETERANS MENTAL HEALTH STEERING COMMITTEE

CHAIR AND VICE CHAIR APPOINTMENTS

Chair, ADMH Commissioner Kimberly G. Boswell

Vice Chair, ADVA Commissioner's Designee, Major General (Ret.) Paulette Risher

EXECUTIVE AND LEGISLATIVE APPOINTMENTS

Governor's Designee, Doryan Carlton, *State Budget Officer, Executive Budget Office*

Lt. Governor's Designee, Jess Skaggs, *Chief of Staff, Lt. Governor's Office*

Speaker's Designee, Representative Ed Oliver

Senate Pro Tern Designee, Senator Keith Kelley

Minority Leader of the House Designee, Representative Neil Rafferty

Minority Leader of the Senate Designee, Senator Bobby Singleton

House Sponsor of Act 2024-358, Representative Chip Brown

Senate Sponsor of Act 2024-358, Senator Andrew Jones

AGENCY HEAD APPOINTMENTS

Alabama National Guard, Helena Young, *Director of Psychological Health ALARNG*

ADRS Commissioner's Designee, April Turner, *State Head Injury Coordinator*

ADMH APPOINTMENTS

Jeremy Blair, CEO of Wellstone

Chris Greenleaf, *Veteran and Clinician at East Alabama Mental Health Center*

Chris Retan, *Executive Director of Aletheia House*

ADVA APPOINTMENTS

Dr. John Duffey, *Founder of the Alabama Institute of Behavioral Health*

Jeffrey Newton, *Commissioner, Alabama Department of Veterans Affairs*

Master Sergeant USMC (Ret.) Jason Smith, *Resilience, Risk Reduction, and Suicide Prevention Coordinator for the Alabama National Guard*

EX-OFFICIO, NON-VOTING MEMBERS

Nicole Walden, *ADMH Associate Commissioner of Mental Health & Substance Use Services*

Sissy Louise Moore, *ADVA Veterans Well-Being Program Manager*

LETTER TO THE GOVERNOR

The Honorable Kay Ivey
Governor of Alabama
State Capitol, 600 Dexter Avenue
Montgomery, AL 36130

June 30, 2025

Dear Governor Ivey,

As Chair of the Veterans Mental Health Steering Committee, it is my pleasure to present the Veterans Mental Health Steering Committee Comprehensive Plan. The purpose of the plan is to maximize new and existing opportunities for veterans' access to behavioral health care.

Veterans' mental health is a critical issue that requires comprehensive attention and support Alabama has one of the highest rates of veteran suicide. The mental health challenges faced by veterans can include post-traumatic stress disorder (PTSD), depression, anxiety, and substance use disorders. These conditions can significantly impact quality of life, relationships, and reintegration into civilian life.

The committee has met five times. The first meeting was held on August 29, 2024, with the last on March 26, 2025. During these meetings, committee members heard from experts in behavioral health care, individuals with lived experience, and reviewed documents. Presentations addressed the unique behavioral health needs of Alabama veterans as defined in Act 2024-358.

As a result of the meetings, the committee identified four main goals to help craft the recommendations for the Comprehensive Plan. Those goals are:

- Improve Lethal Means Safety
- Enhance Crisis Care, Behavioral Health Care, and Care Transitions
- Increase Access to and Delivery of Effective Care
- Address Upstream Risk and Protective Factors

During the April 25, 2025 meeting, the Committee favorably supported the following recommendations:

- Establish the Alabama Veterans Resource Center (Act 2025-20) and support the $5M appropriation in the Education Trust Fund Supplemental to establish the Center.
- Support the $2.5M in the Education Trust Fund appropriation to expand Traumatic Brain Injury Programs in Alabama.
- Implement the Storing Ammunition and Firearms to Enhance Resilience (S.A.F.E.R.) Together Program in Alabama through Act 2025-93.

- Develop a partnership agreement with ADMH and ADVA to address the collaborative efforts required to implement the plan.
- Organize a Veterans Mental Health Summit to educate providers, veterans, and their families.
- Evaluate best practices using data from pilot programs to determine which programs should be replicated statewide.

Several recommendations were addressed during the 2025 legislative session:

- Act 2025-20 established the Veterans Resource Center.
- Traumatic Brain Injury services were expanded through an increase in the Education Trust Fund appropriation for the Alabama Department of Rehabilitation Services.
- Act 2025-93 established the S.A.F.E.R. Together Program to improve lethal means safety

The State of Alabama is making a significant financial investment of $12 million to enhance services and opportunities for veterans. Included in this investment is the $5 million Alabama Veterans Resource Center, $2.5 million to expand the Traumatic Brain Injury Program, $3 million for veteran pilot programs, and $1.5 for continuation funding of the successful pilot programs. Through these notable investments, Alabama is demonstrating its commitment to improving the well-being of those who have served.

The Alabama Veterans Mental Health Steering Committee believes that the enactment of these initiatives and recommendations will address the purpose for which it was established—to maximize new and existing opportunities for veterans' access to behavioral health care—no matter where they need it, when they need it, or whether they are enrolled in VA care.

The Alabama Veterans Mental Health Steering Committee remains committed to ongoing efforts to ensure that veterans receive the mental health care and support they need to lead fulfilling lives after their service.

Sincerely,

Kimberly G. Boswell, Chair
Veterans Mental Health Steering Committee

OVERVIEW

The Veterans Mental Health Steering Committee (VMHSC) was established through Act 2024-358 within the Alabama Department of Mental Health. As authorized in the Act, the Committee is charged with developing a comprehensive plan to address the unique behavioral health needs of Alabama veterans. To create the comprehensive plan, the VMHSC must conduct a review of:

- The current state of Alabama veterans' mental health and rates of substance use.
- Current mental health, substance use, recovery and other support services in Alabama.
- Needs assessments previously conducted for the purpose of identifying gaps in services.

Below is a brief summary of the Act, which outlines the Committee's purpose, timeline, and pilot project parameters.

Act 2024-358 authorized the following:

ESTABLISHING THE VETERANS MENTAL HEALTH STEERING COMMITTEE (VMHSC) AND ITS PURPOSE.

- The VMHSC is made up of 20 members, including 18 voting and 2 ex-officio, non voting members.
- The VMHSC is to conduct a review of the following:
  - *The current state of Alabama veterans' mental health and rates of substance use.*
  - *Current mental health, substance use, recovery, and other support services in Alabama.*
  - *Needs assessments previously conducted for the purpose of identifying gaps in services and support.*
- In response to the review, the VMHSC is charged with developing a comprehensive plan to address the unique behavioral health needs of Alabama veterans.
- ADMH shall align the comprehensive plan with state and national behavioral health standards, and implement it upon the Legislature's review/feedback, and Governor's approval.

PROVIDING A TIMELINE FOR THE VMHSC'S DEVELOPMENT OF A COMPREHENSIVE PLAN.

- June 1, 2024: The Act goes into effect.
- July 1, 2024: Deadline for VMHSC appointments.
- September 1, 2024: Deadline for the first meeting of the VMHSC.
- January 1, 2025: Deadline for the VMHSC's full review.
- April 1, 2025: Deadline for a comprehensive plan to be presented to the House and Senate Veterans and Military Affairs Committees
- June 30, 2025: Deadline for ADMH to submit Comprehensive Plan to the Governor.

- August 31, 2025: The Governor shall act on the Comprehensive Plan no later than this date.
- Continued Meetings: Upon the Governor's approval, ADMH will implement the Comprehensive Plan, and ADMH will update the VMHSC on its progress.

CREATING OPPORTUNITY FOR PILOT PROJECTS WITH NEWLY APPROPRIATED DOLLARS

- ADMH may establish pilot projects utilizing evidence-based services certified by ADMH or organizations which agree to become certified by ADMH.
- Pilot projects will be awarded funding by ADMH through a fair and transparent Request for Proposal (RFP) process.
- Pilot projects may begin upon the appropriation of funds and certification of projects
- Note: through Act 2024-426, ADMH received $3 million in Opioid Settlement Funds for this purpose.

BACKGROUND

To inform the comprehensive plan, leverage resources, and identify gaps in care, the committee conducted an extensive review. This included presentations to the committee as well as written documents that were overviewed as part of the committee's work.

The committee's review period began at its first meeting, August 29, 2024, continued at its second meeting, October 23, 2024, and concluded at its third meeting, December 18, 2024. During these meetings, committee members heard from experts in behavioral healthcare and veterans' services, as well as individuals with lived experience. Below is an overview of presentations related to the committee's review and their findings:

REVIEW OF FEDERAL VETERANS BEHAVIORAL HEALTH POLICY LANDSCAPE

Presented by Jake Proctor, Alabama Military Stability Foundation

- Congress has taken several actions over the last decade to expand and invest in non-VA healthcare, including the passage of the Mission Act and Compact Act.
- The Mission Act was passed in 2018 to increase veterans' access to community-based healthcare and cover certain non-VA healthcare services through the Veteran Community Care Program. It was noted that Region 3 (which includes Alabama) is behind other regions in enrolled community care options, and it was recommended that providers be identified and enrolled in the network.
- The Compact Act was passed in 2020 and went into effect in 2023. The act provides mental health care at no cost to veterans experiencing acute suicidal crisis, regardless of whether they are enrolled in VA healthcare. Thanks to the Compact Act, the VA covers 30 days of inpatient care or 90 days of outpatient care at VA or non-VA providers.

OVERVIEW OF ALABAMA VETERANS DEMOGRAPHICS

Presented by Major General (Ret.) Paulette Risher, Vice Chair

- Approximately 7.7 percent of Alabama's population are veterans, which is higher than the national average of 6.2 percent. Further, 91 percent of Alabama veterans are male, and 38 percent are over the age of 65.
- Veterans in Alabama have better employment outcomes than non-veterans, with veterans having slightly lower rates of unemployment than individuals not in the labor force compared to non-veterans.
- Alabama veterans make their homes across the state. While the majority live in Madison (34,224), Jefferson (34,009), Mobile (26,290), and Baldwin (20,740) counties, over 36% live in less populated, and in many cases, highly rural counties of the state.

ALABAMA CRISIS SERVICES

Presented by Commissioner Kimberly Boswell, Alabama Department of Mental Health

- Due to proration, mental health services received a $43 million cut from the General Fund in 2010. Thanks to Governor Ivey and the Alabama Legislature's significant investments in behavioral healthcare, the department's appropriations reached pre-proration funding levels in 2022. Further, from 2018 to 2024, ADMH received a 95 percent increase in the General Fund Budget. Fifty percent of the total increase from fiscal year 2018 to fiscal year 2024 funded crisis services.
- Alabama's Crisis System of Care consists of three service components: someone to call (988), someone to come to you (Mobile Crisis Teams), and somewhere to go (Crisis Centers). These services are relatively new to Alabama, as the first investment in Crisis Centers occurred in 2021, and 988 launched in 2022.
- From July 2022 to July 2024, Alabama 988 call centers received 99,943 contacts. From October 2022 to July 2024, Mobile Crisis Teams served 6,462 adults. From May 2021 to July 2024, 12,948 people were evaluated at Alabama Crisis Centers, with 9,482 avoiding the ER and 2,185 avoiding jail.

S.A.F.E.R. TOGETHER & VETERANS SUICIDE PREVENTION INITIATIVES

Presented by Master Sergeant USMC (Ret.) Jason Smith, Alabama National Guard

- S.A.F.E.R. Together is a voluntary, confidential, and temporary firearm ammunition storage option for veterans, military members, and first responders. It allows for individuals to go to a participating gun store and voluntarily store their weapons in a safe place, no questions asked. S.A.F.E.R. Together is also designed to change cultural beliefs about seeking mental health support and utilizing lethal means safety as a prevention strategy.
- The Alabama National Guard is leading a legislative effort to pass a hold harmless bill for participating gun stores. The draft bill would give gun stores civil immunity for safely storing participants' weapons while they seek mental health assistance.
- Significant research shows that when we create time and space between a person in crisis and access to lethal means through initiatives like this, we save lives.

REDUCING MILITARY AND VETERAN SUICIDE: ADVANCING A COMPREHENSIVE, CROSS-SECTOR, EVIDENCE-INFORMED PUBLIC HEALTH STRATEGY

Report by the White House, Presented by Commissioner Kimberly Boswell, Alabama Department of Mental Health

- The White House's report, *Reducing Military and Veteran Suicide,* states five goals: improve lethal means safety, enhance crisis care and facilitating care transitions, increase access to and delivery of effective care, address upstream risk and protective factors and increase research coordination, data sharing, and evaluation efforts.
- This report provides a framework for the committee to develop its Comprehensive Plan.

REVIEW OF EXISTING ALABAMA VETERANS NEEDS ASSESSMENTS

Presented by Major General (Ret.) Paulette Risher, Vice Chair

- After several calls to veterans groups and researchers to provide existing needs assessments for Alabama veterans, three needs assessments were identified and reviewed with the Veterans Mental Health Steering Committee: Southwest Alabama Veterans Needs Assessment (2017), Greater Birmingham Area Needs Assessment (2022), and Communities Serve: A Systematic Review of Needs Assessments on U.S. Veteran and Military-Connected Populations (2019).
- Recommendations from the needs assessments included improving transition support, employment services, mental health care, outreach for minority veterans, and educational support. Further, the need to reduce mental health stigma and barriers to VA access were noted.
- A statewide needs assessment or report specifically about the behavioral health of Alabama veterans did not exist.

UPSTREAM RISK AND PROTECTIVE FACTORS OVERVIEW

Presented by Beverly Johnson, Alabama Department of Mental Health

- Protective factors refer to characteristics, conditions, or behaviors that help mitigate the risk of negative outcomes and enhance an individual's ability to cope with challenges. They play a crucial role in promoting mental health and well-being and buffering individuals from potential adverse effects in their environment.
- Risk factors are conditions, characteristics, or behaviors that increase the probability of experiencing negative outcomes or adverse events. They play a significant role in the development of mental health disorders, highlighting the importance of identifying and addressing these factors for preventive strategies.
- Risk and protective factors can occur at the individual, relationship, and community levels. Examples of individual-level protective factors include job security, financial security, and healthy childhood experiences, while examples of individual level risk factors include financial insecurity, history of mental illness, or criminal justice issues. Relationship-level protective factors include positive connections to family and friends, versus relationship-level risk factors such as family conflicts, violence, or social isolation. Finally, community-level protective factors include access to mental and physical health services as well as quality education, and community-level risk factors include limited access to said services and limited education and financial opportunities.

ALABAMA'S TRAUMATIC BRAIN INJURY SERVICES & NEEDS

Presented by April Turner, Alabama Department of Rehabilitation Services

- The Department of Defense defines Traumatic Brain Injury (TBI) as "a brain injury caused by an external force that results in a structural injury or physiological disruption of brain function." An estimated 102,000 Alabamians have a TBI, and more than 8,000 Alabamians acquired a TBI between 2023 and 2024.
- Significant research has been published about the effects of TBI. The VA confirms that veterans with TBI face high risks for mental health challenges, including PTSD, anxiety, depression, and substance use. About 35 percent of veterans with combat-related TBI meet criteria for PTSD. Almost half of adults with TBI who have no pre-injury history of mental health problems develop mental health problems after TBI. TBI increases risk of alcohol use by 31.9% and doubles the risk of substance use disorders by 100% in post-deployment U.S. Army soldiers (Brenner, et. al, 2023). Individuals with TBI are highly sensitive to some mental health medications, making TBI screenings during assessments critical.
- The Alabama Department of Rehabilitation Services (ADRS) has a nationally recognized TBI program. Currently, ADRS can serve individuals whose injury occurred within the last two years. It is recommended that this program be expanded, so that individuals and veterans can be served regardless of the date of injury.

ALABAMA BEHAVIORAL HEALTH LANDSCAPE

Presented by Dr. David Albright, and extended review presented by Dr. Paige Parish, LICSW, of VitAL with the University of Alabama

- In partnership with the Veterans Mental Health Steering Committee, the Alabama Department of Mental Health and VitAL with the University of Alabama developed the state's first report of its kind: The 2024 Alabama Veteran Behavioral Health Landscape. The purpose of this report is to provide a comprehensive baseline of veterans' mental health and substance use rates, identify existing services and gaps, and support the Veterans Mental Health Steering Committee in making data-driven recommendations to the Comprehensive Plan.
- An in-depth prevalence analysis was provided to the Committee and in the report. Alabama veterans demonstrated higher prevalence than nonveterans in the following categories: Serious Mental Illness (SMI) (3.5 percent of veterans, 3.2 percent of nonveterans) and co-occurring SMI and substance use disorder (SUD) (.8 percent of veterans, .4 percent nonveterans). While the national prevalence for opioid misuse is 3.1 percent for veterans and 3.5 percent for nonveterans, in Alabama the prevalence rates are 33.7 percent for veterans and 29.7 percent for nonveterans.
- When looking at service availability, 66% of counties exceeded the average number of state- and federally-funded mental health and substance use services, while 48% of counties exceeded the average number of state- or federally-funded veteran services. These statistics were based on the population of the county compared to the average population of county in the state.

TEDX: HOW TO SUCCESSFULLY TRANSITION FROM MILITARY TO CIVILIAN LIFE

TED Talk presentation by Sergeant (Ret.) Brian O'Connor

- After serving in the United States Marine Corps, retired Sergeant Brian O'Connor found it difficult to transition from military to civilian life. Unfortunately, more than two-third of veterans report this difficulty. Further, one of Sergeant O'Connor's colleagues who left the Marines and joined the corporate world was found dead in his apartment due to a drug overdose. This event inspired Sergeant O'Connor to help fellow veterans transition, as well as help companies assist in this transition.
- Eventually, Sergeant O'Connor became a leader of a tech company that employs former service members and helps them successfully transition to civilian life both personally and professionally. He cites the importance of using a strength-based model and focusing on three key elements: identity, purpose, and belonging.
- Sergeant O'Connor walks through several exercises to help veterans find a sense of identity, discover their purpose, and foster a sense of belonging. He stated that when we do these things, "we can transition from being in the service to being of service."

INVESTING IN ALABAMA'S HEROES: VETERANS WORKFORCE NEEDS & RESOURCE CENTER CONCEPT

Presented by R.B. Walker, Alabama Power Company

- Veterans face unique challenges transitioning from military to civilian life: accessing benefits, finding fulfilling careers, and addressing mental health needs.
- Alabama Power is committed to supporting veterans through a public-private partnership and establishing a center to help welcome and transition veterans into civilian life.
- To address upstream risk and protective factors, the center would take a jobs-first approach and help veterans find fulfilling careers. Services such as workforce assistance, education assistance, peer connections, and mental health and wellness.

REVIEW OF ALCOHOL USE DISORDER AND FEDERAL REPORTS

Presented by Associate Commissioner Nicole Walden, Alabama Department of Mental Health

- The U.S. Surgeon General published an advisory on the use of alcohol and its associated cancer risk. The direct link between alcohol consumption and cancer risk is well established in seven types of cancer including cancers of the breast, colorectum, esophagus, liver, mouth, throat, and voice box.
- Pew Charitable Trust reported that alcohol is the leading driver of substance use related fatalities in America, and nearly 30 million people are estimated to have alcohol use disorder (AUD).
- In Alabama, 9.4 percent of veterans show rates of alcohol misuse, compared to nonveterans at 8.3 percent. This is higher than the national averages, which are 6.5 percent for veterans and 5.3 percent for nonveterans.

WRITTEN DOCUMENTS PUBLISHED FOR THE COMMITTEE'S WORK

Published by the Alabama Department of Mental Health and VitAL with the University of Alabama

As noted above, a statewide needs assessment of the behavioral health needs and resources for Alabama veterans did not yet exist. Thus, the Alabama Department of Mental Health and VitAL with the University of Alabama published two documents that are the first of their kind in Alabama:

- 2024 Alabama Veteran Behavioral Health Landscape
- 2025 Alabama Veteran Behavioral Health Literature Review
    - Best Practices: Service Implementation Overview

The VMHSC carefully studied these documents over the course of two meetings, and the documents were used in the development of the Request for Proposal (RFP) for veterans' behavioral health pilot programs. Thanks to the work of the Committee and the researchers at VitAL, the reports will now be a resource to state agencies, lawmakers, community organizations, nonprofits, and other partners to inform them on the current Alabama veteran landscape. Further, the VMHSC and others can recommend data-driven policies and programs for the unique needs of veterans in each catchment area. These documents can be found in the appendix.

After an extensive review of the current state of veterans' behavioral health, the following section lists the *Comprehensive Plan's* goals and strategies.

GOALS & STRATEGIES

While Act 2024-358 does not speak specifically to veteran suicide, Alabama has one of the highest rates of suicide in the nation. Consequently, the publication Reducing Military and Veteran Suicide: Advancing a Cross-Sector, Evidence-Informed Public Health Strategy was used as a framework for the development of the plan's goals and strategies.

The following section reviews the VMHSC purpose, goals and strategies.

PURPOSE: To maximize new and existing opportunities for veterans' access to behavioral health care, defined as the prevention, diagnosis, and treatment of mental health conditions, substance use disorders, and behavioral health crisis—no matter where they need it, when they need it, or whether they are enrolled in VA care.

GOAL 1: Improve Lethal Means Safety - Implement interventions that aim to address lethal means safety training, safe storage options, or safety planning care

STRATEGIES:

1. Pass and implement safe storage legislation
2. Promote VA Safety Planning Checklist for all providers
3. Support other legislative efforts to address gun safety
4. Promote access to naloxone to prevent lethal overdose

GOAL 2: Enhance Crisis Care, Behavioral Health Care, and Care Transitions - Enhance crisis and behavioral health care services that are effective and paired with improved facilitation of follow-up care and continued treatment

STRATEGIES:

1. Increase awareness of 988 and the Alabama Crisis System of Care
2. Educate veterans and their family members and providers about COMPACT Act benefits: 30 days of inpatient and 90 days of out-patient care
3. Promote state certified integrated care models for improved treatment and follow up care
4. Strengthen partnerships between ADMH, ADVA, and community providers

GOAL 3: Increase Access to and Delivery of Effective Care - Coordinate efforts designed to increase capacity, ease access to, and improve the delivery of evidence-based behavioral healthcare

STRATEGIES:

1. Research and implement evidence-based peer support models, so veterans can be helped by fellow veterans
2. Increase the number of veteran peers to receive care, assist with care, and to coordinate safety planning
3. Identify and enroll mental health providers in the Non-VA Community Care Network, as established in the MISSION Act's Veteran Community Care Program
4. Address traumatic brain injury (TBI) by increasing access to screening and connection to the state's TBI resources and supports
5. Train all providers in military culture and trauma-informed care
6. Increase awareness of telehealth in rural areas
7. Increase access to medication assisted treatment (MAT) to address the high prevalence of opioid misuse

GOAL 4: Address Upstream Risk & Protective Factors - Implement programs and practices that reduce risk factors and strengthen protective factors

STRATEGIES:

1. Research and implement evidence-based prevention models for veterans and their families
2. Support veterans' successful transition from military to civilian life by prioritizing rapid workforce reintegration for veterans through a jobs-first strategy
3. Improve awareness of Alabama GI Dependent Scholarship Program through the Alabama Department of Veteran Affairs
4. Improve county veteran service officer awareness of mental health resources to veterans

RECOMMENDATIONS

Recommendations of the VMHSC are comprised of the six items below:

1. ESTABLISH THE ALABAMA VETERANS RESOURCES CENTER (AVRC)

Act 2025-20 (Appendix A) creates and designates a public-private partnership to establish a one-stop center that prioritizes rapid workforce reintegration for Alabama veterans and their families through a jobs-first strategy. This will be achieved by leveraging partnerships with employers and educational institutions to offer career counseling, skills training, and job placement services. The AVRC's primary focus is to lower veteran unemployment rates and facilitate their successful transition into fulfilling civilian careers. In addition, the AVRC will integrate health and behavioral health care access and support veteran to veteran connections. The AVRC addresses upstream risk and protective factors by:

- Supporting veterans' successful transition from military to civilian life by prioritizing rapid workforce reintegration for veterans through a jobs-first strategy
- Support the $5M appropriation for the Alabama Veterans Resource Center in the Education Trust Fund - Supplemental (HB 170)

2. EXPAND TRAUMATIC BRAIN INJURY (TBI) PROGRAMS IN ALABAMA

There is a gap in TBI care for veterans in Alabama that could be addressed by expanding the state's current TBI Navigators and TBI Care Coordinators programs within the Alabama Department of Rehabilitation Services. Specifically, these programs could be expanded to include veterans regardless of the date of their injury. To increase access and delivery of effective care, we are:

- Addressing traumatic brain injury (TBI) by removing the two-year time frame from the eligibility requirements
- Supporting the $2.5M appropriation to Expand Traumatic Brain Injury Programs in Alabama in the Education Trust Fund (SB 113)

3. IMPLEMENT THE STORING AMMUNITION AND FIREARMS TO ENHANCE RESILIENCE (S.A.F.E.R.) TOGETHER PROGRAM IN ALABAMA

S.A.F.E.R. Together stands for Storing Ammunition & Firearms to Enhance Resilience - Together. This initiative will allow participating Alabama gun owners the ability to safely store their weapons at participating gun stores or law enforcement offices. In order to increase the number of gun stores and law enforcement officers willing to store firearms, the Houston Hunter Act (Appendix A) has been drafted and sponsored by Representative Russell Bedsole (R) and Senator Keith Kelley (R). This bill would codify firearms hold agreements between individual firearm owners and Federal Firearms Licensees (FFL) or participating municipal/county law enforcement officers and provide those FFLs/LEOs with civil immunity. This bill will also help reduce stigma about firearm ownership as well as seeking mental assistance, and it is not associated with any red flag law. We are recommending implementing interventions that aim to improve lethal means safety by:

- Passing and implementing voluntary safe storage legislation that does not infringe on 2nd Amendment Rights, protects Federal Firearm Licensees (FFLs) who participate in

the program, and provides the Military, Veteran, and First Responder (MVFR) community a voluntary, temporary, and confidential safe storage option

- Enhancing MVFR community access to MVFR peer-to-peer services across the state in step with the S.A.F.E.R. Together Project and the Alabama Governors Challenge promoting awareness and education on the importance of lethal means safety and peer support
- Research, develop, and make future amendments to the Houston Hunter Bill that address other lethal means safety concerns, specifically the overprescribing and over usage of prescription medications and illegal substances
- Research, integrate, and partner with those MVFR organizations that promote connection, post traumatic growth, sobriety, service to others, and resilience to improve quality of life, connectedness, and ultimately help reduce suicide risk throughout the state

4. DEVELOP A PARTNERSHIP AGREEMENT

A partnership agreement with the Alabama Department of Mental Health and the Alabama Department of Veterans Affairs will strengthen the relationship between the two organizations. The partnership will train all providers in military culture and trauma informed care. The following strategies will be operationalized through the agreement and address all four VMHSC goals:

- Promote VA Safety Planning Checklist for all providers
- Promote access to naloxone to prevent lethal overdose
- Increase awareness of 988 and the Alabama Crisis System of Care
- Educate veterans and their family members and providers about the COMPACT Act benefits: 30 days of in-patient and 90 days of out-patient care
- Strengthen partnerships between ADMH, ADVA, and community providers
- Increase the number of veteran peers to receive care, assist with care, and to coordinate safety planning
- Identify and enroll mental health providers in the Non-VA Community Care Network, as established in the MISSION Act's Veterans Community Care Program
- Improve awareness of Alabama GI Dependent Scholarship Program through the Alabama Department of Veterans Affairs

5. ORGANIZE A VETERANS MENTAL HEALTH SUMMIT

The creation of a veterans mental health summit will highlight the partnership between ADMH, ADVA and Veterans Service Organizations across the state. The summit will have numerous sessions with a focus on the current needs or topics that would provide helpful information to veterans, their families, and community organizations. The strategies below address all four goals:

- Promote VA Safety Planning Checklist for all providers
- Promote access to naloxone to prevent lethal overdose
- Increase awareness of 988 and the Alabama Crisis System of Care
- Educate veterans and their family members and providers about the COMPACT Act benefits: 30 days of in-patient and 90 days of out-patient care

- Strengthen partnerships between ADMH, ADVA, and community providers
- Increase the number of veteran peers to receive care, assist with care, and to coordinate safety planning
- Identify and enroll mental health providers in the non-VA Community Care Network, as established in the MISSION Act's Veterans Community Care Program
- Improve awareness of Alabama GI Dependent Scholarship Program through the Alabama Department of Veterans Affairs

6. EVALUATE BEST PRACTICES USING DATA FROM PILOT PROGRAMS

Once the Request for Proposals (RFP) are awarded and the providers are able to use the funds to pilot their programs, we will use their outcomes to decide which programs should be replicated statewide. RFPs were arawrded to pilot programs seeking to,

- promote state certified integrated care models for improved treatment and follow up care;
- research and implement evidence-based peer support models, so veterans can be helped by fellow veterans;
- train all providers in military culture and trauma-informed care;
- increase access to medication assisted treatment (MAT) to address the high prevalence of opioid misuse; and/or
- research and implement evidence-based prevention models for veterans and their families.

CONCLUSIONS

As the Committee began its work, it became evident that there were some issues we could address without waiting for the Comprehensive Plan to be completed. They include safe storage legislation, expansion of TBI services and the establishment of the Veterans Resource Center.

Through the work of Alabama's Challenge and the Alabama National Guard, safe storage legislation had been drafted during the previous legislative session. The VMHSC was briefed during the first meeting. Legislative support was secured along with bill sponsors. Governor Ivey signed HB216 into law on April 7, 2025, creating Act 2025-93 The Houston Hunter Act.

We know from the data that the combination of substance use disorder and TBI places veterans at the greatest risk of suicide. Given that Alabama has a nationally recognized TBI program and one of the highest rates of veteran suicide, work began to seek funding to expand access to screening and services beyond the current two-year post injury requirement. The VMHSC supported the effort to increase funding to the Alabama Department of Rehabilitation Services to expand access to services to anyone with a TBI regardless of when the injury occurred. Currently, there is a $2.5M line item in the ETF budget for this purpose.

During the 2025 legislative session, Act 2025-20 created a public-private partnership to provide a one-stop center to prioritize rapid workforce reintegration through a jobs-first strategy. The act established the Veterans Resource Center which will integrate health and behavioral health care in addition to the reintegration strategy. Currently, there is a $5M line item in the ETF-Supplement budget for this purpose.

The Alabama Veterans Mental Health Steering Committee believes that the enactment of these initiatives and recommendations will address the purpose for which it was established to maximize new and existing opportunities for veterans' access to behavioral health care, no matter where they need it, when they need it, or whether they are enrolled in VA care.

APPENDIX 1:
ACT 2025-20 THE ALABAMA VETERANS RESOURCE CENTER

SB70

WK2R555-2

By Senators Jones, Allen, Bell, Kitchens, Elliott, Price,

Butler, Sessions, Williams, Stewart, Roberts, Hatcher, Kelley,

Stutts, Smitherman, Beasley

RFD: Veterans and Military Affairs

First Read: 4-Feb-25

Enrolled, An Act,

To establish the Alabama Veterans Resource Center Act; to create and designate the Alabama Veterans Resource Center as a public corporation; to provide for the membership of a board of directors for the center; to provide for the duties and powers of the board in managing the center; and to authorize the center to enter into public-private partnerships.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. This act shall be known and cited as the Alabama Veterans Resource Center Act.

Section 2. The Legislature finds and declares all of the following:

(1) Alabama has the highest per capita veteran population in the United States.

(2) Veterans face unique challenges when moving from military service to civilian life including, but not limited to, accessing benefits, finding employment, and addressing mental health needs.

(3) A comprehensive, coordinated system of support is essential to veterans and their families.

(4) Public-private partnerships can leverage resources and expertise to effectively serve veterans.

Section 3. (a) The Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate shall present to the Secretary of State an application, signed by each of them, for the formation of the Alabama Veterans Resource Center as a public corporation, having a

legal existence separate and apart from the state and any county, municipality, or political subdivision, which shall set forth all of the following:

(1) The name, official designation, and official office location of each of the applicants, together with a certified copy of the commission evidencing each applicant's right to office.

(2) The date on which each applicant was sworn into office and the term of office of each applicant.

(3) The name of the proposed public corporation, which shall be the Alabama Veterans Resource Center.

(4) The location of the principal office of the proposed corporation.

(5) Any other matter relating to the corporation that the applicants may choose to insert and that is not inconsistent with this act or state law.

(b) The application shall be subscribed and sworn to by each applicant before an officer authorized by the laws of the state to take acknowledgments to deeds. The Secretary of State shall examine the application, and, if he or she finds that the application substantially complies with the requirements of this section, the application shall be filed and recorded in an appropriate book of records in the office of the Secretary of State.

(c) When the application has been made, filed, and recorded as provided in subsection (b), the applicants shall constitute a public corporation under the name stated in the application, and the Secretary of State shall make and issue to the applicants a certificate of incorporation pursuant to this act, under the Great Seal of the State, and shall record

the certificate with the application. There shall be no fees paid to the Secretary of State in connection with the corporation.

(d) Notwithstanding any provision of law to the contrary, the corporation incorporated pursuant to this section shall not be deemed to be a part of the state for any purpose but shall be treated as a public corporation and body politic separate and apart from the state.

Section 4. (a) The center shall be under the management and control of a board of directors, and all power necessary or appropriate for the management and control of the center shall be vested solely in that board.

(b) The board shall have all of the following members:

(1) Three members appointed by the Governor, one of whom shall be a female veteran.

(2) One member appointed by the Speaker of the House of Representatives.

(3) One member appointed by the Lieutenant Governor in his or her role as Chair of the Alabama Military Stability Commission.

(4) One member appointed by the President Pro Tempore of the Senate.

(5) The Commissioner of the State Department of Veterans Affairs, who shall serve as an ex officio member and vice chair of the board.

(6) The Commissioner of the Department of Mental Health, who shall serve as an ex officio member.

(7) The Secretary of the Alabama Department of Workforce, who shall serve as an ex officio member and chair of the board.

(8) The Minority Leader of the House of Representatives, or his or her designee.

(9) The Minority Leader of the Senate, or his or her designee.

(c) All board members are voting members of the board and shall be considered in determining whether a quorum is present.

(d)(1) Each ex officio member may designate an individual to serve in his or her place at any meeting of the board or may designate an individual to serve in his or her place at all meetings of the board until the expiration of his or her term. An ex officio member may withdraw his or her designation at any time.

(2) A designee shall be counted for purposes of both establishing a quorum and voting.

(3) An ex officio member shall continue to serve on the board as long as he or she holds the position that authorizes his or her service on the board.

(e) In making appointments, the appointing authorities shall coordinate their appointments to assure the board membership is inclusive and reflects the racial, gender, geographic, urban, rural, and economic diversity of the state.

(f)(1) Each appointed member shall serve a term of two years following his or her date of appointment.

(2) Each appointed member shall continue to serve until he or she is reappointed or a successor is appointed to his or her place on the board.

(3) An appointed member may only serve a maximum of two consecutive terms of office and may be reappointed after not serving for a period of at least two years.

(4) An appointed member may be removed by his or her appointing authority at any time and for any reason. Upon removal, the respective appointing authority shall appoint a successor to serve for the unexpired term.

(5) An individual appointed to fill a vacancy, for any reason, shall serve the remainder of the unexpired term and may be reappointed to serve an additional term.

(g) No board member shall receive compensation because of his or her service as a member. Each member may be reimbursed for actual and reasonable travel expenses incurred in the performance of his or her duties as a member.

(h) A majority of the board members shall constitute a quorum for the transaction of business by the board, and decisions shall be made on the basis of a majority of the quorum then present and voting. No vacancy in the membership of the board or the voluntary disqualification or abstention of any member shall impair the right of a quorum to exercise all of the powers and duties of the board.

(i) Members of the board may participate in meetings of the board in person, by means of telephone conference, video conference, or other similar communications equipment, so that all individuals participating in the meeting may hear each other at the same time. Participation by any such means shall constitute presence in person at a meeting for all purposes, including for purposes of establishing a quorum.

(j) The board may appoint other officers to perform duties not inconsistent with this act or applicable law, as the board deems necessary or appropriate.

(k) In addition to regular meetings of the board, as may be provided by law or bylaws adopted by the board, special

meetings of the board may be called by the chair acting alone or by any three other board members acting in concert, in each case upon notice to each board member given in person, by email, by registered letter, or by other means. Notice to each board member may be waived upon the unanimous written consent of all board members, either before or after the meeting with respect to which the notice would otherwise be required.

Section 5. (a) The board shall have all of the powers necessary to carry out and effectuate the purposes of this act. Without limiting the generality of the foregoing, the board shall have and exercise all of the following powers:

(1) Provide comprehensive support services to veterans and their families residing in this state including, but not limited to, all of the following:

a. Assistance with accessing federal and state benefits.

b. Career counseling and job placement services.

c. Mental health and wellness programs.

d. Education and training opportunities.

e. Support for military spouses, dependents, and families.

(2) Develop, monitor, implement, and update as necessary the strategic plan and strategies for the center.

(3) Oversee the operations and finances of the center.

(4) Employ an executive director or other employees, or both, to manage the day-to-day operations of the center.

(5) Establish committees as necessary.

(6) Develop and implement a hub and spoke model for the center, with a central office providing core services and a network of regional offices offering localized support and

access points through a public private-partnership. The center may also utilize an online portal and other physical structures or technology to conduct its operations.

(7) Adopt, alter, and repeal bylaws as necessary for the regulation and conduct of the affairs and business of the center, and for the implementation of this act.

(8) Make and enter into contracts, leases, and agreements and take other actions as the board determines necessary or desirable to accomplish the purposes of this act and the center and exercise any power necessary for the accomplishment of the purposes of the center or incidental to the powers expressly provided by this act.

(9) Appoint, employ, and contract with employees, agents, advisors, consultants, and service providers including, but not limited to, attorneys, accountants, financial experts, and other advisors, consultants, and agents as the board determines necessary or desirable to accomplish any purpose of the center or incidental to the powers expressly provided by this act, and to fix the compensation of those individuals.

(10) Manage, invest, and expend funds at its disposal.

(11) Grant monies and things of value in aid of or to, any individual, firm, corporation, or other business entity, public or private, as the board determines necessary or desirable to accomplish any purpose of the center or incidental to the powers expressly provided by this act.

(12) Take any action necessary to exercise its rights or fulfill its obligations relevant to the center under state law.

(13) All other powers necessary to carry out and

effectuate the purposes of this act. These powers shall be construed broadly, so that the failure to state a power of the board shall not be considered a limitation upon the board, as long as the board determines the power is necessary to allow the board to fulfill the purpose of the center, as provided by this act.

(b) The board may make, enter into, and execute contracts, agreements, and other instruments with, accept appropriations, loans, gifts, aid, and grants from, and cooperate with, any other individual or entity including, but not limited to, all of the following:

(1) The United States of America, the state, or any agency, instrumentality, or political subdivision of either.

(2) For profit and nonprofit private entities.

(3) Public bodies, departments, or authorities including, but not limited to, any entity in the Executive Branch of the state, to act on behalf of the board in carrying out functions that the board determines are consistent with this act and the powers of the center.

(c)(1) Members of the board shall be subject to the state ethics laws under Chapter 25 of Title 36, Code of Alabama 1975, but members of the board shall not be required to submit a statement of economic interests under Section 36-25-14, Code of Alabama 1975. The center is not a business for purposes of the state ethics laws, Chapter 25 of Title 36, Code of Alabama 1975, and a public official or public employee holding a position on the board is not precluded from taking official actions affecting the center as long as there is no impermissible personal gain.

(2) The board is subject to the Alabama Open Meetings

Act under Chapter 25A of Title 36, Code of Alabama 1975. In addition to the reasons set forth in Section 36-25A-7, the board may go into executive session to discuss sensitive issues related to veteran needs, programs, or services.

Section 6. (a) The board may enter into contracts, leases, agreements, investments, and may otherwise expend monies without compliance with competitive bid laws under Article 5, commencing with Section 41-4-110, of Chapter 4 of Title 41, Code of Alabama 1975, and Chapter 2 of Title 39, Code of Alabama 1975.

(b) Solely as a result of entering into contracts, leases, agreements, investments, or otherwise as provided in subsection (a), no for-profit or nonprofit private entity, nor the officers, employees, agents, or directors of any of the foregoing, shall become subject to state ethics laws or the Alabama Open Meetings Act under Chapter 25 and Chapter 25A of Title 36, Code of Alabama 1975; competitive bid laws under Article 5, commencing with Section 41-4-110, of Chapter 4 of Title 41, Code of Alabama 1975; Chapter 2 of Title 39, Code of Alabama 1975; or public records laws under Article 3, commencing with Section 36-12-40, of Chapter 12 of Title 36, Code of Alabama 1975.

Section 7. In addition to the powers provided in Section 5, the board may enter into annual public-private partnerships with nonprofit organizations and other entities to leverage resources and expertise in support of the center's mission and purpose. Each public-private partnership is subject to annual renewal by the board.

Section 8. (a) The Alabama Veterans Resource Center Fund is created in the State Treasury. All monies received by

the board pursuant to this act or otherwise from any source permitted by this act shall be deposited into the State Treasury to the credit of the fund. Amounts deposited into the fund shall be budgeted and allotted in accordance with Sections 41-4-80 through 41-4-96 and Sections 41-19-1 through 41-19-12, Code of Alabama 1975.

(b) The center may accept additional funding from public and private sources, including appropriations, loans, federal gifts, grants, corporate sponsorships, and individual donations.

Section 9. The board, at any time and by majority vote, may cause its application for formation to be amended by having three members of its board of directors file an amendment with the Secretary of State, which shall be sworn to by each signatory thereto before an officer authorized to take acknowledgments to deeds.

Section 10. (a) The board, at any time and by a three-quarters vote, may dissolve the center by having three-quarters of the members of the board file with the Secretary of State an application for dissolution, which shall be sworn to by each signatory thereto by an officer authorized to take acknowledgments to deeds.

(b) Upon the filing of the application for dissolution, the center shall cease to exist. The Secretary of State shall file and record the application for dissolution, and shall make and issue, under the Great Seal of the State, a certificate that the center is dissolved, and shall record the certificate with the application for dissolution. Title to all property held in the name of the center shall be vested in the state upon dissolution of the center, and the ex officio board

members, by written consent, shall direct how to dispose of any monies in the Alabama Veterans Resource Center Fund.

Section 11. This act shall be liberally construed to effectuate its purposes.

Section 12. This act shall become effective on June 1, 2025.

_____

President and Presiding Officer of the Senate

_____

Speaker of the House of Representatives

SB70

Senate 06-Feb-25

I hereby certify that the within Act originated in and passed the Senate, as amended.

Patrick Harris,

Secretary.

_____

House of Representatives

Amended and passed: 18-Feb-25

_____

Senate concurred in House amendment 18-Feb-25

_____

By: Senator Jones

APPENDIX 2:
ACT 2025-93 THE HOUSTON HUNTER ACT

SB40

QN79744-2

By Senators Kelley, Jones, Kitchens, Beasley

RFD: County and Municipal Government

First Read: 4-Feb-25

Enrolled, An Act,

Relating to firearms; to define firearm hold agreements; and to provide civil immunity for federal firearm licensees who enter into firearm hold agreements under certain conditions.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. (a) This section shall be known as and may be cited as the Houston/Hunter Act.

(b) For the purposes of this act, the following terms to have the following meanings:

(1) FEDERAL FIREARMS LICENSEE. Any person who is licensed pursuant to 18 U.S.C. Chapter 44.

(2) FIREARM. Has the same meaning as provided in 18 U.S.C. § 921.

(3) FIREARM HOLD AGREEMENT. A private transaction between a federal firearm licensee and an individual firearm owner where the licensee agrees to: (i) take physical possession of the owner's lawfully possessed firearm at the owner's request; (ii) hold the firearm for an agreed period of time; and (iii) return the firearm to the owner.

(c) No individual shall have a private cause of action against a federal firearm licensee operating lawfully in this state for returning a firearm to the firearm owner at the termination of a firearm hold agreement.

(d) The immunity from civil liability provided in subsection (c) shall not apply to any action arising from a

firearm hold agreement if that action is the result of unlawful conduct on the part of the federal firearm licensee.

(e)This section shall not apply to firearm transfers made in violation of Title 13A or Chapter 27 of Title 41, Code of Alabama 1975.

Section 2. This act shall become effective on June 1, 2025

2024

Alabama Veteran Behavioral Health Landscape

CREATED BY

VitAL Improving Wellness in Alabama

ADMH Alabama Department of Mental Health

Created by VitAL

The report was compiled by VitAL.
VitAL thanks the following individuals who created, drafted, and reviewed components in the *Alabama Veteran Behavioral Landscape Report*.

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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 health care: 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 health care, a baseline for current needs and available services must be established. The goal of the *Alabama Veteran Behavioral Health Landscape* is to do just that—provide a robust picture of the current status of Alabama Veterans' mental health status, substance use status, and the supports currently in place to address these needs. The report provides insight for establishing a baseline on state, regional, and local levels across Alabama.

VitAL's scope of work for the report included (a) reporting the prevalence of common mental health and substance use categories in Alabama, and (b) compiling an inventory of what behavioral services exist currently for Alabama's veterans, National Guard, and Reserve component members.

This report has been purposefully organized so that the reader can take the information provided regarding the current landscape of needs and services across Alabama and begin to create a comprehensive picture that includes strengths of services, gaps in services, and how those may vary across the state. In order to meet this goal, the *Alabama Veteran Behavioral Landscape Report* is organized into the following sections:

1. *Alabama Mental Health and Substance Use Prevalence Analysis*
2. *State Status: Serving Veterans*
3. *Clinical Service and Community Resource Analysis*

The three sections of the report were designed and ordered purposefully. This intentionality includes beginning with the big picture of the prevalence of specific mental health and substance use categories across the state. This data analysis is presented in the *Alabama Mental Health and Substance Use Prevalence Analysis* section. Though the report's key points are highlighted in the first section, the full version of the study's methods, data collection, analysis, and results can be found in *Appendix 2*.

Following the *Prevalence Analysis,* the report provides an overview of the state in light of the prevalence report findings paired alongside the third section of the report, the *Clinical Service and Community Resource Analysis section*. WIthin *State Status: Serving Veterans*, an overview of both primary parts of the report are summarized before launching into a detailed, region-by-region analysis of available services across the state. This detailed section of the report addresses the types of services

available to veterans on both the state and more micro, county-level in the *Clinical Service and Community Resource Analysis*. The *Clinical Service and Community Resource Analysis* is divided into two parts—a *State Overview* of available services followed by twenty individual regional reports organized by the Alabama Department of Mental Health's (ADMH) Community Mental Health Center (CMHC) catchment areas across the state. Dividing the reports into smaller sections allows for the strengths and needs of the status of veteran services in the areas to be explored more closely. Each CMHC catchment area is comprised of two to five counties. In both the *State Overview* and the catchment area reports, two types of services are reported: those available to veterans that are funded by the state or federal government, and those available to veterans that are located in the community (typically non-profit and/or volunteer organizations).

Through the intentional organization of the report, the reader may begin to understand or add to current understanding regarding the status of mental health, substance use, and supportive services for Alabama's veterans. This knowledge was purposefully gathered, analyzed, and presented in order to support the Veterans Mental Health Steering Committee in their efforts to establish a baseline for the current status of available services to veterans across the state.

HOW TO READ THIS REPORT

The *Alabama Veteran Behavioral Landscape Report* is comprised of three primary sections following the *Methods* of the report:

1. **Alabama Mental Health and Substance Use Prevalence Analysis**
2. **State Status: Serving Veterans**
3. **Clinical Services and Community Resource Analysis.**

The division of the report into these three sections is intentional, as the division helps organize the data into similar categories pertaining to topic, location, or both. *How to Read This Report* can be used as a reference for where to find the specific information pertaining to the reader's interests and/or region.

METHODS

In *Methods*, the reader can find a detailed review of the process by which the data included in each section was collected, synthesized, and presented in the report. This section is helpful for understanding the process and context of the presented data.

ALABAMA MENTAL HEALTH AND SUBSTANCE USE PREVALENCE

In the *Alabama Mental Health and Substance Use Prevalence Analysis*, the reader can find summaries of the status of Alabama Veterans across five mental health and substance use categories:

1. Mental illness & distress
2. Suicidal ideation or planning
3. Opioid misuse
4. Illicit drug use
5. Alcohol misuse
6. Tobacco use

STATE STATUS: SERVING VETERANS

In *State Status: Serving Veterans*, the reader can find an overview of the findings of the data collection efforts detailed in the remainder of the report. This section includes:

1. Key points from the *Alabama Mental Health and Substance Use Prevalence Analysis*.
2. The total numbers of ADMH mental health and substance use services across the state.

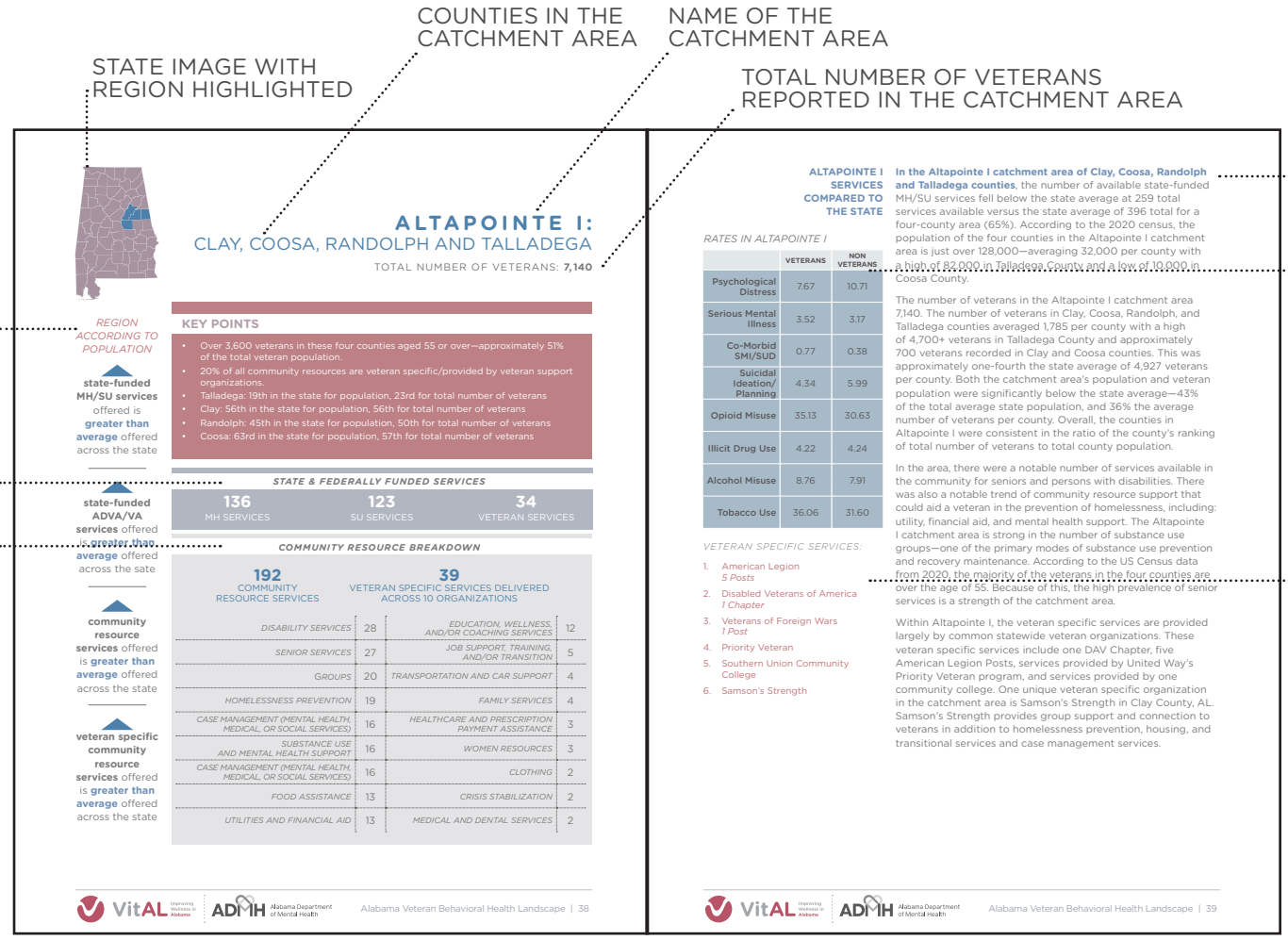
3. The total numbers of Alabama Department of Veterans Affairs (ADVA) and Veterans Affairs (VA) services across the state.
4. The total number of local community resources and veteran specific community resources across the state.
5. Detailed processes for determining regional status of state and federally funded services and community resources across the state.
6. A breakdown of the overall status of regions across the state (what percentage were well-served according to population, etc.).

CLINICAL SERVICES AND COMMUNITY RESOURCE ANALYSIS

The *Clinical Services and Community Resource Analysis* is the most robust and information-filled section of the report as the collected data is presented across twenty distinct sections. These twenty sections correspond with the twenty CMHC catchment areas established by ADMH. In the *Clinical Services and Community Resource Analysis*, the reader will find specific information detailing the various elements of the analysis.

1. ***Region According to Population:*** This is information regarding the number of services reported in the region as compared to the region's population.
2. ***State & Federally Funded Services:*** This is the total number of services provided by ADMH, ADVA, and the VA in the area.
3. ***Community Resource Breakdown:*** This is the total number of community resources located in the area. On the left, the total number of resources is stated. On the right, the total number of veteran specific community resources is stated. The veteran specific community resources are also included in the total number of community resources. Definitions for each of these can be found in *Appendix 3*.
4. ***CMHC State Status:*** Here, the reader will find detailed information about the region's population and number of services located within the region as compared to the average population of the counties and the average number of services/resources across the state. This section provides narrative information regarding:
    - The number of the region's MH/SU services compared to the state average.
    - The number of the region's population compared to the state average.
    - The number of the region's state and federally funded services as compared to the state average.
    - A description of notable key points includeing a.) frequently occurring community resources; b.) a breakdown of specific ADVA/VA services in the region; and c.) additional key points relevant or oustanding within the region.
5. ***Catchment Area Prevalence Rates***: a quick look at the prevalence rates for the catchment area with numbers for veterans versus nonveterans.
6. ***Veteran Specific Community Resources:*** Each region has a list of the veteran specific services captured in the community resource breakdown

The image at below mimics the spread format found in each regional report. For reader-friendly usability, the six sections listed on page 8 as well as other details are identified in the image.



LEFT PAGE

RIGHT PAGE

TABLE OF CONTENTS

METHODS

The overarching goal of the *Alabama Veteran Behavioral Health Landscape Report* is to establish a baseline for the current status of Alabama's veteran behavioral health needs and available services as a foundation for maximizing opportunities for veteran care in the state. Here, the methods of each section are described in detail.

LIMITATIONS

The *Alabama Veteran Behavioral Landscape Report* attempts to present a snapshot of the status of veteran behavioral health and the services available to veterans at varying levels across the state. As such, this report does not attempt to quantify, assume, or report on the quality and availability of these services as an Alabama Veteran may experience them. In addition, there is no data throughout the report that addresses the number of veterans served by these organizations, nor does it contain information as to which veteran populations to which the services are available. These three factors—the quality of the services, the populations served by each, and the availability of the services in real time—impact the effectiveness and accessibility of the clinical, support, and case management services explored and identified throughout the report.

In addition to specific data-driven limitations, the report also has limitations regarding the target population. The report solely records, highlights, and presents data regarding services provided to veterans, and not veteran caregivers, spouses, children, families, or other supports. These supports are not only vital to the overall well-being and quality of life of our state's veterans, specifically within the discussion of behavioral health needs, but historically these groups have needed greater access to support as well. However, the scope of this report is focused on the veteran.

316,473
ALABAMA VETERANS

Reported by the U.S. Census, this number for veterans is used by federal and state agencies for the purposes of planning and assessment.

ABOUT VETERANS

According to the U.S. Department of Veterans Affairs (VA), the term veteran means "a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable" and includes Reservists or members of the National Guard when they have either served in a capacity beyond training for a certain number of days or if the Reservist or member of the National Guard was disabled during training or active duty[1]. According to SB135, Act 2024-358, a veteran is any resident of the State of Alabama who meets the standard VA definition of veteran in addition to any resident of the State of Alabama who was a member of the (1) Army National

Guard; (2) Air National Guard; or (3) the reserve component of the Armed Forces, with no exceptions given to active duty or service beyond training. For the complete bill, see *Appendix 4*.

For the purposes of this project, in an effort to capture the scope of the definition of *veteran* laid out by SB135, the report approaches veteran services across the State of Alabama in two ways. First, the *Alabama Veteran Behavioral Landscape Report* uses the U.S. Census number for veterans for the estimated prevalence rates in the *Alabama Mental Health and Substance Use Prevalence Analysis*. In the *Clinical Service and Community Resource Analysis*, the report uses the broader definition outlined by SB135, Act 2024-358. In the *Resource Analysis*, the researchers did not define veteran explicitly, deferring instead to each organization's definition of veteran. The *Resource Analysis* solely attempted to capture any time a preventative, treatment, or recovery service was cited as veteran specific.

ALABAMA MENTAL HEALTH AND SUBSTANCE USE PREVALENCE ANALYSIS

The National Survey on Drug Use and Health (NSDUH) is a highly valid and reliable data source for research on substance use and mental health issues. Justifications for its use include its rigorous methodology, comprehensive data coverage, large sample size, and consistent administration since 1971.

The purpose of the *Alabama Mental Health and Substance Use Prevalence Analysis* is to describe the current prevalence of six mental health and substance use categories: (1) mental illness & distress, (2) suicidal ideation or planning, (3) opioid misuse, (4) illicit drug use, (5) alcohol misuse, and (6) tobacco use in Alabama; specifically the prevalence of these six categories as compared across certain socio-demographic attributes of Alabamian adults (aged 18+) such as: age, sex, race, veteran status, and rurality of the participant's permanent location or home.

All mental health and substance use-related data were derived from the United States National Survey on Drug Use and Health (NSDUH)—an annual survey that is conducted nationally with persons aged 12 years and over. Using certain items from the NSDUH, the report compared the six mental health and substance use categories across the socio-demographic categories using statistical analyses. Population data was provided by Census counts. Prevalence rates were derived by comparing the frequency of the six mental health and substance use categories to the respective county's population.

Once prevalence rates were established, prevalence of each mental health and substance use categories were then organized and displayed on maps of the state with the counties clearly separated and keyed to the map's intended category's prevalence range. During the presentations of the results, special emphasis was placed on the prevalence rates of the four categories in veteran populations versus nonveteran populations across the state.

CLINICAL SERVICE AND COMMUNITY RESOURCE ANALYSIS

The purpose of the *Clinical Service and Community Resource Analysis* is to evaluate the number and type of clinical and community resources available for use by veterans across the state. For this, services that are available to veterans in the State of Alabama were explored, gathered, and analyzed. The results were organized into two major groups:

1. State and Federally Funded Services: services provided by ADMH, ADVA, or the VA.
2. Community Resources: services provided by non-profit, often volunteer, organizations in the community in order to meet a specific need. These resources are further organized into two categories:
    a. Total Number of Community Resources: the total number of community resource services provided in the catchment area that are easily accessible through community resource guides, the internet, etc.
    b. Total Number of Veteran Specific Community Resources: Community resources that are reported to be veteran specific or serving only veteran populations.

When gathering the data, services provided by ADMH were determined via administrative code for the program type and/or program descriptions. Each credentialed mental health (MH) or substance use (SU) program was organized, and the services recorded. Each individual service provided by a program was recorded and reported in the analysis. This means each program could have more than one provided service recorded. The number of services offered by a program ranged from one to twenty-two services per program. The categories of service provision are as follows:

MENTAL HEALTH SERVICES

Mental health services included therapeutic services provided to an individual, group, family, or couple in residential, outpatient, and/or intensive day treatment or partial hospitalization programs. Also included were medication services provided in a clinical mental health context such as psychiatric services, medication management, and/or psychoeducation regarding the medication, diagnosis, treatment plan, etc. Included in mental health services were those services provided through state credentialed services for co-morbid diagnoses, and case management services including services such as resource navigation, job training, homelessness intervention, and/or other prevention services.

SUBSTANCE USE SERVICES

Substance use services include services provided for substance use intervention and co-morbid disorders, including substance use outpatient therapy, medication assisted treatment, substance use residential or intensive day treatment programs, and additional case management services including education, service navigation, and service linkage.

ADVA SERVICES

Services provided by ADVA were determined via administrative code, specifically the job description of the county service officer. Locations of county service officers were determined using information from public sources, including the ADVA website. Each ADVA office was designated as providing five individual services regardless of the hours of the office (part time or full-time business hours). State veteran homes were also included in this data and were recorded as providing fourteen individual services to veterans in the area where they were located.

VA SERVICES

Services provided by the VA fell into either MH, SU, or other services; however, all VA services were categorized exclusively in *State and Federally Funded Services: Total Number of Veteran Services* only. In reporting, all VA and ADVA services provided fell into this category, while all services provided by ADMH were organized into *State and Federally Funded Services: Total Number of MH Services* and *Total Number of SU Services*. The types of services provided by the VA locations were derived from public information such as the organization's website. VA programs offered a variety of mental health, substance use, and/or medical services ranging from fourteen individual services per location to sixty-five. Services provided by both ADVA and the VA were organized into a category of *Other Services*.

OTHER SERVICES

Other services recorded in the *Clinical Service and Community Resource Analysis* included clinical services that were not offered in a state-certified mental health or substance use organization. These largely included veteran benefit navigation, non-therapeutic groups, all medical services from primary care to specialized services, rehabilitation, physical therapy, and others that are available through the Alabama VA Medical Centers. Medical related transportation, equipment, residential programs (such as nursing home services), pharmacy and lab services were also included here.

Community resource data was recorded through the pursuit and collection of resource demographics and provision of services via various collection sources, including digital information, community resource information publications, phone calls, and conversations with case managers across the state. As information regarding the resource was gathered, the data was sorted according to the types of services the organization offered. In this data set, organizations demonstrated provision of services ranging from a lower limit of one service provided per organization to an upper limit of twelve services provided. Originally, the services were organized into one of fifty eight categories; however, those categories were then merged into eighteen overarching community resource service categories. The number of easily accessible community resources within these eighteen categories is presented within each *Clinical Service and Community Resource Analysis* report.

COMMUNITY RESOURCES

Community Resources included services provided by service organizations in the community, and fell into the common categories of case management, clothing, disability services, family and caregiver support, education or coaching, homelessness prevention, community (free) medical or dental services, utility assistance, non-therapeutic groups, transportation, home repair or home items, prescription/healthcare payment assistance, and resources specifically for women.

It is important to note what was not recorded in the *Clinical Service and Community Resource Analysis*. Community services provided by state and federally-funded organizations aside from ADMH, ADVA, or the VA were intentionally excluded from the analysis. These services are widely available across the state, vast, and would dilute the numbers in the data in a way that might have made it difficult to ascertain if a significant number of community resources and services specific to MH/SU and veterans existed in Alabama counties. As such, common safety net resources such as WIC (Women, Infant, Children), TANF (Temporary Assistance for Needy Families), Section 8 Housing Support, ARC (Association for Retarded Citizens), and the like were also excluded from this report. The only exception to this exclusion were services provided by

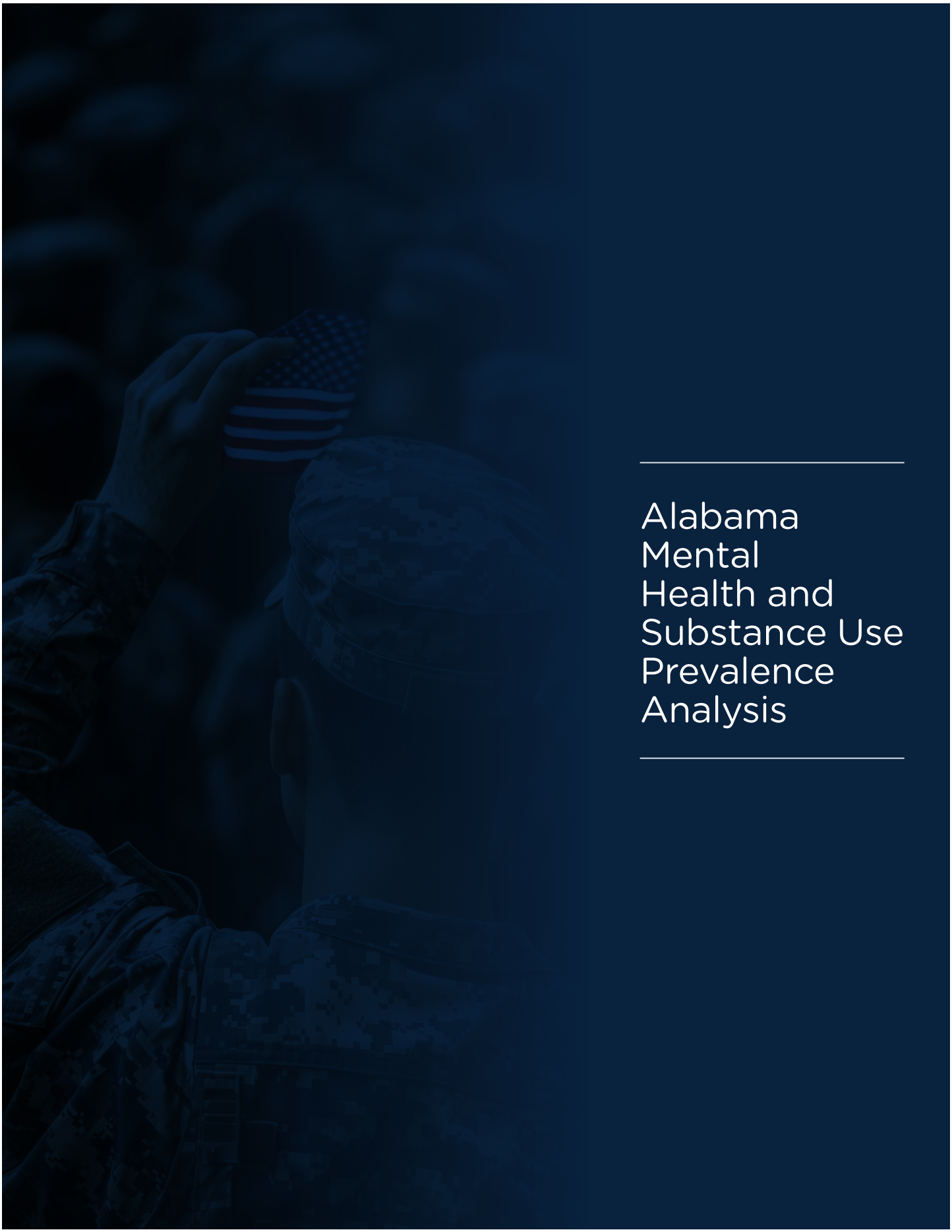
the Area Agencies on Aging across the state. As a recipient of various grants dependent on the Agency's location and aim, AAAs—or Regional Commissions on Aging—were included, and their services provided were counted.

Regarding the eighteen common community resource categories, the data assigned to the respective categories met specific definition requirements. These definitions can be found in *Appendix 4*.

RESULTS AND DISCUSSION

After calculating the frequency of services across state/federally funded services ((1) MH/SU services and (2) veteran services) and community resources ((1) community resource services and (2) veteran specific community resources) the results of the sixty-seven counties were organized by ADMH CMHC catchment areas. There are twenty catchment areas across the state. The results of grouping the data according to catchment area are discussed in two places: (1) *State Status: Serving Veterans*, and (2) the twenty individual *Clinical Service and Community Resource Analyses* organized according to CMHC catchment area.

Within each of the reports, the data are analyzed through a lens of the catchment area's total population, and total population compared to that of the other counties across the state. After establishing a foundation for population and need, there is a discussion of the veteran frequency followed by a discussion of the four recorded service categories—two state/federally funded service categories and the two community resource categories. There is discussion in each catchment area report regarding special considerations for unequally distributed populations across counties within the designated catchment areas, or other nuances, attributes, and/or traits of the catchment area that bear consideration when exploring veteran resources in the area.



Alabama Mental Health and Substance Use Prevalence Analysis

ALABAMA MENTAL HEALTH AND SUBSTANCE USE PREVALENCE ANALYSIS

All data was derived from the United States National Survey on Drug Use and Health (NSDUH). All data is self-reported by participants. It is important to remember that veterans typically underreport symptoms of mental distress, substance use, and/or alcohol use. When national data is applied on a county-level, the data may lose some potency. However, the data supplied by the NSDUH provides the most dynamic picture of the prevalence categories explored in this report. Using the NSDUH as the data source paired with these specific prevalence categories yields a strong picture of the overarching mental health and substance use status of Alabama's veterans.

MENTAL HEALTH AND SUBSTANCE USE CATEGORIES	SOCIO-DEMOGRAPHIC ATTRIBUTES
MENTAL ILLNESS & DISTRESS	AGE
SUICIDAL IDEATION OR PLANNING	SEX
OPIOID MISUSE	RACE
ILLICIT DRUG USE	VETERAN STATUS
ALCOHOL MISUSE	RURALITY OF THE HOME
TOBACCO USE	

The *Alabama Mental Health and Substance Use Prevalence Analysis* compares common mental health and substance use categories to certain socio-demographic attributes of adults in Alabama. The full report can be found in *Appendix 2*.

Prevalence was determined by taking the numbers from the predictive data models and determining how frequently the specific category was occurring based on the population of the county. During the discussion of the results, special emphasis was placed on the prevalence rates of the six categories in veteran populations versus nonveteran populations across the state.

SUMMARY

The analysis of behavioral health issues in Alabama reveals that across the six prevalence groups, four show statistically significant differences between veteran and nonveteran populations, where veteran populations have higher numbers: opioid misuse, illicit drug use, alcohol misuse, and tobacco use. With regards to both psychological distress and suicidal ideation and planning, though the difference was not statistically significant, the numbers for each category were higher for veterans than nonveterans across the state.

Overall, the most significant disparities in both population groups occurred when the group was analyzed according to geographic location. The geographic distribution of these behavioral health issues in Alabama illustrates that both veterans and nonveterans face varied risks depending on their location. Rural areas often experience higher rates of psychological distress, drug use, alcohol misuse, and tobacco use compared to urban areas in veteran and nonveteran populations.

MENTAL ILLNESS AND DISTRESS

The prevalence of mental illness and distress is an exploration of three prevalence categories. The first, serious mental illness, is derived straight from the NSDUH data regarding the reporting of mental illness diagnoses and a score of fifty or less on the Global Assessment of Functioning (GAF). According to the detailed methodology of the NSDUH, the GAF is a scale of activities of daily living and the impact mental illness diagnoses may have in decreasing or interfering with these activities. The scale spans zero to one-hundred, with fifty or less yielding a score of "significant impairment."

PREVALENCE RATES BY CATCHMENT AREA: VETERANS VS. NONVETERANS

CATCHMENT AREAS	Psychological Distress		Serious Mental Illness		Co-Morbid SMI/SUD	
	VETERANS	NONVETERANS	VETERANS	NONVETERANS	VETERANS	NONVETERANS
Altapointe I	7.67	10.71	3.52	3.17	0.77	0.38
Altapointe II	7.10	10.64	3.05	3.22	0.79	0.42
Cahaba	7.51	10.40	3.33	3.15	1.03	0.46
Carastar	8.01	10.51	3.54	3.38	0.89	0.45
Central Alabama Wellness	7.66	10.78	3.45	3.02	0.73	0.38
CED	7.35	10.20	3.35	2.72	0.68	0.40
East Alabama	7.67	11.20	3.26	3.63	0.86	0.37
East Central	8.95	10.75	4.23	3.20	0.96	0.45
Highland	6.87	11.39	3.16	3.67	0.81	0.38
Indian Rivers	7.49	10.49	3.05	3.16	0.82	0.43
JBS	7.88	10.21	3.34	2.78	0.66	0.41
Mountain Lakes	7.96	11.27	3.61	3.75	0.61	0.38
North Central	8.21	11.66	3.75	3.74	0.76	0.39
Northwest	7.77	10.43	3.80	2.75	0.75	0.36
Riverbend	6.67	10.33	3.05	2.99	0.73	0.44
South Central	7.93	11.13	3.70	3.50	0.83	0.37
Southwest	8.11	10.44	3.83	3.28	0.80	0.45
Spectracare	8.32	11.37	3.81	3.74	0.78	0.38
Wellstone	7.85	9.64	3.39	2.42	0.71	0.44
West Alabama	8.24	10.63	3.85	3.01	1.03	0.37
ENTIRE STATE	**7.76**	**10.71**	**3.50**	**3.21**	**0.80**	**0.41**

It is important to consider serious mental illness (SMI) when establishing a baseline for the prevalence of mental health issues across the State of Alabama. According to the NSDUH, mental illness questions included diagnoses that were derived from a practitioner or mental health professional, i.e.: a formal source external of the individual who has a well-established knowledge of mental illness criteria and the scales for mental illness severity. Within SMI, the results showed that serious mental illness was more likely among individuals with younger age, female sex, White race, and living in a suburban or rural county. Additionally, results

Additionally, results showed that veterans were more likely than nonveterans to report SMI, even after controlling for the aforementioned variables.

showed that veterans were more likely than nonveterans to report SMI, even after controlling for the aforementioned variables.

In general, veterans exhibited greater odds of SMI compared to nonveterans within similar demographic groups and residential settings. Probabilities of SMI are notably higher in suburban, compared to urban and rural, areas for both veterans and nonveterans, with younger White females exhibiting the highest risk. Overall, the statewide veteran prevalence rate (3.50%) is slightly higher than the nonveteran rate (3.21%), with significant variability across regions. For instance, the East Central catchment area reports the highest veteran prevalence rate (4.23%), markedly exceeding the nonveteran rate (3.20%). Conversely, the Highland catchment area shows a higher nonveteran rate (3.67%) compared to veterans (3.16%). Notably, areas like Wellstone and Northwest also show substantial disparities, with veterans experiencing higher SMI rates.

The second prevalence category is Serious Mental Illness with Co-Occurring Substance Use Disorder (SMI/SUD). This prevalence category measures the same criteria as SMI, above, with the addition of reported Substance Use Disorder (SUD) criteria being met as well. Overall, the results of the SMI/SUD were that old age was a protective factor against SMI/SUD unless the individual was a White male. Overall, compared to White individuals, "Other" racial groups show a significant decrease in likelihood of SMI/SUD, whereas Black individuals did not differ significantly. This was one of the few prevalence categories where rural and suburban settings showed no significant differences compared to urban areas, indicating that rurality may not strongly influence this outcome. Overall, veterans were significantly more likely to experience SMI with SUD.

Veterans consistently showed higher probabilities of SMI with SUD compared to nonveterans across all subgroups and geographic settings. Female veterans exhibited slightly higher probabilities than male veterans in most scenarios, with White and Black females having the highest probabilities among veterans. Among racial groups, individuals categorized as "Other" showed the lowest probabilities, particularly in rural areas. Probabilities are generally lower in suburban and rural settings compared to urban areas for all groups.

When comparing the prevalence of SMI/SUD among veterans and nonveterans across various counties in Alabama, in every county, veterans exhibit a higher prevalence of these conditions compared to nonveterans. For example, in counties like Bullock, Greene, and Sumter, veteran prevalence exceeds 1%, while nonveteran rates remain below 0.4%. This disparity is consistent throughout the state. Counties such as Jefferson and Madison show relatively smaller gaps, yet the veteran prevalence still remains higher.

Psychological distress is the third prevalence category contributes to the picture of mental health status of veterans across the state. Psychological distress (PD) was measured with the Kessler Psychological Distress Scale ("K6"). The K6 is a 6-item self-administered questionnaire that includes a scale for response options ranging from 1 (none of the time) to 5 (all of the time). The questionnaire asks the participant to rank how often they felt feelings of nervousness, hopelessness, restlessness, depression, and worthlessness over the past 30 days. Scores of 13 or more are considered indicative of clinically significantly psychological distress. Therefore, in this report, we categorized individuals as having psychological distress if their scoring pattern resulted in a summative score of 13 or more. The self-report modality of the K6 utilized in the NSDUH survey can be directly contrasted with the formal diagnoses reported in serious mental illness. Though

PD adds to the complete picture of veteran mental health across the state, the results are not as distinct as those provided by the exploration of SMI.

For example, across Alabama, veterans did not show a significant difference in distress levels compared to nonveterans. For veterans, the percentage of individuals experiencing PD varies significantly between counties, with some counties like Russell (9.02%) and Elmore (9.60%) showing higher levels, while others such as Lauderdale (6.21%) and Baldwin (6.50%) demonstrate lower distress levels. In comparison, nonveterans generally report higher rates of PD across all counties, with the highest percentages observed in counties like Pike (12.09%) and Bibb (11.63%). The nonveteran population consistently shows higher psychological distress across most counties compared to veterans. The consistent pattern of higher distress in suburban and rural counties also suggests geographic factors may play a critical role in shaping mental health outcomes.

The difference in the results of SMI and PD provided by the NSDUH survey reinforce the idea that it is important to view the prevalence of veteran mental health and substance needs through a multi-faceted lens rather than a single-lens silo of information.

For example, across Alabama, veterans did not show a significant difference in distress levels compared to nonveterans.

It is important to remember that historically veterans have been more likely to underreport feelings of mental distress than their nonveteran peers. What does it say about veteran mental health that on a formal scale—SMI—veterans were more likely than nonveterans to report SMI, however they were also more likely to report equal or less psychological distress? These data points—when considered in light of each other—point to both the resiliency of veterans but also may contribute to the lack of veterans seeking out mental health treatment. If a veteran does not view themselves as in distress, however they are exhibiting symptoms of moderate to serious mental illness, it is important to capture these symptoms early so that connections to appropriate services, including psychoeducation, can be made.

SUICIDAL IDEATION OR PLANNING

In the NSDUH, questions regarding suicidal ideation or planning (SI/P) include participants providing information regarding serious thoughts of suicide, whether or not the individual has made any plans to commit suicide, if the individual has attempted suicide, received treatment for a suicide attempt, and/or stayed overnight in a hospital for a suicide attempt. The NSDUH collects data on these points for the past year and categorizes participants as having “any” or “none” of these suicidality measures.

Within the report, significant risk factors for SI/P for adults in Alabama include being female, being White, veteran status, and geographic factors such as living in a suburban and or rural area. One protective factor is older age. Age over 64 years is associated with a significant decrease in SI/P indicating that older individuals are less likely to think about or attempt suicide. Geographical location also seems to influence probabilities of SI/P, with suburban populations often displaying slightly higher SI/P than their urban and rural counterparts, regardless of veteran status. Other protective factors include being part of the “other” race category (not Black or White) and living in an urban area.

Regarding veteran status, veterans displayed slightly higher probabilities of SI/P than nonveterans across most subgroups. For both veterans and nonveterans,

younger individuals (under 65 years) exhibit higher probabilities of S/IP compared to older individuals (over 64 years), across all racial and gender subgroups. White females under 65, for example, show the highest probabilities, with suburban areas having the largest values.

Across most counties, nonveteran SI/P rates range from about 4.6 to 6.4, while veteran rates generally fall between 3.2 and 5.4. However, there are some counties where veteran suicide rates are relatively higher or close to nonveteran rates, such as Bullock, Dale, and Elmore. Conversely, counties like Jefferson, Tuscaloosa, and Autauga show a more pronounced gap, where nonveteran rates are significantly higher than veteran rates.

PREVALENCE RATES BY CATCHMENT AREA: VETERANS VS. NONVETERANS

CATCHMENT AREAS	Suicidal Ideation/Planning		Opioid Misuse		Illicit Drug Use	
	VETERANS	NONVETERANS	VETERANS	NONVETERANS	VETERANS	NONVETERANS
Altapointe I	4.34	5.99	35.13	30.63	4.22	4.24
Altapointe II	3.84	5.79	33.74	29.65	4.00	4.15
Cahaba	4.15	5.58	35.79	29.23	4.05	4.11
Carastar	4.30	5.58	33.90	28.37	4.13	4.11
Central Alabama Wellness	4.08	5.98	32.88	30.93	4.06	4.17
CED	3.97	5.58	32.87	30.77	4.03	4.02
East Alabama	3.99	6.10	32.73	29.04	3.99	4.24
East Central	4.78	5.85	34.25	29.70	4.14	4.19
Highland	3.81	6.21	34.28	28.96	4.06	4.27
Indian Rivers	4.14	5.71	34.53	29.72	4.13	4.14
JBS	4.26	5.50	32.95	30.22	4.14	3.97
Mountain Lakes	4.40	6.17	33.14	28.86	4.23	4.29
North Central	4.45	6.33	32.64	29.11	4.24	4.29
Northwest	4.36	5.77	33.83	31.02	4.25	4.06
Riverbend	3.53	5.40	32.63	28.91	3.84	3.93
South Central	4.35	6.03	33.76	29.22	4.21	4.17
Southwest	4.40	5.53	33.75	28.51	4.10	4.06
Spectracare	4.50	6.20	33.27	28.99	4.20	4.28
Wellstone	4.19	5.17	32.68	30.61	4.13	3.88
West Alabama	4.66	5.91	35.65	30.86	4.28	4.16
ENTIRE STATE	**4.22**	**5.82**	**33.72**	**29.67**	**4.12**	**4.14**

OPIOID MISUSE

Regarding veteran status, veterans displayed slightly higher probabilities of SI/P than nonveterans across most subgroups. In all Alabama counties, opioid misuse rates are higher among veterans than nonveterans.

Within the NSDUH, opioid misuse includes participants who reported misuse of prescription pain relievers and/or heroine. Within the report, results showed that opioid misuse was more likely among individuals with older age, female sex, White race, and living in a rural county. Additionally, results showed that veterans were more likely than nonveterans to report opioid misuse. This was true across all Alabama counties. The percentage difference between veteran and nonveteran opioid misuse is significant, ranging from 4-5 percentage points, and in some cases, more. Counties like Wilcox, Lowndes, and Perry show the highest rates of opioid misuse for both groups, with veteran rates exceeding 37%. Results show that rural counties may have elevated levels of opioid misuse, particularly among veterans.

In all Alabama counties, opioid misuse rates are higher among veterans than nonveterans. The percentage difference between veteran and nonveteran opioid misuse is significant, ranging from 4-5 percentage points, and in some cases, more. Counties like Wilcox, Lowndes, and Perry show the highest rates of opioid misuse for both groups, with veteran rates exceeding 37%. Results show that rural counties may have elevated levels of opioid misuse, particularly among veterans. In general, veterans show greater odds of opioid misuse compared to nonveterans within similar demographic groups and residential settings. Probabilities are notably higher in rural areas for both veterans and nonveterans, with older females across all racial categories exhibiting the highest risk. White and Black populations have consistently higher predicted probabilities than those classified as "Other," with women, particularly those over 64, showing the highest odds of opioid misuse.

The data shows consistently higher prevalence rates of opioid misuse among veterans, with rates ranging from 32.63% to 35.78%, compared to nonveteran rates, which range from 28.37% to 31.02%.

The data shows consistently higher prevalence rates of opioid misuse among veterans, with rates ranging from 32.63% to 35.78%, compared to nonveteran rates, which range from 28.37% to 31.02%. The Cahaba catchment area had the highest veteran prevalence (35.79%), while Riverbend had the lowest (32.63%). Similarly, nonveteran misuse rates are highest in the Northwest (31.02%) and lowest in Carastar (28.37%).

ILLICIT DRUG USE

Within the NSDUH, illicit drug use includes reported use of cocaine (including crack), heroin, hallucinogens, inhalants, methamphetamine, or prescription psychotherapeutics that were misused. Misuse of prescription psychotherapeutics include drugs such as pain relievers, tranquilizers, stimulants, and sedatives that have been taken outside of how the medication was prescribed.

Across Alabama, veteran status is positively associated with illicit drug use; suggesting that veterans may have a slightly higher risk of engaging in illicit drug use compared to nonveterans. There are other socio-economic and geographical variables of illicit drug use across the counties. The results indicate that older age is significantly associated with a lower likelihood of illicit drug use while male sex is not a significant predictor. Racial differences show that Black and Other racial groups have slightly lower, though not statistically significant, likelihoods of illicit drug use compared to White individuals.

As with other prevalence categories, individuals living in rural and suburban areas have marginally higher probabilities of illicit drug use compared to those in urban areas.

As with other prevalence categories, individuals living in rural and suburban areas have marginally higher probabilities of illicit drug use compared to those in urban areas. Overall, age and veteran status were the most significant predictors in this model. Across the catchment areas, the data reveals minimal differences between the two groups, with veteran prevalence rates ranging from 3.84% in Riverbend to 4.28% in West Alabama, and nonveteran rates ranging from 3.87% in Wellstone to 4.29% in Mountain Lakes and North Central. In most catchment areas, the prevalence rates differ by less than 0.2 percentage points. Notably, JBS and Wellstone are among the few areas where veterans exhibit slightly higher prevalence rates than nonveterans.

PREVALENCE RATES BY CATCHMENT AREA: VETERANS VS. NONVETERANS

CATCHMENT AREAS	Alcohol Misuse		Tobacco Use	
	VETERANS	NONVETERANS	VETERANS	NONVETERANS
Altapointe I	8.76	7.91	36.06	31.60
Altapointe II	9.26	8.32	31.34	28.67
Cahaba	8.20	8.59	36.06	27.89
Carastar	9.54	9.03	32.61	25.98
Central Alabama Wellness	9.80	7.63	29.61	31.61
CED	9.58	7.51	29.96	30.20
East Alabama	9.89	8.74	29.23	28.16
East Central	9.04	8.44	32.89	29.61
Highland	9.05	8.84	33.07	28.69
Indian Rivers	9.11	8.32	34.76	28.93
JBS	9.85	7.74	31.42	28.66
Mountain Lakes	9.76	8.95	32.54	28.41
North Central	10.27	8.83	32.11	28.76
Northwest	9.47	7.43	34.15	31.63
Riverbend	9.43	8.40	27.56	25.48
South Central	9.55	8.52	33.73	27.96
Southwest	9.13	8.85	32.18	25.81
Spectracare	9.78	8.85	32.20	28.30
Wellstone	10.10	7.49	30.42	29.00
West Alabama	8.63	7.62	38.84	31.21
ENTIRE STATE	**9.41**	**8.30**	**32.54**	**28.83**

ALCOHOL MISUSE

Past year alcohol misuse was based on an NSDUH calculated index, borrowing from DSM-5 criteria for alcohol use disorder, from questions about the consumption of five or more drinks on one occasion and heavy consumption throughout the week.

Within the report, there are several significant factors influencing the likelihood of misuse. Age appears to be a protective factor, with individuals over 64 years being significantly less likely to misuse alcohol. Males, however, are more likely to misuse alcohol, and race also plays a significant role, with both Black and Other racial groups being less likely to misuse alcohol compared to White individuals. Finally, rurality has a modest effect, with individuals living in rural areas being less likely to misuse alcohol compared to their urban counterparts, while suburban residence does not significantly differ from urban residence in terms of alcohol misuse.

Although veteran status is associated with a slightly higher likelihood of alcohol misuse, this result is not statistically significant. Veterans generally have higher probabilities of alcohol misuse across all sub-populations compared to nonveterans. Among the veteran population, younger White males in urban areas show the highest probability of alcohol misuse with a gradual decrease in risk as the population becomes older, female, or lives in rural areas. However, veterans in rural areas consistently exhibit lower probabilities of misuse compared to their urban counterparts.

The geographic distribution of alcohol misuse among veterans and nonveterans in Alabama counties shows that veterans generally have higher rates of alcohol misuse compared to nonveterans across the state. For instance, in counties like Coffee (10.98% for veterans vs. 8.79% for nonveterans), Lee (10.56% vs. 9.29%), and Madison (10.43% vs. 8.98%), the difference is particularly noticeable, with veterans exhibiting misuse rates significantly higher than their nonveteran counterparts. However, there are also counties where the rates are more closely aligned or the veteran rates are slightly lower, such as Greene County (7.82%

for veterans vs. 6.25% for nonveterans) and Wilcox County (7.28% vs. 6.47%). Across CMHC catchment areas, veterans generally exhibit higher rates of alcohol misuse than nonveterans, with veteran prevalence rates ranging from 8.63% in West Alabama to 10.27% in North Central. In contrast, nonveteran rates are consistently lower, ranging from 7.43% in Northwest to 8.59% in Cahaba. The greatest disparities between veteran and nonveteran rates are observed in areas such as Central Alabama Wellness and Wellstone, where veterans report significantly higher levels of alcohol misuse.

Although veteran status is associated with a slightly higher likelihood of alcohol misuse, this result is not statistically significant.

Veterans are more likely to use tobacco than nonveterans.

TOBACCO USE

Past year tobacco use was based on an NSDUH calculated index which combined responses on questions about cigarette use, cigar use, pipe use, or smokeless tobacco use. Overall, across Alabama, there are several significant predictors associated with tobacco use. Age over 64 years is associated with a significant decrease in tobacco use, indicating that older individuals are less likely to use tobacco compared to younger individuals. Male sex is a significant positive predictor of tobacco use, suggesting that men are more likely to use tobacco than women. Race also plays a role in predicting tobacco use, with the "Other" racial category showing a significant negative association as compared to the reference category, White. Geographic factors also influence tobacco use, with individuals living in suburban and rural areas more likely to use tobacco compared to those in urban areas.

Veterans are more likely to use tobacco than nonveterans. The predicted probabilities of tobacco use across different sub-populations reveal notable variations between veterans and nonveterans, as well as across urban, suburban, and rural settings. For both veterans and nonveterans, tobacco use is generally higher among younger individuals and those who identify as White or Black compared to other racial groups. Specifically, younger White and Black males show higher probabilities of tobacco use across all settings, with rural areas exhibiting the highest probabilities. For instance, White males under 65 years old have the highest predicted probabilities of tobacco use in rural settings while the probabilities decrease with age and in suburban and urban areas.

The data indicates that location and age significantly impact tobacco use, with rural settings and younger age groups being associated with higher predicted probabilities of tobacco use, particularly among veterans. Across Alabama catchment areas, the data show higher tobacco use among veterans in most areas, with rates ranging from 27.56% in Riverbend to 38.84% in West Alabama. Nonveteran prevalence is consistently lower, ranging from 25.48% in Riverbend to 31.63% in Northwest and Central Alabama Wellness. The largest disparity is observed in Cahaba, where the veteran prevalence is 36.06%, compared to 27.89% for nonveterans. Notably, in Central Alabama Wellness and CED, nonveterans exhibit slightly higher tobacco use rates than veterans, suggesting local variations in usage patterns.

State Status: Serving Veterans

STATE STATUS: SERVING VETERANS

In *State Status: Serving Veterans*, the highlights from the respective parts of the *Alabama Veteran Behavioral Landscape Report* can be found. First, the highlights of the *Prevalence Report* are organized according to behavioral health categories: mental illness and distress, suicidal ideation or planning, opioid use, illicit drug use, alcohol misuse, and tobacco use. Next, there is an overview of the organization and analysis of services across the state on three levels: across the state as a whole, across regions within the state, and finally, at a county level. This overview includes the frequencies for state and federally funded services such as those provided by ADMH, ADVA, and the VA; and those provided by the individual communities.

PREVALENCE REPORT HIGHLIGHTS

MENTAL ILLNESS & DISTRESS

- Results showed that veterans were more likely than nonveterans to report SMI, even after controlling for the demographic variables.
- Veterans consistently showed higher probabilities of SMI with SUD compared to nonveterans across all subgroups and geographic settings.
- Though slightly higher, across Alabama, veterans did not show a significant difference in distress levels compared to nonveterans

SUICIDAL IDEATION OR PLANNING

- Regarding veteran status, veterans displayed slightly higher probabilities of SI/P than nonveterans across most subgroups.
- White females under 65 show the highest probabilities, with suburban areas having the largest values.

OPIOID MISUSE

- In all Alabama counties, opioid misuse rates are higher among veterans than nonveterans.
- Probabilities are notably higher in rural areas for both veterans and nonveterans, with older females across all racial categories exhibiting the highest risk.

ILLICIT DRUG USE

- Generally on par with nonveterans
- Younger White male veterans (<65 years) living in rural areas have the highest predicted probability of compared to their non-veteran counterparts. The likelihood of IDU tapers as the individual ages with older White female nonveterans in rural areas having the lowest predicted probability of use.

ALCOHOL MISUSE

- Generally higher rates of alcohol misuse compared to nonveterans
- There were large discrepancies in the difference between veteran and nonveteran alcohol misuse across the state. At times, the percentage of use between the two was very large, and at others it was barely noticeable.

TOBACCO USE

- Generally higher rates of tobacco use compared to nonveterans
- Rural and less populated areas displayed elevated tobacco use rates among veterans. In contrast, urban counties have relatively lower tobacco use rates for both veterans and nonveterans.

STATE & FEDERALLY FUNDED RESOURCES

Recorded state and/or federally funded resources are categorized as:

1. Mental Health Clinical Services
2. Substance Use Clinical Services
3. Veteran Services

The majority of the service data collected is from ADMH and ADVA; however, when applicable, services provided by the VA were also recorded. All VA services were recorded in "Veteran Services" as they are veteran specific versus veteran informed. Though the VA definition of "veteran" often excludes those who have served in the Reserves or National Guard, services that were veteran only were organized into the "Veteran Service" category.

MENTAL HEALTH SERVICES	SUBSTANCE USE SERVICES	VETERAN SERVICES
STATE TOTAL **3,329**	STATE TOTAL **3,284**	STATE TOTAL **902**
COUNTY AVERAGE **50**	COUNTY AVERAGE **49**	COUNTY AVERAGE **14**

COMMUNITY RESOURCES	VETERAN SPECIFIC COMMUNITY RESOURCES
STATE TOTAL **5,064**	STATE TOTAL **1,165**
COUNTY AVERAGE **76**	COUNTY AVERAGE **17**

MENTAL HEALTH & SUBSTANCE USE SERVICES

The mental health (MH) and substance use (SU) services listed above are available in all 67 counties and are required to be accessible by the community. *Accessible* within MH and SU services mean that they are reachable 24/7/365 for acute mental health and substance use needs. Walk-in appointments, crisis intervention services, and assessments are available during traditional business hours at outpatient centers and round-the-clock at both the five crisis centers across the state and through twelve statewide mobile crisis teams. All sixty-seven counties are connected with the five crisis centers, enabling any Alabamian to receive appropriate mental health and/or substance use care at any time. Though these are statewide services, services provided by the crisis centers were only recorded and designated to the county in which the primary center was located. For example, though the Altapointe II Crisis Center serves multiple counties, the services provided by the center were only attributed to Mobile County.

Across the 380 programs, data was driven by the program type. These programs provide anywhere from one to twenty-two individual services depending on the type and purpose of the program. MH/SU services also include the 988-crisis line and 311 community resource connection lines. In total, there were 6,613 MH/SU services recorded across the state, averaging 99 per county. Of the twenty catchment areas explored in this report, twelve of these catchment areas were considered served above their average population compared to the rest of the state. These twelve catchment areas were comprised of a total of 44 counties. An additional two counties were deemed to be served appropriately, meaning that the ratio of MH/SU services provided in the area to the population was at or around 1:1.

In catchment areas where the ratio of services to population was less than 1:1, these areas were labeled as having service availability that was below their average population. There were six catchment areas that fell into this category, or seventeen counties across the state, total. Of these six below average MH/SU service areas, most were the more largely populated catchment areas including those that house Mobile, Jefferson, Madison, Montgomery, and Shelby counties. The only exception to this is the five-county catchment area of North Central, which houses five, sparsely populated counties just north of Tuscaloosa County.

CATCHMENT MH/SU RESOURCE RATIO

$$\frac{\text{CATCHMENT AREA'S TOTAL NUMBER OF MH/SU SERVICES}}{\text{STATE OF ALABAMA'S AVERAGE NUMBER OF MH/SU SERVICES PER COUNTY TIMES THE NUMBER OF COUNTIES IN THE CATCHMENT AREA}} \bullet \frac{\text{CATCHMENT AREA'S TOTAL POPULATION}}{\text{STATE OF ALABAMA'S AVERAGE AVERAGE POPULATION PER COUNTY TIMES THE NUMBER OF COUNTIES IN THE CATCHMENT AREA}}$$

VETERAN SERVICES

Veteran services included services that were provided by the ADVA and/or the VA across the state. ADVA has offices in sixty-one counties. Within these counties, the Veteran Service Officer (VSO) was recorded as providing five distinct services, including: benefits navigation, mental health case management, social service case management, homelessness prevention, and education, coaching, and/or

mentoring. Further details of what each of these services entail can be found in the *Definitions of Common Community Resources in Appendix 3*. The designation of these services was given to any county where a VSO was located, regardless of the hours or full-time status of the VSO in the county. In addition, ADVA was given credit for services provided by the Alabama Veteran Homes, which provided fourteen distinct services to those who engage with the Homes.

In addition to services provided through VSO offices, many counties have a VA presence of varying intensity. When a VA Medical Center, Veteran Center, and/or Community-based Outpatient Clinic was located in a county, there was a specific number of services recorded ranging from fourteen services (Community-based Outpatient Clinics) to sixty-three (Medical Centers). These services—like those of the VSO offices and statewide MH/SU services—were only recorded in the county in which the organization was located. For example, though the Tuscaloosa VA Medical Center serves veterans from across West Alabama and the state, those sixty-three services were only recorded in Tuscaloosa County.

Across Alabama's counties, there were a total of 920 specific veteran services that are state and federally funded recorded. This averages to just under fourteen per county. Across the twenty catchment areas explored in this report, eight of the catchment areas were designated as having above average veteran services as compared to the area's population, and an additional three were designated as having a number of state and federally funded services that were *on par* with the area's population. These were the catchment areas that—when calculated—had at or above a 1:1 average of total veteran services in the catchment area over the average number of veteran services for a catchment area of that size compared to population. Any catchment area where this ratio of veteran services to population calculated to less than 1:1 was designated as having below average veteran services. Of the nine catchment areas that were designated as below average, six had some degree of VA presence in the area, but there were other factors that skewed this ratio. The first consideration was that in a handful of these catchment areas, the population was so large that the services did not calculate as equal to the population of the area. This is the case in Altapointe II (Mobile) and Wellstone (Madison). In other locations, there is a strong ADVA/VA presence in one county, but the other counties in the catchment area had few to no state or federally funded veteran service presence in the area. This is the case with the Riverbend catchment area (Colbert, Franklin, and Lauderdale counties). In Riverbend, there are a total of twenty-four veteran services recorded—ten attributed to ADVA by the VSO offices in Lauderdale and Franklin counties, and fourteen attributed to the VA Community-based Outpatient Clinic in Colbert County. There is not a VSO office in Colbert County, as all Colbert County veterans are directed to the VSO in Florence. Despite the VA presence, the three-county catchment area has a ratio of 7:10—meaning that based on population, Riverbend only has 70% of the average veteran services available to an area of this size across the state.

COMMUNITY RESOURCES

Across the state, there are a number of organizations—both government organizations and community resources—serving veteran populations, specifically. Organizations with a presence in multiple counties throughout the state, and the general services they likely provide to veteran populations are listed below. Within the twenty catchment areas across the state, these organizations are recorded as "veteran specific community resource services."

As previously mentioned, services provided through ADVA are included in the state and twenty catchment reports within the *State and Federally Funded Services: Total Number of Veteran Services*. Statewide veteran specific community resources are services provided by non-profit and/or volunteer groups based in respective communities. These services do not include services already recorded and reported in the *State and Federally Funded Services* section of the report

STATEWIDE VETERAN SPECIFIC COMMUNITY RESOURCES

In Alphabetical Order

American Legion

Each American Legion Post across the state was recorded as providing the area within which it is located with two individual services: (1) groups (non-therapeutic); and (2) education, coaching, and/or mentoring.

College System of Alabama

Across the State of Alabama, there are approximately forty public community, junior, and four-year universities. At each public college, there are offices to assist enrolled veterans with specific services and provide support to veterans and their dependents as they navigate higher education opportunities. Within the communities where these colleges are situated, four individual services were recorded as being provided to veterans in the area: education, coaching, and/or mentoring; benefit navigation; mental health case management; groups (non-therapeutic); and social service case management.

Disabled American Veterans (DAV)

The DAV has over thirty chapters across four districts within the state. Though each chapter operates with minute differences, all DAV locations were recorded as providing seven individual services to veterans within the county within which they are situated. These services included: transportation, food assistance, legal aid, homelessness prevention, groups (non-therapeutic), utility aid and benefit navigation.

Priority Veteran

Priority Veteran is an intensive case management program to specifically assist veterans access mental health resources, manage finances well, and avert homelessness. Priority Veteran serves 65 of the 67 counties in Alabama with the exception of Baldwin and Mobile counties. Within the counties Priority Veteran serves, the following six services were recorded as veteran specific resource services: mental health case management; social service case management; clothing; home items; homelessness prevention; and education, coaching, and/or mentoring.

Veterans of Foreign Wars (VFW)

The VFW has over sixty posts across Alabama. In the communities where each of these posts are located, the following four services were recorded as veteran specific community resources: groups (non-therapeutic), family support, benefit navigation, and transportation.

COMMUNITY RESOURCE RESULTS

In all, there were over 5,000 community resource services recorded across the state. Of these 5,000, the category with the highest frequency of services,

or those categories with at or more than 400 recorded services across the state, included: homeless prevention (486), case management services (627), senior services (400), food assistance (523), non-therapeutic groups (468), and education, wellness, and/or coaching services (391). Those with the least number of attributed services, or around 50 services recorded across the state, were medical and dental services (51), women's resources (61), and crisis stabilization services (66). It is important to note that the crisis stabilization services captured in this section of the report are services that are offered free-of-charge to the community through community organizations, or organizations that are provided outside of state agencies (such as community behavioral centers and hospitals). Instead, here, crisis stabilization captures emergency relief, domestic violence, and human trafficking services. Complete definitions for each of the eighteen community resource categories can be found in *Appendix 3*. If a service serves the entire state—such as the Wellhouse in Birmingham, a human trafficking rehabilitation and support center—the services may have only been captured in one county (here, Jefferson). Overall, the less populated the catchment area, the less community resources there were, and the less variety the multi-county catchment area would have.

For example, in the catchment area of JBS (Jefferson, Blount, and St. Clair counties)—the largest catchment area in the state—there were a total of 517 community resources recorded. For JBS, across the eighteen community resource categories, the frequency of the services ranged from two (women resources) to eighty-six (case management), and the average was 28 services per category. However, in one of the lesser populated three-county catchment areas, CED (Cherokee, DeKalb, and Etowah counties) with a population that is one-fourth of that of JBS, there are a total of 245 services recorded. Though the total of community resource services recorded in CED is just under half that recorded in JBS, the range varies more. There are four services that have less than five opportunities for engagement recorded, and these are on par with the lowest frequency services across the state: (1) medical and dental services; (2) women's resources; (3) healthcare and prescription payment assistance; and (4) crisis stabilization; and the services range in frequency from one service offered to forty-five services offered with an average of 13.5 services per community resource category. This pattern in CED's catchment area is one that is repeated across the state.

Overall, of the twenty catchment areas explored across the state, thirteen of the areas came in at above average as compared to the area population for the total number of community resources available. This means in the State of Alabama, there are 48 counties who have community services that average higher than their population average. This number was found by comparing the ratio of the number of community resources available in the area to the average number across the state per county compared to the catchment area's population compared to that of the state:

CATCHMENT COMMUNITY RESOURCE RATIO

$$\frac{\text{CATCHMENT AREA'S TOTAL NUMBER OF COMMUNITY RESOURCES}}{\text{STATE OF ALABAMA'S AVERAGE NUMBER OF COMMUNITY RESOURCES PER COUNTY TIMES THE NUMBER OF COUNTIES IN THE CATCHMENT AREA}} \bullet \bullet \frac{\text{CATCHMENT AREA'S TOTAL POPULATION}}{\text{STATE OF ALABAMA'S AVERAGE AVERAGE POPULATION PER COUNTY TIMES THE NUMBER OF COUNTIES IN THE CATCHMENT AREA}}$$

Of the remaining seven catchment areas, two had community service resource numbers that were on par with the area's population. This means that the ratio above was at or close to 1:1. The remaining five catchment areas had community resource numbers that fell below the area's average population. Of note regarding the below average community resourced catchment areas: these were most often the largest populated areas with a high number of community resources; however, the ratio was frequently less than 1:1. Three of these areas included Altapointe II which includes Mobile and Baldwin counties; JBS with Jefferson; and Wellstone with Madison.

Veteran specific community resources were derived in the same way that community resource services were. These community resources specifically stated that they served, gave preferential treatment to, or had specific programs for veterans. Very rarely did the community resource specify a VA or non-VA definition of veteran.

Of the twenty catchment areas across the state, eleven had veteran specific community resource numbers that exceeded the area's average population and two catchment areas were *on par*. Seven of these catchment areas were determined to have veteran specific resource numbers that fell below the population average for the area. Of these seven, four of the catchment areas also had VA medical centers, and five of the catchment areas had additional state and federally funded veteran services in addition to those provided by ADVA through VSO offices. It seems that the larger the presence of the VA in an area, the less likely that there will be a high frequency of community-based veteran services. This is logical as community-based services are usually created out of community need, and the community may not perceive a need for additional services to veterans if there is a widespread VA presence in the area.

CONCLUSION

Overall, approximately half of the counties across the state exceeded their average populations across all four service categories:

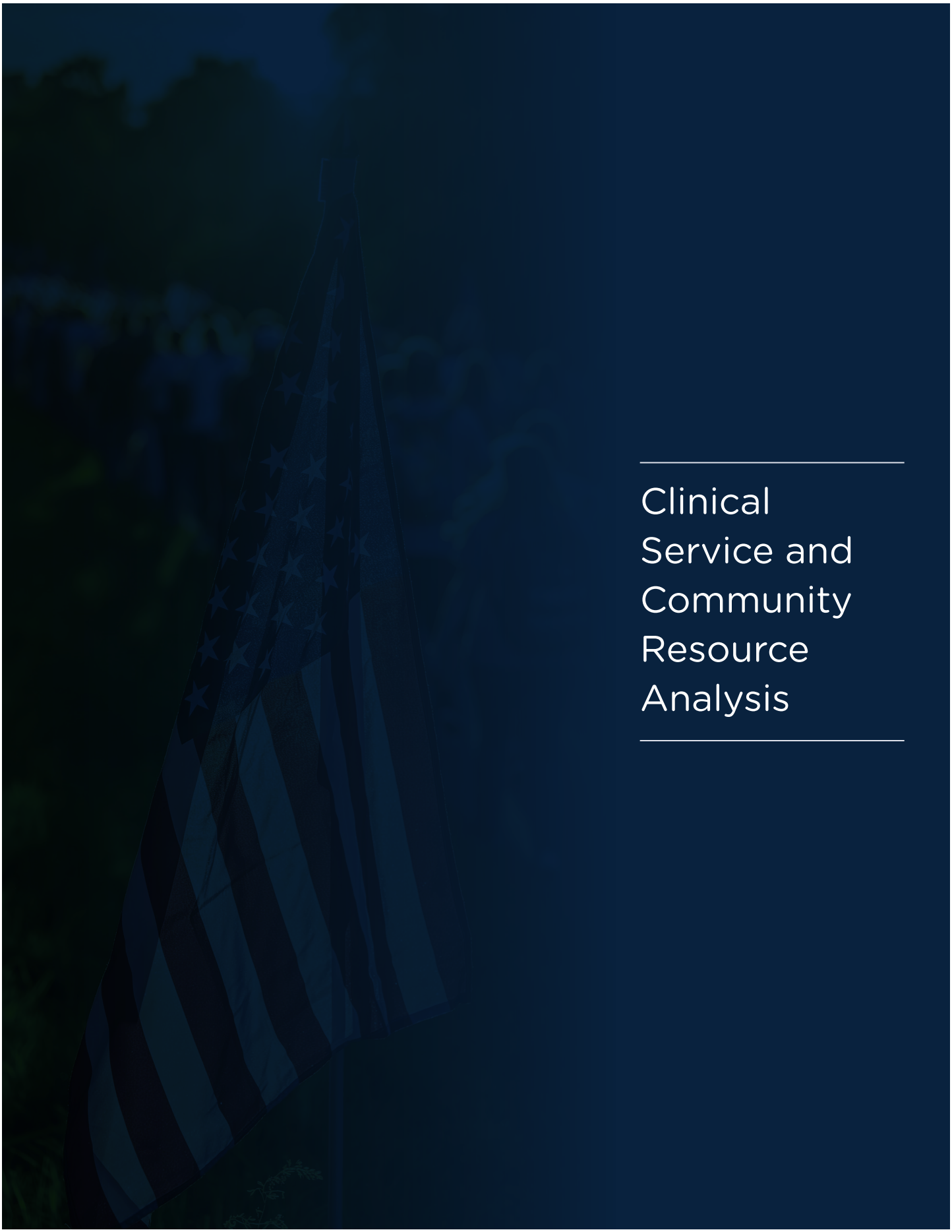
- *State and Federally Funded MH/SU Services: 66%*
- *State and Federally Funded Veteran Services: 48%*
- *Local Community Resource Services: 72%*
- *Local Veteran Specific Community Resource Services: 62%*

	COUNTIES THAT EXCEED POPULATION AVERAGE	*COUNTIES THAT FALL BELOW POPULATION AVERAGE*	*COUNTIES THAT ARE ON PAR WITH POPULATION AVERAGE*
STATE & FEDERALLY FUNDED			
MH/SU SERVICES	44 (66%)	6 (9%)	17 (25%)
VETERAN SERVICES	32 (48%)	25 (37%)	10 (15%)
LOCALLY FUNDED			
COMMUNITY RESOURCE SERVICES	48 (72%)	12 (18%)	7 (10%)
VETERAN SPECIFIC COMMMUNITY RESOURCE SERVICES	41 (62%)	8 (12%)	18 (27%)

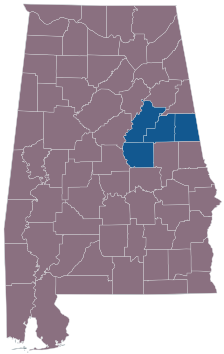
The average percentage of counties that exceeded the population average of the area across the four service areas was 62%—meaning that approximately 41 of the 67 counties in Alabama had a service to population ration that was greater than 1:1. When including the counties where the services numbers recorded were on par with the population, that percentage goes up to 81%—or 54 of the 67 Alabama counties.

Earlier in the report, the average number for all four service categories was reported. For MH/SU services, there were 99 on average per county. With this in mind, think of the population of Etowah County: 103,434—or 137% the state average. For Etowah County to be considered "above average according to population," the percentage of services for the county would have had to equate 137% of the state average for each of the four service categories, respectively. Whatmore, Etowah County is organized into the ADMH CMHC catchment area, CED, which also includes Cherokee and DeKalb counties—two counties with lower populations than Etowah. Overall, the CED catchment area has an average population of 200,000, or a population that is 88% of the average population for a three-county catchment area in the state. This means that if the number of services in any category was compared to this population percentage: 88%. CED had above average population ratios in total MH/SU, Community Resources, and Veteran Specific Community Resources; and below average population ratio in Total State and Federally Funded Veteran Services. To address nuances such as these, each individual region was given a dedicated section with a corresponding in-depth narrative within the Clinical Service and Community Resource Analysis.

It is also important to remember the purpose of the *Alabama Veteran Behavioral Landscape Report* is to provide an overall status report of services for Alabama's veterans in light of the prevalence of specific behavioral health and substance use needs that may exist. If solely going by the population of the twenty catchment areas, four out of five counties in Alabama would be assumed to be served according to their population. This conclusion would be irresponsible as it discounts the limitations of this report. As previously stated, the report does not include data regarding the quality, accessibility, and/or populations of veterans served across all services recorded. Further studies would be needed to draw conclusions regarding these elements of veteran services in Alabama. However, it is clear that there are numerous mental health, support, and community resource services available to Alabama's veterans across the state. The next step would be to ensure that these services are accessible to any veteran, anywhere, and everywhere in the state.



Clinical Service and Community Resource Analysis



ALTAPOINTE I:
CLAY, COOSA, RANDOLPH AND TALLADEGA

TOTAL NUMBER OF VETERANS: **7,140**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **greater than average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **greater than average** offered across the state

KEY POINTS

- Over 3,600 veterans in these four counties aged 55 or over—approximately 51% of the total veteran population.
- 20% of all community resources are veteran specific/provided by veteran support organizations.
- Talladega: 19th in the state for population, 23rd for total number of veterans
- Clay: 56th in the state for population, 56th for total number of veterans
- Randolph: 45th in the state for population, 50th for total number of veterans
- Coosa: 63rd in the state for population, 57th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

136	123	34
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

192 COMMUNITY RESOURCE SERVICES

39 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 10 ORGANIZATIONS

DISABILITY SERVICES	28	*EDUCATION, WELLNESS, AND/OR COACHING SERVICES*	12
SENIOR SERVICES	27	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	5
GROUPS	20	*TRANSPORTATION AND CAR SUPPORT*	4
HOMELESSNESS PREVENTION	19	*FAMILY SERVICES*	4
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	16	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	3
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	16	*WOMEN RESOURCES*	3
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	16	*CLOTHING*	2
FOOD ASSISTANCE	13	*CRISIS STABILIZATION*	2
UTILITIES AND FINANCIAL AID	13	*MEDICAL AND DENTAL SERVICES*	2

ALTAPOINTE I SERVICES COMPARED TO THE STATE

RATES IN ALTAPOINTE I

	VETERANS	NON VETERANS
Psychological Distress	7.67	10.71
Serious Mental Illness	3.52	3.17
Co-Morbid SMI/SUD	0.77	0.38
Suicidal Ideation/ Planning	4.34	5.99
Opioid Misuse	35.13	30.63
Illicit Drug Use	4.22	4.24
Alcohol Misuse	8.76	7.91
Tobacco Use	36.06	31.60

VETERAN SPECIFIC SERVICES:

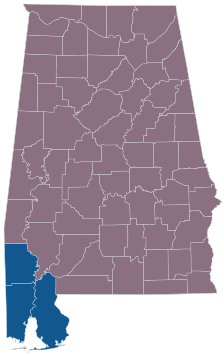
1. American Legion
   5 Posts
2. Disabled Veterans of America
   1 Chapter
3. Veterans of Foreign Wars
   1 Post
4. Priority Veteran
5. Southern Union Community College
6. Samson's Strength

In the Altapointe I catchment area of Clay, Coosa, Randolph and Talladega counties, the number of available state-funded MH/SU services fell below the state average at 259 total services available versus the state average of 396 total for a four-county area (65%). According to the 2020 census, the population of the four counties in the Altapointe I catchment area is just over 128,000—averaging 32,000 per county with a high of 82,000 in Talladega County and a low of 10,000 in Coosa County.

The number of veterans in the Altapointe I catchment area 7,140. The number of veterans in Clay, Coosa, Randolph, and Talladega counties averaged 1,785 per county with a high of 4,700+ veterans in Talladega County and approximately 700 veterans recorded in Clay and Coosa counties. This was approximately one-fourth the state average of 4,927 veterans per county. Both the catchment area's population and veteran population were significantly below the state average—43% of the total average state population, and 36% the average number of veterans per county. Overall, the counties in Altapointe I were consistent in the ratio of the county's ranking of total number of veterans to total county population.

In the area, there were a notable number of services available in the community for seniors and persons with disabilities. There was also a notable trend of community resource support that could aid a veteran in the prevention of homelessness, including: utility, financial aid, and mental health support. The Altapointe I catchment area is strong in the number of substance use groups—one of the primary modes of substance use prevention and recovery maintenance. According to the US Census data from 2020, the majority of the veterans in the four counties are over the age of 55. Because of this, the high prevalence of senior services is a strength of the catchment area.

Within Altapointe I, the veteran specific services are provided largely by common statewide veteran organizations. These veteran specific services include one DAV Chapter, five American Legion Posts, services provided by United Way's Priority Veteran program, and services provided by one community college. One unique veteran specific organization in the catchment area is Samson's Strength in Clay County, AL. Samson's Strength provides group support and connection to veterans in addition to homelessness prevention, housing, and transitional services and case management services.



ALTAPOINTE II:
WASHINGTON, BALDWIN, & MOBILE

TOTAL NUMBER OF VETERANS: **47,763**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **less than average** offered across the state

state-funded ADVA/VA services offered is **less than average** offered across the sate

community resource services offered is **less than average** offered across the state

veteran specific community resource services offered is **less than average** offered across the state

KEY POINTS

- One-third of all community resources are provided by veteran specific community organizations.
- Seven community resource categories tout 25+ services
- Baldwin: 4th in the state for population; 4th for total number of veterans
- Mobile: 2nd in the state for population; 3rd for total number of veterans
- Washington: 53rd in the state for population; 55th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

205	283	68
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

368 COMMUNITY RESOURCE SERVICES

114 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 28 ORGANIZATIONS

HOMELESSNESS PREVENTION	47	*TRANSPORTATION AND CAR SUPPORT*	16
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	43	*UTILITIES AND FINANCIAL AID*	15
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	38	*FAMILY SERVICES*	13
GROUPS	37	*HOME REPAIR, HOME ITEMS, ETC.*	10
JOB SUPPORT, TRAINING, AND/OR TRANSITION	34	*MEDICAL AND DENTAL SERVICES*	6
FOOD ASSISTANCE	32	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	5
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	27	*CLOTHING*	4
DISABILITY SERVICES	18	*CRISIS STABILIZATION*	3
SENIOR SERVICES	17	*WOMEN RESOURCES*	3

ALTAPOINTE II: STATE STATUS

RATES IN ALTAPOINTE II

	VETERANS	NON VETERANS
Psychological Distress	7.10	10.64
Serious Mental Illness	3.05	3.22
Co-Morbid SMI/SUD	0.79	0.42
Suicidal Ideation/ Planning	3.84	5.79
Opioid Misuse	33.74	29.65
Illicit Drug Use	4.00	4.15
Alcohol Misuse	9.26	8.32
Tobacco Use	31.34	28.67

VETERAN SPECIFIC SERVICES:

1. American Legion
   9 Posts
2. Disabled Veterans of America
   3 Chapters
3. Veterans of Foreign Wars
   6 Posts
4. Priority Veteran, Washington County
5. University of South Alabama
6. Bishop State Community College
7. Coastal Alabama Community College
8. Remington College, Mobile
9. Vets Recover
10. Supportive Services for Veterans and their Families
11. Housing First
12. The Veterans Closet
13. South Alabama Veterans Council
14. Eagle's Landing

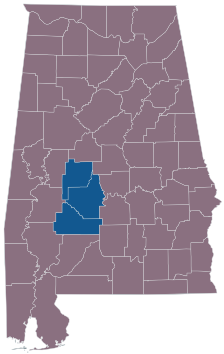
In the Altapointe II catchment area of Baldwin, Mobile, and Washington counties, the number of available state-funded MH and SU services superseded the state average at 488 total services available to the community versus the state average of 297 total for a three-county area (164%). According to the 2020 census, the population of the three counties in the Altapointe II catchment area is one of the largest in the state at 661,996—with a high of 414,809 in Mobile County and a low of 15,389 in Washington County. Washington County has 4% of the population of Mobile County. Because of this, the catchment area has a diverse population demographic. The majority of both the state/federal funded services and the community based resources in Altapointe II fell outside of Washington County.

The number of veterans in the Altapointe II catchment area is 47,763. The number of veterans in Baldwin, Mobile, and Washington counties averaged 15,901 per county with a high of 26,290 veterans in Mobile County and 733 veterans in Washington County. Overall, the counties in the Altapointe II catchment area were consistent in the ratio of the county's ranking of total number of veterans to total county population.

Altapointe II has a high number of state and federally funded veteran services for a three-county area. In Altapointe II, 68 total veteran services were recorded as opposed to the state average of 42 services per three-county area. Of the 68 services, five were located in Washington County—a VSO office open two days a week. Despite the hours of the office, the full five services were attributed to the county. The remaining 63 services were attributed to a combination of the VA and ADVA services across one veteran home, one VA Vet Center, and one VA Community-based Outpatient Clinic.

Regarding community-based services there were 114 services recorded across twenty-nine veteran specific organizations in the Altapointe II catchment area. Of these services, 83 were provided by statewide veteran agencies such as American Legion Posts, DAV Chapters, and VFW Posts; however thirty-one of the services were provided by Altapointe II-specific organizations such as Eagle's Landing, Vets Recover, The Veterans Closet and the South Alabama Veterans Council. In Altapointe II's area, Priority Veteran only serves Washington County.

The Altapointe II catchment area boasts four higher education institutions including the University of South Alabama. In areas where a large university is located, it is likely that the number of services available to veterans is not accurately captured. This is due to the nature of the ever-evolving student efforts in the communities surrounding the university. This may be the case in Baldwin County, as it is the seat of the the University of South Alabama. Dates and current status of university programs varied, and therefore were excluded from the data set. Though these services were not recorded here, it is likely that Baldwin County and Altapointe II veterans can be supported through the university.



CAHABA:
DALLAS, PERRY, & WILCOX

TOTAL NUMBER OF VETERANS: **2,568**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **less than average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **greater than average** offered across the state

KEY POINTS

- The majority of the case management services in Cahaba were veteran or senior benefit navigation (7 of the 21 total).
- Population of area = 26% of state average | Clinical Service Numbers = 53% of the state average | Total Number of veterans: 17% of the state average per county
- Cahaba was strong in material needs support including the provision of food, clothing, and home items.
- Wilcox: 62nd in the state for population; 62nd for total number of veterans
- Dallas: 36th in the state for population; 31st for total number of veterans
- Perry: 67th in the state for population; 66th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

90	58	5
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

128 COMMUNITY RESOURCE SERVICES

28 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 7 ORGANIZATIONS

CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	21	*FAMILY SERVICES*	4
DISABILITY SERVICES	16	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	4
FOOD ASSISTANCE	16	*SUBSTANCE USE AND MENTAL HEALTH SUPPORT*	4
SENIOR SERVICES	16	*UTILITIES AND FINANCIAL AID*	4
GROUPS	10	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	3
HOMELESSNESS PREVENTION	9	*TRANSPORTATION AND CAR SUPPORT*	3
HOME REPAIR, HOME ITEMS, ETC.	6	*MEDICAL AND DENTAL SERVICES*	2
CLOTHING	4	*CRISIS STABILIZATION*	1
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	4	*WOMEN RESOURCES*	1

CAHABA: STATE STATUS

RATES IN CAHABA

	VETERANS	NON VETERANS
Psychological Distress	7.51	10.40
Serious Mental Illness	3.33	3.15
Co-Morbid SMI/SUD	1.03	0.46
Suicidal Ideation/ Planning	4.15	5.58
Opioid Misuse	35.79	29.23
Illicit Drug Use	4.05	4.11
Alcohol Misuse	8.20	8.59
Tobacco Use	36.06	27.89

VETERAN SPECIFIC SERVICES:

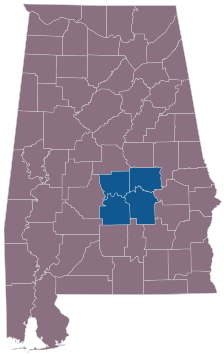
1. American Legion
   3 Posts
2. Disabled Veterans of America
   1 Post
3. Veterans of Foreign Wars
   1 Post
4. Marion Military Institute
5. Wallace State Community College, Selma

In the Cahaba catchment area of Wilcox, Perry, and Dallas counties, the number of available state-funded MH/SU services fell below the state average at 148 total services available to the community versus the state average of 297 total for a three-county region (50%). According to the 2020 census, the population of the three counties in the Cahaba catchment area is right at 57,000—averaging 19,000 per county with a high of 38,458 in Dallas County and a low of 8,513 in Perry County. The average population of the counties is approximately 26% of the average population per county for the state.

The number of veterans in the Cahaba catchment area is 2,568. This is one-half the average population per county across the state. The number of veterans in Wilcox, Perry, and Dallas counties averaged 856 per county with a high of 1,800+ veterans in Dallas County and 244 veterans recorded in Perry County. This was approximately 17% of the state average of 4,927 veterans per county. Both the catchment area's population and veteran population were significantly below the state average—26% of the total average state population, and 17% the average number of veterans per county. At the same point, the counties in the Cahaba catchment area were consistent in the ratio of the county's ranking of total number of veterans to total county population.

In the area, there were a notable number of services available in the community for the provision of material and vital goods including food, clothing, and home items. There was also a higher frequency of community resource supports that could aid a veteran in the prevention of homelessness, such as a high number of case management services. The Cahaba catchment area is strong in the number of available case management services—including veteran benefit navigation, mental health case management, medical and social services case management services. This translates into available services in the Cahaba catchment area for veterans to have the opportunity for professional support through all phases of treatment: from prevention to assessment and diagnosis, through recovery phases. In rural areas where transportation and frequency of service availability may be lower, case management support is a welcome service as individuals contemplate how to prevent, begin, and/or maintain recovery journeys.

Within Cahaba, the veteran specific services are provided largely by common statewide veteran organizations. These veteran specific services include one DAV Chapter, one VFW Post, three American Legion Posts, services provided by one community college, and services provided by the Marion Military Institute. The Marion Military Institute (MMI) was given special consideration regarding services provided to veterans, and data for Cahaba reflected that MMI provided more services to veterans than a traditional public college.



CARASTAR:
AUTAUGA, ELMORE, LOWNDES, & MONTGOMERY

TOTAL NUMBER OF VETERANS: **27,039**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **less than average** offered across the state

state-funded ADVA/VA services offered is **greater than average** offered across the sate

community resource services offered is **on par with the average** offered across the state

veteran specific community resource services offered is **greater than average** offered across the state

KEY POINTS

- The majority of the case management services in the Carastar area were provided veteran or senior support services
- 64% of Montgomery County veterans are aged 55 years or older
- Montgomery: 24th in the state for population; 21st for total number of veterans
- Lowndes: 65th in the state for population; 64th for total number of veterans
- Autauga: 24thin the state for population; 21st for total number of veterans
- Elmore: 17th in the state for population; 14th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

268	145	124
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

401 COMMUNITY RESOURCE SERVICES

114 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 27 ORGANIZATIONS

CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	61	*UTILITIES AND FINANCIAL AID*	18
HOMELESSNESS PREVENTION	41	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	15
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	39	*TRANSPORTATION AND CAR SUPPORT*	14
SENIOR SERVICES	35	*WOMEN RESOURCES*	12
GROUPS	35	*CLOTHING*	9
FOOD ASSISTANCE	32	*HOME REPAIR, HOME ITEMS, ETC.*	9
DISABILITY SERVICES	26	*CRISIS STABILIZATION*	4
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	26	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	4
FAMILY SERVICES	18	*MEDICAL AND DENTAL SERVICES*	3

CARASTAR: STATE STATUS

RATES IN CARASTAR

	VETERANS	NON VETERANS
Psychological Distress	8.01	10.51
Serious Mental Illness	3.54	3.38
Co-Morbid SMI/SUD	0.89	0.45
Suicidal Ideation/ Planning	4.30	5.58
Opioid Misuse	33.90	28.37
Illicit Drug Use	4.13	4.11
Alcohol Misuse	9.54	9.03
Tobacco Use	32.61	25.98

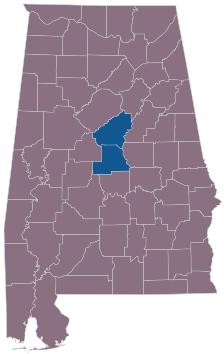
VETERAN SPECIFIC SERVICES:

1. American Legion Post
   13 locations
2. Disabled American Veterans
   3 Posts
3. Veterans of Foreign Wars
   1 Post
4. Alabama State University
5. Priority Veteran Montgomery
6. Priority Veteran Central Alabama
7. Auburn University at Montgomery
8. Trenholm State Community College
9. Pounds of Care
10. Engaging Recovery Support: PEERS Caring Home for Veterans

In the Carastar catchment area of Montgomery, Lowndes, Autauga, and Elmore counties, the number of available state-funded MH/SU services were on par with the state average at 413 total services available versus the state average of 396 total for a four-county region (104%). According to the 2020 census, the population of the four counties in the Carastar catchment area is right at 386,000—averaging 96,500 per county with a high of 228,952 in Montgomery County and a low of 10,321 in Lowndes County. The average population of the counties is approximately 128% of the average population per county for the state. If Montgomery is taken out of the equation—as the county's population is 2.5 times more than the next highest population—the remaining counties' in the catchment area population is approximately 70% of the average Alabama county population.

The number of veterans in the Carastar catchment area is 27,039. The number of veterans in Montgomery, Lowndes, Autauga and Elmore counties averaged 6,760 per county with a high of 15,300+ veterans in Montgomery County and approximately 450 veterans recorded in Lowndes County. This was approximately 1.3 times more than the state average of 4,927 veterans per county. Both the catchment area's population and veteran population were on par with one another.

A strength of the area was the number of state and federally funded veteran services, specifically those provided by the Montgomery VA. In addition to the VA Medical Center, Carastar's catchment area also houses a VA Vet Center, one VA Community-based Outpatient Clinic, homeless transition funding for projects such as Project Assistance in Transition from Homelessness (PATH), and a robust number of community resources that provide veteran specific services. The majority of the case management services in the Carastar community are provided by these veteran specific services including Priority Veteran and the area's education institutions. Additional group support is abundant across the area through both general community and veteran specific community resources. In the area, there were a twenty-seven substance use recovery groups in Montgomery County, alone, in addition to the non-therapeutic group support provided by the DAV, VFW, and American Legion. Of the 124 state or federally funded veteran services recorded, fifteen were attributed to the VSO offices in Montgomery, Autauga, and Elmore counties. Lowndes County is served through the Montgomery VSO office. The Montgomery office is open three days a week; despite this, all five services were attributed to the office. The remaining 184 services are provided through a combination of VA medical services, all located in Montgomery County.



CENTRAL ALABAMA WELLNESS (CAW): SHELBY & CHILTON

TOTAL NUMBER OF VETERANS: **13,846**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **less than average** offered across the state

state-funded ADVA/VA services offered is **less than average** offered across the sate

community resource services offered is **less than average** offered across the state

veteran specific community resource services offered is **less than average** offered across the state

KEY POINTS

- Shelby and Chilton counties have a high number of homeless prevention services for a two-county catchment area.
- Alabaster Veteran Center, Inc.: an add-on service to the Shelby County VSO office funded by the City of Alabaster and American Legion Post 138
- Shelby: 7th in the state for population; 6th for total number of veterans
- Chilton: 29th in the state for population; 37th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

96	126	10
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

237 COMMUNITY RESOURCE SERVICES

52 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 14 ORGANIZATIONS

FOOD ASSISTANCE	35	*UTILITIES AND FINANCIAL AID*	12
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	28	*HOME REPAIR, HOME ITEMS, ETC.*	11
GROUPS	25	*FAMILY SERVICES*	7
HOMELESSNESS PREVENTION	24	*CLOTHING*	6
TRANSPORTATION AND CAR SUPPORT	19	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	5
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	18	*CRISIS STABILIZATION*	4
DISABILITY SERVICES	12	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	3
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	12	*MEDICAL AND DENTAL SERVICES*	3
SENIOR SERVICES	12	*WOMEN RESOURCES*	1

CENTRAL ALABAMA WELLNESS: STATE STATUS

RATES IN CAW

	VETERANS	NON VETERANS
Psychological Distress	7.66	10.78
Serious Mental Illness	3.45	3.02
Co-Morbid SMI/SUD	0.73	0.38
Suicidal Ideation/ Planning	4.08	5.98
Opioid Misuse	32.88	30.93
Illicit Drug Use	4.06	4.17
Alcohol Misuse	9.80	7.63
Tobacco Use	29.61	31.61

VETERAN SPECIFIC SERVICES:

1. American Legion
   7 Posts
2. Disabled Veterans of America
   1 Post
3. Veterans of Foreign Wars
   1 Post
4. Priority Veteran Central Alabama
5. University of Montevallo
6. Three Hots & A Cot
7. Alabaster Veterans Center, INC
8. Central Alabama Veterans Collaborative

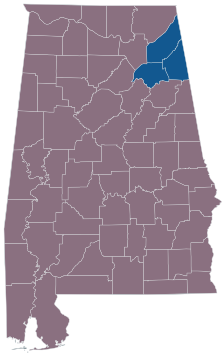
In the CAW catchment area of Shelby and Chilton counties, the number of available state-funded MH/SU services superseded the state average at 222 total services available to the community versus the state average of 198 total for a two-county region (112%). According to the 2020 census, the population of the two counties in the CAW catchment area is right at 268,049; however, the population of Shelby County is five times that of Chilton County (223,038 versus 45,011). The average population of Shelby County is three times the state average, and the population of Chilton County is approximately 60% of the state average.

The number of veterans in the CAW catchment area 13,846—with 12,047 veterans reported in Shelby County (87%) and 1,799 reported in Chilton County (13%). Together, the number of veterans in the two-county catchment area is 140% the average across the state. The catchment area houses approximately 5% of the state's total population and 4% of the state's veterans. Overall, the counties in CAW were consistent in the ratio of the county's ranking of total number of veterans to total county population.

In the area, there were a notable number of homeless prevention services. This is largely due to two veteran specific community resources in the area: Three Hots and a Cot and the Alabaster Veteran Center, Inc. The Alabaster Veteran Center, Inc., is housed in the same location in Shelby County as the VSO and funded through a collaborative effort between a local American Legion Post and the City of Alabaster. If this collaboration is successful, it may be a model of service connection that can be replicated throughout the state. These two organizations, when added to the efforts of Priority Veteran Central Alabama and the Central Alabama Veterans Collaborative, establish a strong support service foundation for veterans in the two counties. These four organizations comprise 23 of the 52 recorded veteran specific services offered in CAW's catchment area.

The area also has high numbers of recorded case management services. This translates into veterans in the CAW catchment area having the opportunity for professional support through all phases of treatment: from prevention to assessment and diagnosis, through recovery phases. In rural areas where transportation and frequency of service availability may be lower, and in more population-dense areas where starting or navigating treatment can be difficult, case management support is a welcome service as individuals contemplate how to prevent, begin, and/or maintain recovery journeys. This describes both Chilton County and Shelby County, respectively.

Within CAW, the veteran specific services are provided largely by a balanced mixture of statewide and local veteran organizations. These veteran specific services include one DAV Chapter, one VFW Post, seven American Legion Posts, services provided by one university, Priority Veteran, and services of three veteran-focused community resource organizations.



CED:
CHEROKEE, ETOWAH & DEKALB

TOTAL NUMBER OF VETERANS: **10,137**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **less than average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **greater than average** offered across the state

KEY POINTS

- High number of case management and group support community services.
- Eighteen veteran specific community resource organizations across the three counties
- DeKalb: 20th in the state for population; 25th for total number of veterans
- Etowah: 13th in the state for population; 18th for total number of veterans
- Cherokee: 41st in the state for population; 39th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

118	274	29
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

245 COMMUNITY RESOURCE SERVICES

60 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 18 ORGANIZATIONS

CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	45	*HOME REPAIR, HOME ITEMS, ETC.*	10
FOOD ASSISTANCE	24	*TRANSPORTATION AND CAR SUPPORT*	10
GROUPS	22	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	9
DISABILITY SERVICES	19	*CLOTHING*	8
SENIOR SERVICES	18	*FAMILY SERVICES*	8
UTILITIES AND FINANCIAL AID	18	*WOMEN RESOURCES*	3
HOMELESSNESS PREVENTION	17	*CRISIS STABILIZATION*	2
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	15	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	1
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	15	*MEDICAL AND DENTAL SERVICES*	1

CED: STATE STATUS

RATES IN CED

	VETERANS	NON VETERANS
Psychological Distress	7.35	10.20
Serious Mental Illness	3.35	2.72
Co-Morbid SMI/SUD	0.68	0.40
Suicidal Ideation/ Planning	3.97	5.58
Opioid Misuse	32.87	30.77
Illicit Drug Use	4.03	4.02
Alcohol Misuse	9.58	7.51
Tobacco Use	29.96	30.20

VETERAN SPECIFIC SERVICES:

1. American Legion
   7 Posts
2. Veterans of Foreign Wars
   5 Posts
3. Priority Veteran
4. Northeast Alabama Community College
5. Gadsden State Community College
6. Snead State Community College
7. Veteran Upward Bound, GSCC
8. Etowah Memorial Chapel

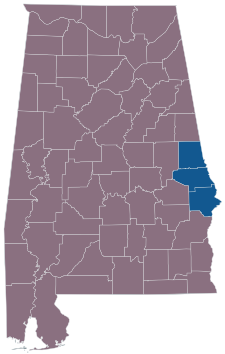
In the CED catchment area of DeKalb, Etowah, and Cherokee counties, the number of available state-funded MH/SU services superseded the state average at 392 total services available versus the state average of 297 total for a three-county area (131%). According to the 2020 census, the population of the three counties in the CED catchment area is right at 200,000. Overall, the average county population within the area is 89% of the average county population of the state (66,675 versus 75,000), with a high population of 71,617 in Etowah County and a low population of 24,973 in Cherokee.

The number of veterans in the CED catchment area is 10,137—with 3,209 veterans reported in DeKalb County (32%), 5,512 in Etowah County (54%), and 1,416 reported in Cherokee County (14%). Together, the number of veterans in the three-county catchment area is 69% the average of all counties across the state. Overall, the counties in the CED catchment area were consistent in the ratio of the county's ranking of total number of veterans to total county population.

In the area, there were a notable number of case management services. This translates into the veterans in the CED catchment area have the opportunity for professional support through all phases of treatment—from prevention to assessment and diagnosis, through recovery phases. In rural areas where transportation and frequency of service availability may be lower case management support is a welcome service as individuals contemplate how to prevent, begin, and/or maintain recovery journeys. According to the Alabama Rural Health Association, "rural" describes both DeKalb and Cherokee counties. Though Etowah County is more densely populated that the other counties in the CED catchment area, its population is ranked only thirteenth in the state whereas their veteran population is ranked eighteenth.

In addition to case management services, veteran specific community resource services also contributed to the higher number of homelessness prevention, groups, and education services in the area. Regarding the state and federally funded services, there were many more available SU services in the area than MH services, and the majority of veteran services were provided by the VA's community-based outpatient clinic in Gadsden (fourteen services total) with an additional fifteen services provided by the area's three ADVA offices.

In CED the majority of the veterans are aged 55 and over. For example, in Etowah County alone, over 3,600 or the 5,512 veterans housed here are over the age of 55—66% of the total veteran population. In CED, there are basic senior services provided by the East Alabama Regional Planning and Development Commission/Area Agency on Aging, and the Top of Alabama Council of Governments/Area Agency on Aging in the area; however fifteen of the fifty-two veteran specific community services were provided by colleges in the area, which are services less likely to be utilized by the older age demographics.



EAST ALABAMA:
CHAMBERS, LEE, RUSSELL, & TALLAPOOSA

TOTAL NUMBER OF VETERANS: **20,757**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **on par with the average** offered across the state

state-funded ADVA/VA services offered is **less than average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **greater than average** offered across the state

KEY POINTS

- High number of homelessness prevention services including two independent housing units for veterans in Lee County.
- Twenty-two veteran specific community resource organizations across the four counties
- In areas where a large university is located, it is likely that the number of services available to veterans may not be accurately captured. This is likely for Lee County and Auburn University.
- Lee County: 8th in the state for population; 8th for total number of veterans
- Chambers: 34th in the state for population; 33rd for total number of veterans
- Russell: 22nd in the state for population; 15th for total number of veterans
- Tallapoosa: 30th in the state for population; 29th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

211	198	34
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

363 COMMUNITY RESOURCE SERVICES

90 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 22 ORGANIZATIONS

CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	50	*TRANSPORTATION AND CAR SUPPORT*	17
FOOD ASSISTANCE	45	*CLOTHING*	16
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	31	*UTILITIES AND FINANCIAL AID*	10
HOMELESSNESS PREVENTION	31	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	9
DISABILITY SERVICES	29	*HOME REPAIR, HOME ITEMS, ETC.*	8
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	29	*WOMEN RESOURCES*	8
GROUPS	27	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	6
SENIOR SERVICES	24	*CRISIS STABILIZATION*	4
FAMILY SERVICES	17	*MEDICAL AND DENTAL SERVICES*	2

EAST ALABAMA: STATE STATUS

RATES IN EAST ALABAMA

	VETERANS	NON VETERANS
Psychological Distress	7.67	11.20
Serious Mental Illness	3.26	3.63
Co-Morbid SMI/SUD	0.86	0.37
Suicidal Ideation/ Planning	3.99	6.10
Opioid Misuse	32.73	29.04
Illicit Drug Use	3.99	4.24
Alcohol Misuse	9.89	8.74
Tobacco Use	29.23	28.16

VETERAN SPECIFIC SERVICES:

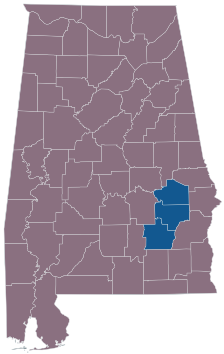
1. American Legion
   8 Posts
2. Disabled Veterans of Americans
   3 Chapters
3. Veterans of Foreign Wars
   4 Posts
4. Priority Veteran
5. Central Alabama Community College
6. Auburn University
7. Chattahoochee Valley Community College
8. Still Serving Veterans, North Alabama
9. Branches Homes for Veterans
10. Central Alabama Veteran Collaborative

In the East Alabama catchment area of Tallapoosa, Chambers, Lee, and Russell counties, the number of available state-funded MH/SU services met the state average at 409 total services available to the community versus the state average of 396 services for a four-county region (103%). According to the 2020 census, the population of the four counties in the East Alabama catchment area is 309,510, or 6% of the state's population. Overall, the average county population within the area is 103% of the average county population of the state (77,378 versus 75,000), with a high population of 174,247 in Lee County and a low population of 34,772 in Chambers County. The range of the population in the East Alabama catchment area is 139,000—with the populations of three of the four counties ranging from 34,000 to 59,000. Overall, Lee County houses 56% of the population in the catchment area. This is significant as the size of the counties imply different needs across the veteran populations.

The number of veterans in the East Alabama catchment area is 20,757—or approximately 6.5% of the total veteran population of the state. Together, the average number of veterans across the four-county catchment area is just over the average county veteran population across the state. However, Lee County houses a veteran population that is twice the number of the average county veteran population across the state (10,309 versus 4,927). The remaining counties' veteran population averages out to 71% of the state's average veteran population per county: 3,483 versus 4,927.

Veterans in the East Alabama catchment area have the opportunity for professional support through all phases of treatment—from prevention to assessment and diagnosis, through recovery phases—through case management services, including veteran benefit navigation. In rural areas where transportation and frequency of service availability may be lower, case management support is a welcome service as individuals contemplate how to prevent, begin, and/or maintain recovery journeys. This would describe three of the four counties in this catchment area.

In addition to case management services there were a notable number of homelessness prevention and food assistance services in the catchment area. Over half of these resources are in Lee County. This is appropriate as Lee County also houses over half the area's population. Of the thirty-five, state funded veteran services in the area, twenty of these services are attributed to the respective ADVA offices, and fourteen additional services were derived from the services provided by the Veteran Home in Alexander City.



EAST CENTRAL:
BULLOCK, MACON, & PIKE

TOTAL NUMBER OF VETERANS: **3,615**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **greater than average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **greater than average** offered across the state

KEY POINTS

- 38 Senior Support Services
- 76% of veterans in this catchment area are 65 or older.
- 73 services provided by the VA and ADVA
- Macon: 47th in the state for population; 42nd in the state for veteran population
- Bullock: 64th in the state for population; 65th in the state for veteran population
- Pike: 36th in the state for population; 34th in the state for veteran population

STATE & FEDERALLY FUNDED SERVICES

157	94	73
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

204 COMMUNITY RESOURCE SERVICES

37 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 10 ORGANIZATIONS

SENIOR SERVICES	38	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	7
FOOD ASSISTANCE	31	*EDUCATION, WELLNESS, AND/OR COACHING SERVICES*	6
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	18	*HOME REPAIR, HOME ITEMS, ETC.*	6
DISABILITY SERVICES	18	*TRANSPORTATION AND CAR SUPPORT*	6
GROUPS	17	*CLOTHING*	2
HOMELESSNESS PREVENTION	16	*CRISIS STABILIZATION*	2
UTILITIES AND FINANCIAL AID	16	*WOMEN RESOURCES*	2
FAMILY SERVICES	9	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	1
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	8	*MEDICAL AND DENTAL SERVICES*	1

EAST CENTRAL: STATE STATUS

RATES IN EAST CENTRL

	VETERANS	NON VETERANS
Psychological Distress	8.95	10.75
Serious Mental Illness	4.23	3.20
Co-Morbid SMI/SUD	0.96	0.45
Suicidal Ideation/ Planning	4.78	5.85
Opioid Misuse	34.25	29.70
Illicit Drug Use	4.14	4.19
Alcohol Misuse	9.04	8.44
Tobacco Use	32.89	29.61

VETERAN SPECIFIC SERVICES:

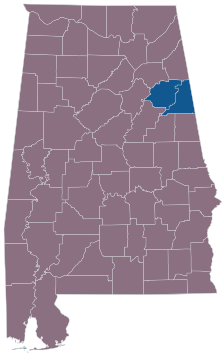
1. American Legion
   4 Posts
2. Disabled American Veterans
   1 Chapters
3. Veterans of Foreign Wars
   3 Posts
4. Priority Veteran
5. Troy University

In the East Central catchment area of Bullock, Macon, and Pike counties, the number of available state-funded MH/SU services fell below the state average at 251 total services available to the community versus the state average of 297 services for a three-county region (84%). According to the 2020 census, the population of the three counties in the East Central catchment area is 62,889, making it one of the lesser-populated catchment areas in the state. Overall, the average county population within the area is only 28% of the average county population of the state (20,963 versus 75,000), with a high population of 33,000 in Pike County and a low population of 10,360 in Bullock County. The range of the population in the East Central catchment area is less than 23,000—meaning that the counties are most likely similar in resource factors associated with their rurality. Overall, the counties in East Central were consistent in the ratio of the county's ranking of total number of veterans to total county population.

Though the population of the East Central catchment area is low compared to other areas in the state, the area is rich in resources. First, East Central's population to MH/SU ratio shows that though the number of MH/SU services in the area is only 84% of the average across the state, the population of the counties is only 28% of the state's average. This means the services to population ratio here is 1:3. Anything above 1:1 superceeds expectations. Overall, the MH/SU services provided by ADMH in East Central are robust compared to the population in the area.

Next, East Central boasts high numbers of state and federally funded services in the catchment area. Overall, there are 73 documented services provided by the VA and ADVA with the majority of these services attributed to the VA Medical Clinic in Tuskegee. The remaining ten services are attributed to the ADVA VSO offices in Macon and Bullock counties. There is not an ADVA/VSO office located in Pike County. Instead, VSO services are provided to the county by the Montgomery office.

In addition to robust MH, SU, and VA services, East Central is also rich in senior services. The East Central catchment area is served by the South Central Alabama Development Commission/Area Agency on Aging and multiple senior centers who provide services across the area. This is relevant, as the vast majority of the veterans in the area are aged 55 and up. Over the three counties, 83% of the veterans are over the age of 55, and 76% are 65 or older. The number of veterans in the East Central catchment area is 3,615—or approximately 1% of the total veteran population of the state. Together, the average number of veterans across the three-county catchment area is significantly below the average veteran population, as 1,205 veterans on average per county yields 24% of the average number of veterans per county across the state.



HIGHLAND:
CALHOUN & CLEBURNE

TOTAL NUMBER OF VETERANS: **9,018**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **on par with the average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **greater than average** offered across the state

KEY POINTS

- 12 veteran specific community organizations
- One-fourth of all community services are offered by veteran specific community organizations
- Calhoun: 10th in the state for population; 10th in the state for veteran population
- Cleburn: 54th in the state for population; 52ndin the state for veteran population

STATE & FEDERALLY FUNDED SERVICES

107	90	24
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

168 COMMUNITY RESOURCE SERVICES

HOMELESSNESS PREVENTION	26
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	24
FOOD ASSISTANCE	20
UTILITIES AND FINANCIAL AID	14
DISABILITY SERVICES	12
GROUPS	12
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	11
SENIOR SERVICES	11
HOME REPAIR, HOME ITEMS, ETC.	10

44 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 12 ORGANIZATIONS

CLOTHING	5
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	5
TRANSPORTATION AND CAR SUPPORT	5
HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE	3
JOB SUPPORT, TRAINING, AND/OR TRANSITION	3
CRISIS STABILIZATION	2
FAMILY SERVICES	2
WOMEN RESOURCES	2
MEDICAL AND DENTAL SERVICES	1

HIGHLAND: STATE STATUS

RATES IN HIGHLAND

	VETERANS	NON VETERANS
Psychological Distress	6.87	11.39
Serious Mental Illness	3.16	3.67
Co-Morbid SMI/SUD	0.81	0.38
Suicidal Ideation/ Planning	3.81	6.21
Opioid Misuse	34.28	28.96
Illicit Drug Use	4.06	4.27
Alcohol Misuse	9.05	8.84
Tobacco Use	33.07	28.69

VETERAN SPECIFIC SERVICES:

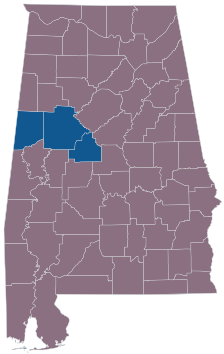
1. American Legion
   6 Posts
2. Disabled Veterans of America
   1 Chapter
3. Priority Veteran
4. Jacksonville State University
5. Calhoun Community College
6. Veterans Helping Veterans
7. Inspire Real Change

In the Highland catchment area of Calhoun and Cleburne counties, the number of available state-funded MH/SU services on par with the state average at 197 total services available to the community versus the state average of 198 services for a two-county region (85%). According to the 2020 census, the population of the two counties in the Highland catchment area is 131,498; however, there is a large population discrepancy in the Highland area as Calhoun County has 116,441 residents and Cleburne County 15,057. Across the counties, Calhoun has 150% of the average county population, and Cleburne only 20%. The range of the population in the Highland catchment area is over 100,000—meaning that the counties may not be similar in resources associated with their rural or urban status.

The number of veterans in the Highland catchment area is 9,018—or approximately 92% of the average veteran population for a two-county area. Calhoun County houses a veteran population that is eight times the number of veterans reported in Cleburne County (8,128 versus 802). Whereas Calhoun County's veteran population is 165% that of the average per county across the state, the veteran population is Cleburne County is 16% of the average. Despite the population differences, the counties in the Highland catchment area were consistent in the ratio of the county's ranking of total number of veterans to total county population.

Of the 197 MH/SU services available in the Highland catchment area, 70 of these services are available in Cleburne, and 127 in Calhoun. Regarding the state and federally funded veteran services, ten of these services were attributed to ADVA offices in the two counties. The ADVA office in Calhoun County is open traditional business hours, and the ADVA office in Cleburne County is reportedly open on Tuesday and Thursdays only. The Highland catchment area is home to the Anniston-Oxford Veterans Clinic, which contributed fourteen individual veteran services recorded for this area.

The Highland catchment area is richest in community resources that support homelessness prevention, food assistance, and case management services. Of all the community resource services recorded, one-third of the services derived from veteran specific community resource organizations. Calhoun and Cleburne County veterans have the support of six American Legion Posts, one DAV chapter, two colleges, Priority Veteran, and two local veteran support services that both assist in homeless prevention and case management services including benefit navigation and/or clinical case management.



INDIAN RIVERS:
BIBB, PICKENS, & TUSCALOOSA

TOTAL NUMBER OF VETERANS: **14,038**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **greater than average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **less than average** offered across the state

KEY POINTS

- 78 total services provided by ADVA and the VA
- Rich community and veteran resources compared to other West Alabama counties
- Tuscaloosa: 6th in the state for population; 7th for total number of veterans
- Bibb: 44th in the state for population; 40th for total number of veterans
- Pickens: 49th in the state for population; 48th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

222	159	78
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

307 COMMUNITY RESOURCE SERVICES

52 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 16 ORGANIZATIONS

CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	51	*CLOTHING*	12
FOOD ASSISTANCE	51	*HOME REPAIR, HOME ITEMS, ETC.*	10
HOMELESSNESS PREVENTION	31	*UTILITIES AND FINANCIAL AID*	10
SENIOR SERVICES	23	*SUBSTANCE USE AND MENTAL HEALTH SUPPORT*	8
GROUPS	21	*TRANSPORTATION AND CAR SUPPORT*	8
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	19	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	7
FAMILY SERVICES	18	*CRISIS STABILIZATION*	3
DISABILITY SERVICES	15	*MEDICAL AND DENTAL SERVICES*	3
JOB SUPPORT, TRAINING, AND/OR TRANSITION	14	*WOMEN RESOURCES*	3

INDIAN RIVERS: STATE STATUS

RATES IN INDIAN RIVERS

	VETERANS	NON VETERANS
Psychological Distress	7.49	10.49
Serious Mental Illness	3.05	3.16
Co-Morbid SMI/SUD	0.82	0.43
Suicidal Ideation/ Planning	4.14	5.71
Opioid Misuse	34.53	29.72
Illicit Drug Use	4.13	4.14
Alcohol Misuse	9.11	8.32
Tobacco Use	34.76	28.93

VETERAN SPECIFIC SERVICES:

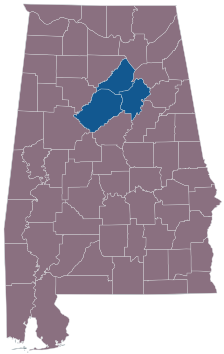
1. American Legion
   9 Posts
2. Disabled Veterans of America
   1 Chapter
3. Veterans of Foreign Wars
   1 Post
4. Priority Veteran
5. Central Alabama Veterans Collaborative
6. Jesus Way Shelters
7. University of Alabama
8. Shelton State Community College

In the Indian Rivers catchment area of Tuscaloosa, Bibb, and Pickens counties, the number of available state-funded MH/SU services superceeded the state average at 381 total services available versus the state average of 297 total for a three-county area (128%). According to the 2020 census, the population of the three counties in the Indian Rivers catchment area is 268,468—averaging 89,489 per county with a high of 227,037 in Tuscaloosa County and a low of 19,130 in Pickens County. Overall, Indian Rivers has 120% the total average population for a three-county region in Alabama. The catchment area has a diverse population demographic, as the population of Tuscaloosa is almost twelve times that of Pickens County.

The number of veterans in the Indian Rivers catchment area is 14,038. The number of veterans in Tuscaloosa, Bibb, and Pickens counties averaged 4,679 per county with a high of 11,597 veterans in Tuscaloosa County and between 1,000 and 1,300 veterans recorded in Bibb and Pickens counties. Though the average is just over the state's average in total veteran population per county, Tuscaloosa houses 83% of the total veteran population in the three counties. Both Bibb and Pickens' population and veteran population were significantly below the state average—28% of the total average state population per county, and 25% the average number of veterans per county. Overall, the counties in the Indian Rivers catchment area were consistent in the ratio of the county's ranking of total number of veterans to total county population.

In the area, there were a notable number of services available in the community for: homeless prevention, case management services, senior services, and food assistance. There was also a notable frequency of community resource support that could aid a veteran in the prevention of homelessness, including: utility, financial aid, and mental health support. According to the US Census data from 2020, the majority of the veterans in the three counties are over the age of 55. Because of this, the high prevalence of senior services is a strength of the catchment area.

Within this catchment area, the veteran specific services are provided largely by common statewide veteran organizations. These veteran specific services include one DAV Chapter, nine American Legion Posts, services provided by United Way's Priority Veteran program, and services provided by one community college in addition to the University of Alabama. In areas where a large university is located, it is likely that the number of services available to veterans is not accurately captured. This is due to the nature of the ever-evolving student efforts in the communities surrounding the university. This may be the case in Tuscaloosa County, as it is the seat of the University of Alabama. During data gathering, there were multiple clubs, organizations, and events associated with the University of Alabama that advertised ...providing a variety of support services; however, the programs were excluded from the data on account that the current status was unable to be determined.



JBS:
JEFFERSON, BLOUNT, & ST. CLAIR

TOTAL NUMBER OF VETERANS: **42,286**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **less than average** offered across the state

state-funded ADVA/VA services offered is **less than average** offered across the sate

community resource services offered is **less than average** offered across the state

veteran specific community resource services offered is **less than average** offered across the state

KEY POINTS

- JBS has the most veteran and community resources per county
- 661 services provided through ADMH
- 23% of recorded community resources are provided by veteran specific organizations
- Jefferson: 1st in the state for population; 2nd for total number of veterans (Madison County is 1st)
- Blount: 23rd in the state for population; 27th for total number of veterans
- St. Clair: 16th in the state for population; 19th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

233	428	145
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

496 COMMUNITY RESOURCE SERVICES

120 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 41 ORGANIZATIONS

CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	86	*DISABILITY SERVICES*	15
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	66	*FAMILY SERVICES*	15
GROUPS	64	*SENIOR SERVICES*	15
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	51	*UTILITIES AND FINANCIAL AID*	15
FOOD ASSISTANCE	41	*HOME REPAIR, HOME ITEMS, ETC.*	13
HOMELESSNESS PREVENTION	33	*MEDICAL AND DENTAL SERVICES*	10
CLOTHING	20	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	6
JOB SUPPORT, TRAINING, AND/OR TRANSITION	20	*CRISIS STABILIZATION*	4
TRANSPORTATION AND CAR SUPPORT	20	*WOMEN RESOURCES*	2

JBS: STATE STATUS

RATES IN JBS

	VETERANS	NON VETERANS
Psychological Distress	7.88	10.21
Serious Mental Illness	3.34	2.78
Co-Morbid SMI/SUD	0.66	0.41
Suicidal Ideation/ Planning	4.26	5.50
Opioid Misuse	32.95	30.22
Illicit Drug Use	4.14	3.97
Alcohol Misuse	9.85	7.74
Tobacco Use	31.42	28.66

VETERAN SPECIFIC SERVICES:

1. American Legion *24 Posts*
2. Disabled Veterans of Americans *3 Chapters*
3. Veterans of Foreign Wars *5 Posts*
4. Central Alabama Veterans Collaborative
5. University of Alabama, Birmingham
6. Fortis Institute, Birmingham
7. Jefferson State Community College
8. Lawson State Community College
9. The Dannon Project
10. Healthcare for Homeless Veterans
11. Cumberland Veterans Legal Assistance Clinic
12. Alabama Veteran

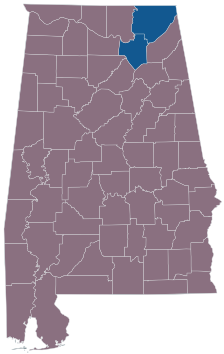
In the JBS catchment area of Jefferson, Blount and St. Clair counties, the number of available state-funded MH/SU services superseded the state average at 661 total services available to the community versus the state average of 297 total for a three-county area (222%). According to the 2020 census, the population of the three counties in the JBS catchment area is one of the largest in the state at 824,938—averaging 274,979 per county with a high of 674,340 in Jefferson County and a low of 59,130 in Blount County. Overall, JBS has 366% the total average population for a three-county region in Alabama, alone. The catchment area has a diverse population demographic, as the population of Jefferson County is eleven times that of Blount County; however, all counties in JBS's catchment area are in the higher half of population rankings across the state at one, twenty-three, and sixteen respectively.

The number of veterans in the JBS catchment area reflects the three-county population at 42,286. The number of veterans in Jefferson, Blount and St. Clair averaged 14,095 per county with a high of 34,009 veterans in Jefferson County, and between 3,000 and 5,000 veterans recorded in Blount and St. Clair counties. Overall, the counties in the JBS catchment area were consistent in the ratio of the county's ranking of total number of veterans to total county population.

JBS has the highest number of ADMH, VA, and ADVA services per county. Because there are so many services available to the veterans in Jefferson, Blount and St. Clair counties, it is a strength of the region that case management services are so abundant as the veterans in the area have the opportunity for professional support through prevention, treatment, and recovery phases. In rural areas where transportation and frequency of service availability may be lower, or in more population-dense areas where surplus service navigation can be confusing or intimidating to a non-professional, case management is vital.

An additional strength of the area was the number of state and federally funded veteran services. Of the 145 recorded state funded veteran services in the JBS catchment area, 130 (90%) are provided through the VA. The 661 total MH/SU services, 449 of these services were provided in Jefferson, leaving 212 across Blount and St. Clair counties—setting them above the state average of 99 MH/SU services per county.

Within this catchment area, the veteran specific services are provided largely by common statewide veteran organizations with thirty-two of the forty-one veteran specific services provided by the American Legion, VFW, DAV, or Priority Veteran. In areas where a large university is located, it is likely that the number of services available to veterans is not accurately captured due to the nature of ever-evolving student efforts in the communities surrounding the university. This may be the case in Jefferson County, as it is the seat of the University of Alabama, Birmingham (UAB).



MOUNTAIN LAKES:
JACKSON & MARSHALL

TOTAL NUMBER OF VETERANS: **8,437**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **on par with the average** offered across the state

state-funded ADVA/VA services offered is **less than average** offered across the sate

community resource services offered is **less than average** offered across the state

veteran specific community resource services offered is **less than average** offered across the state

KEY POINTS

- 27% of the community resources are provided by veteran specific organizations
- Large number of substance use groups provides support for SU maintenance and prevention
- Jackson: 27th in the state for population; 28th for total number of veterans
- Marshall: 14th in the state for population; 17th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

115	94	24
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

106 COMMUNITY RESOURCE SERVICES

29 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 9 ORGANIZATIONS

SUBSTANCE USE AND MENTAL HEALTH SUPPORT	17	*GROUPS*	4
FOOD ASSISTANCE	16	*HOME REPAIR, HOME ITEMS, ETC.*	4
DISABILITY SERVICES	11	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	4
SENIOR SERVICES	11	*TRANSPORTATION AND CAR SUPPORT*	3
HOMELESSNESS PREVENTION	8	*CRISIS STABILIZATION*	2
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	6	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	2
CLOTHING	5	*WOMEN RESOURCES*	2
UTILITIES AND FINANCIAL AID	5	*FAMILY SERVICES*	1
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	4	*MEDICAL AND DENTAL SERVICES*	1

MOUNTAIN LAKES: STATE STATUS

RATES IN MOUNTAIN LAKES

	VETERANS	NON VETERANS
Psychological Distress	7.96	11.27
Serious Mental Illness	3.61	3.75
Co-Morbid SMI/SUD	0.61	0.38
Suicidal Ideation/ Planning	4.40	6.17
Opioid Misuse	33.14	28.86
Illicit Drug Use	4.23	4.29
Alcohol Misuse	9.76	8.95
Tobacco Use	32.54	28.41

VETERAN SPECIFIC SERVICES:

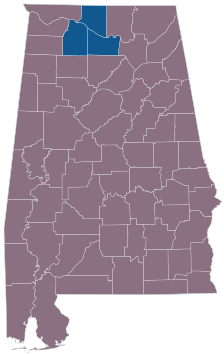
1. American Legion
   5 Posts
2. Disabled Veterans of Americans
   1 Chapter
3. Veterans of Foreign Wars
   2 Posts
4. Priority Veteran

In the Mountain Lakes catchment area of Jackson and Marshall counties, the number of available state-funded MH/SU services fell right at the state average at 209 total services available versus the state average of 198 total for a two-county area (105%). According to the 2020 census, the population of the counties in the Mountain Lakes catchment area is just over 150,000—averaging 75,095 per county with a high of 97,611 in Marshall County and a low of 52,579 in Jackson County. Overall, Mountain Lakes has 100% the total average population for a two-county region in Alabama.

The number of veterans in the Mountain Lakes catchment area 8,437. The number of veterans Jackson and Marshall counties averaged 4,218 per county with a high of 5,500+ veterans in Marshall County, and approximately 2,800 veterans recorded in Jackson County. This was approximately 86% of the state average of 4,927 veterans per county. Both the catchment area's population and veteran population were right at the state average—2.9% of the total state population, and 2.7% of the total state veteran population. Overall, the counties in Mountain Lakes were consistent in the ratio of the county's ranking of total number of veterans to total county population.

The Mountain Lakes catchment area is strong in the number of substance use groups—one of the primary modes of substance use prevention and recovery maintenance. These numbers nicely supplement the number of SU services provided by ADMH in the counties. There were also a notable number of services available in the community for seniors and persons with disabilities. According to the US Census data from 2020, the majority of the veterans in the two counties are over the age of 55. Because of this, the high prevalence of senior services is a strength of the catchment area.

Within Mountain Lakes, the veteran specific services are provided largely by common statewide veteran organizations. These veteran specific services include one DAV Chapter, five American Legion Posts, services provided by United Way's Priority Veteran program, and services provided by two VFW Posts. Of the 24 state and federally funded veteran services, ten of the services were provided by the VSO offices in the two counties, and the remaining fourteen services were attributed to the VA Community-based Outpatient Clinic in Marshall County.



NORTH CENTRAL:
LAWRENCE, LIMESTONE & MORGAN

TOTAL NUMBER OF VETERANS: **16,728**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **less than average** offered across the state

state-funded ADVA/VA services offered is **on par with the average** offered across the sate

community resource services offered is **less than average** offered across the state

veteran specific community resource services offered is **less than average** offered across the state

KEY POINTS

- 50 veteran specific services in community resources
- 20 specific homelessness prevention services in the community
- Limestone 12th in the state for population; 12th for total number of veterans
- Lawrence: 35th in the state for population; 35th for total number of veterans
- Morgan: 9th in the state for population; 11th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

125	84	15
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

255 COMMUNITY RESOURCE SERVICES

49 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 16 ORGANIZATIONS

FOOD ASSISTANCE	38	*FAMILY SERVICES*	11
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	35	*CLOTHING*	10
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	28	*HOME REPAIR, HOME ITEMS, ETC.*	9
GROUPS	21	*DISABILITY SERVICES*	6
HOMELESSNESS PREVENTION	20	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	5
UTILITIES AND FINANCIAL AID	18	*CRISIS STABILIZATION*	4
TRANSPORTATION AND CAR SUPPORT	16	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	4
SENIOR SERVICES	13	*WOMEN RESOURCES*	3
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	13	*MEDICAL AND DENTAL SERVICES*	1

NORTH CENTRAL: STATE STATUS

RATES IN NORTH CENTRAL

	VETERANS	NON VETERANS
Psychological Distress	8.21	11.66
Serious Mental Illness	3.75	3.74
Co-Morbid SMI/SUD	0.76	0.39
Suicidal Ideation/ Planning	4.45	6.33
Opioid Misuse	32.64	29.11
Illicit Drug Use	4.24	4.29
Alcohol Misuse	10.27	8.83
Tobacco Use	32.11	28.76

VETERAN SPECIFIC SERVICES:

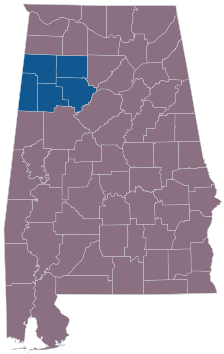
1. American Legion
   5 Posts
2. Disabled Veterans of Americans
   2 Chapters
3. Veterans of Foreign Wars
   4 Posts
4. Priority Veteran
5. Athens State Community College
6. Calhoun Community College
7. Heroes Closet
8. Vets Like Us

In the North Central catchment area of Limestone, Lawrence and Morgan counties, the number of available state-funded MH/SU services fell under the state average at 209 total services available versus the state average of 297 total for a three-county area (70%). According to the 2020 census, the population of the counties in the North Central catchment area is just over 260,000—averaging 86,700 per county with a high of 123,424 in Morgan County and a low of 33,000 in Lawrence County.

The number of veterans in the North Central catchment area is 16,728. The number of veterans averaged 5,576 per county with a high of over 7,400 veterans in Limestone and Morgan counties and approximately 2,000 veterans recorded in Lawrence County. This was approximately 113% of the state average of 4,927 veterans per county. Both the catchment area's population and veteran population were right at the state average—5.2% of the total state population, 5.2% of the total state veteran population. Overall, the counties in North Central were consistent in the ratio of the county's ranking of total number of veterans to total county population. Most service averages were lower than the catchment area's population to veteran ratio.

The North Central case management services catchment area is rich in case management services, translating into CAW veterans having the opportunity for professional support through all phases of treatment, from prevention to assessment and diagnosis, through recovery phases. In rural areas where transportation and frequency of service availability may be lower, or in more population-dense areas, case management support is a welcome service as individuals contemplate how to prevent, begin, and/or maintain recovery journeys. This describes both Limestone and Morgan counties, and Lawrence County respectively. In the area, there was also a notable number of services available in the community for homelessness prevention, food assistance, and education services—including adult education and GED attainment.

Within this catchment area, the veteran specific services are provided largely by common statewide veteran organizations. These veteran specific services include two DAV Chapters, five American Legion Posts, four VFWs, services provided by United Way's Priority Veteran program, and services provided by two institutions of higher education. In addition to these organizations, there were two veteran specific organizations: Heroes Closet and Vets Like Us. Of the 255 total community resources recorded in the area, 49 of these were provided by these veteran specific organizations. Of the 15 state and federally funded veteran services in the North Central catchment area, all were provided by the ADVA through local VSO offices. There was no recorded VA presence in the area. These services were provided by two full-time VSO offices and one part-time office (Lawrence County).



NORTHWEST:
FAYETTE, LAMAR, MARION, WALKER, & WINSTON

TOTAL NUMBER OF VETERANS: **7,502**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **greater than average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **greater than average** offered across the state

KEY POINTS

- One-third of all community resource services were veteran specific
- Fayette 52nd in the state for population; 54th for total number of veterans
- Lamar: 57th in the state for population; 58th for total number of veterans
- Marion: 38th in the state for population; 38th for total number of veterans
- Walker: 21st in the state for population; 26th for total number of veterans
- Winston: 42nd in the state for population; 43rd for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

251	204	39
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

183 COMMUNITY RESOURCE SERVICES

57 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 21 ORGANIZATIONS

GROUPS	38	*CRISIS STABILIZATION*	8
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	24	*DISABILITY SERVICES*	7
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	19	*SENIOR SERVICES*	7
FOOD ASSISTANCE	11	*UTILITIES AND FINANCIAL AID*	7
HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE	11	*CLOTHING*	4
HOMELESSNESS PREVENTION	10	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	4
FAMILY SERVICES	9	*SUBSTANCE USE AND MENTAL HEALTH SUPPORT*	3
HOME REPAIR, HOME ITEMS, ETC.	9	*WOMEN RESOURCES*	2
TRANSPORTATION AND CAR SUPPORT	9	*MEDICAL AND DENTAL SERVICES*	1

NORTHWEST ALABAMA: STATE STATUS

RATES IN NORTHWEST

	VETERANS	NON VETERANS
Psychological Distress	7.77	10.43
Serious Mental Illness	3.80	2.75
Co-Morbid SMI/SUD	0.75	0.36
Suicidal Ideation/ Planning	4.36	5.77
Opioid Misuse	33.83	31.02
Illicit Drug Use	4.25	4.06
Alcohol Misuse	9.47	7.43
Tobacco Use	34.15	31.63

VETERAN SPECIFIC SERVICES:

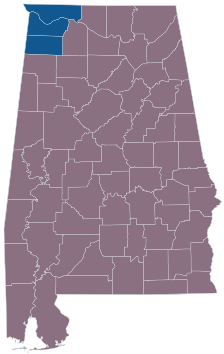
1. American Legion
   15 Posts
2. Veterans of Foreign Wars
   4 Posts
3. Priority Veteran
4. Bevil State Community College

In the Northwest Alabama catchment area of Fayette, Lamar, Marion, Walker and Winston counties, the number of available state-funded MH/SU services fell under the state average at 441 total services available to the community versus the state average of 495 total for a five-county area (89%). According to the 2020 census, the population of the counties in the Northwest Alabama catchment area is just over 148,000—averaging 29,000 per county with a high of 65,000 in Winston County and a low of 13,000 in Lamar County. The range in the population for the Northwest Alabama region was 51,300, though every county was populated below 30,000, save for Winston County.

The number of veterans in the Northwest Alabama catchment area is 7,502. The number of veterans averaged 1,500 per county with a high of 3,194 veterans in Winston County and approximately 700 veterans recorded in both Fayette and Lamar counties. This was approximately one-third of the state average of 4,927 veterans per county. Both the catchment area's population and veteran population were sparsely populated. Overall, the counties in Northwest Alabama catchment area were consistent in the ratio of the county's ranking of total number of veterans to total county population.

Though sparsely populated, each county had close to the average number of MH and/or SU services per county. All-in-all, the Northwest Alabama catchment area had a higher percentage of MH/SU services than population which means the area has an abundance of these services across the five-county catchment area. Regarding state and federally funded veteran services, the catchment area had twenty-five services attributed to ADVA VSO offices. These services are open in the catchment area for five days a week, three days, three days, one day, and one day a week, respectively. The additional fourteen veteran services were from the VA Community-based Outpatient Clinic in Walker County.

Regarding community resources, one-third of the total number of recorded services (183) were attributed to veteran specific community resource organizations. Thirty of these were assigned to the fifteen American Legion Posts across the five-county catchment area. Overall, the region is largely lacking in community resources, comparatively; however, the data does not include the church system in the Northwest Alabama catchment area as these services were difficult to quantify based on the information available. Overall, though the numbers of community resources may seem small, the ratio of resources to population is approximately 1.2:1. This means that according to the Northwest population, the number of community resources is above average as compared to the number of resources in each county across the state. Due to the large size of the Northwest catchment area, and the pressing rural nature of the five counties, other factors may need to be taken into consideration here to address the needs of veterans appropriately.



RIVERBEND:
COLBERT, FRANKLIN, & LAUDERDALE

TOTAL NUMBER OF VETERANS: **9,989**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **less than average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **on par with the average** offered across the state

KEY POINTS

- Multiple community resource categories have 20+ services reported.
- High number of homelessness prevention services
- Colbert: 25th in the state for population; 24th for total number of veterans
- Franklin: 37th in the state for population; 47th for total number of veterans
- Lauderdale: 15th in the state for population; 16th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

150	215	24
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

218 COMMUNITY RESOURCE SERVICES

48 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 12 ORGANIZATIONS

HOMELESSNESS PREVENTION	30	*HOME REPAIR, HOME ITEMS, ETC.*	10
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	22	*SUBSTANCE USE AND MENTAL HEALTH SUPPORT*	9
SENIOR SERVICES	22	*TRANSPORTATION AND CAR SUPPORT*	7
GROUPS	20	*FAMILY SERVICES*	5
DISABILITY SERVICES	19	*CLOTHING*	4
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	18	*CRISIS STABILIZATION*	4
FOOD ASSISTANCE	18	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	4
HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE	11	*MEDICAL AND DENTAL SERVICES*	2
UTILITIES AND FINANCIAL AID	11	*WOMEN RESOURCES*	2

RIVERBEND: STATE STATUS

RATES IN RIVERBEND

	VETERANS	NON VETERANS
Psychological Distress	6.67	10.33
Serious Mental Illness	3.05	2.99
Co-Morbid SMI/SUD	0.73	0.44
Suicidal Ideation/ Planning	3.53	5.40
Opioid Misuse	32.63	28.91
Illicit Drug Use	3.84	3.93
Alcohol Misuse	9.43	8.40
Tobacco Use	27.56	25.48

VETERAN SPECIFIC SERVICES:

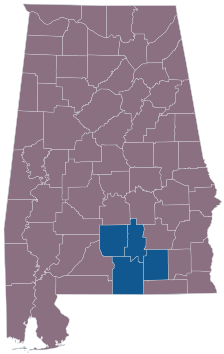
1. American Legion
   4 Posts
2. Veterans of Foreign Wars
   4 Posts
3. Priority Veteran
4. University of North Alabama
5. Northwest Shoals Community College
6. Student Veterans of America

In the Riverbend catchment area of Colbert, Franklin, and Lauderdale counties, the number of available state-funded MH/SU services superseded the state average at 365 total services available to the community versus the state average of 297 total for a three-county area (123%). According to the 2020 census, the population of the counties in the Riverbend catchment area is 182,906—averaging 61,000 per county with a high of 93,500 in Lauderdale County and a low of 32,112 in Franklin County. Overall, the counties in Riverbend averaged 82% of the average state population per county.

The number of veterans in the Riverbend catchment area is 9,989. The number of veterans averaged 3,329 per county with a high of over 3,200 veterans in Colbert County and approximately 1,100 veterans recorded in Franklin County. This was approximately two-thirds of the state average of 4,927 veterans per county. Overall, the counties in Riverbend catchment area were consistent in the ratio of the county's ranking of total number of veterans to total county population.

Each county had over the average number of MH and/or SU services per county. All-in-all, the Riverbend catchment area had a higher percentage of MH/SU services than population which means the area has an abundance of these services across the three-county catchment area. Regarding state and federally funded veteran services, the catchment area had ten services attributed to ADVA VSO offices. This was largely because Lauderdale and Colbert VSO services were from one office located in Lauderdale County. There was no ADVA office in Colbert County. The additional fourteen veteran services were from the VA Community-based Outpatient Clinic in Colbert County.

There were 218 community resources recorded in the Riverbend catchment area. The majority of these services were either homelessness prevention services or senior services; however there were many resource categories that were reported having over twenty recorded services, respectively. Of these, 48 services were attributed to veteran specific community resources including four American Legion Posts, four VFW Posts, three higher education institutions/clubs, and United Way's Priority Veteran.



SOUTH CENTRAL:
BUTLER, COFFEE, COVINGTON, & CRENSHAW

TOTAL NUMBER OF VETERANS: **10,250**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **greater than average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **greater than average** offered across the state

KEY POINTS

- Most of the social service resources in the region are provided by the government.
- Rich in senior services and case management services including veteran benefit navigation
- Butler: 50th in the state for population; 49th for total number of veterans
- Covington: 32nd in the state for population; 30th for total number of veterans
- Crenshaw: 58th in the state for population; 60th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

131	78	34
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

188 COMMUNITY RESOURCE SERVICES

43 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 13 ORGANIZATIONS

DISABILITY SERVICES	26	*CRISIS STABILIZATION*	6
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	23	*HOME REPAIR, HOME ITEMS, ETC.*	6
SENIOR SERVICES	20	*TRANSPORTATION AND CAR SUPPORT*	5
HOMELESSNESS PREVENTION	19	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	4
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	18	*FAMILY SERVICES*	3
GROUPS	18	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	2
FOOD ASSISTANCE	17	*CLOTHING*	1
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	11	*MEDICAL AND DENTAL SERVICES*	0
UTILITIES AND FINANCIAL AID	7	*WOMEN RESOURCES*	0

SOUTH CENTRAL: STATE STATUS

RATES IN SOUTH CENTRAL

	VETERANS	NON VETERANS
Psychological Distress	7.93	11.13
Serious Mental Illness	3.70	3.50
Co-Morbid SMI/SUD	0.83	0.37
Suicidal Ideation/ Planning	4.35	6.03
Opioid Misuse	33.76	29.22
Illicit Drug Use	4.21	4.17
Alcohol Misuse	9.55	8.52
Tobacco Use	33.73	27.96

VETERAN SPECIFIC SERVICES:

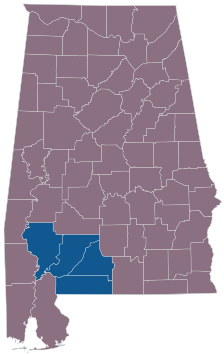
1. American Legion
   7 Posts
2. Disabled Veterans of Americans
   1 Chapter
3. Veterans of Foreign Wars
   2 Posts
4. Priority Veteran
5. Enterprise State Community College
6. Lurleen B. Wallace Community College

In the South Central catchment area of Butler, Coffee, Covington, and Crenshaw counties, the number of available state-funded MH/SU services fell below the state average at 209 total services available to the community versus the state average of 396 total for a four-county area (53%). According to the 2020 census, the population of the counties in the South Central catchment area is 123,261—averaging 30,815 per county with a high of 53,000 in Coffee County and a low of 13,000 in Crenshaw County. Overall, the counties in Riverbend averaged 41% of the average state population per county.

The number of veterans in the South Central catchment area is 10,250. The number of veterans averaged 2,563 per county with a high of over 6,183 veterans in Coffee County and approximately 500 veterans recorded in Crenshaw County. This was approximately one-half of the state average of 4,927 veterans per county. Overall, three of the counties in South Central catchment area were consistent to the ratio of the county's ranking of total number of veterans to total county population. Coffee County ranked 26th in the state for population and 13th for the total number of veterans. This is the largest range for population to veteran ratio in Alabama, and is different from the ratios of population to number of veterans in the remaining three counties.

Though each county had under the average number of MH and/or MH/SU services per county, the catchment area's average population was congruent with the number of services offered. For example, the South Central Catchment area has 41% of the average population and 53% of the average MH/SU services offered. This makes the population to service ratio 41:53. This the same across the South Central catchment area for both MH/SU services and veteran services. In the four counties, there were 34 veteran services recorded that are state and federally funded. This is 61% of the veteran services on average; however the population to veteran service ratio is 41:61, meaning that through the lens of the population of South Central, the federal and state veteran services are above average.

Of the 188 community resources recorded in the area, 43 were provided by veteran specific organizations. These 43 stretched across seven American Legion Posts, one DAV Chapter, two VFW Posts, Priority Veteran, and two institutes of higher education. There were community resources available in the South Central area, however, many of the services were provided by federal, state, and local government agencies. These services were not recorded in this report. In addition to veteran specific community resources, South Central catchment area is also rich in senior and case management services. Case management services include veteran benefit navigation, mental health resource navigation, and the navigation of other services including the navigation of available medical and social services. In the area, 80% of male veterans and half of female veterans are ages 55 and over, making the number of senior services a strength of the South Central catchment area.



SOUTHWEST:
CLARKE, CONECUH, ESCAMBIA, & MONROE

TOTAL NUMBER OF VETERANS: **4,773**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **greater than average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **greater than average** offered across the state

KEY POINTS

- 100% of group support is from veteran specific community organizations
- Most of the social service resources in the region are provided by the government.
- Clarke: 43rd in the state for population; 46th for total number of veterans
- Conecuh: 61st in the state for population; 63rd for total number of veterans
- Escambia: 33rd in the state for population; 31st for total number of veterans
- Monroe: 46th in the state for population; 51st for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

163	39	34
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

173 COMMUNITY RESOURCE SERVICES

34 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 10 ORGANIZATIONS

CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	27	*SUBSTANCE USE AND MENTAL HEALTH SUPPORT*	7
DISABILITY SERVICES	23	*FOOD ASSISTANCE*	6
SENIOR SERVICES	23	*FAMILY SERVICES*	4
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	21	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	4
HOMELESSNESS PREVENTION	18	*CLOTHING*	2
GROUPS	9	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	2
TRANSPORTATION AND CAR SUPPORT	9	*CRISIS STABILIZATION*	1
UTILITIES AND FINANCIAL AID	9	*WOMEN RESOURCES*	1
HOME REPAIR, HOME ITEMS, ETC.	7	*MEDICAL AND DENTAL SERVICES*	0

SOUTHWEST: STATE STATUS

RATES IN SOUTHWEST

	VETERANS	NON VETERANS
Psychological Distress	8.11	10.44
Serious Mental Illness	3.83	3.28
Co-Morbid SMI/SUD	0.80	0.45
Suicidal Ideation/ Planning	4.40	5.53
Opioid Misuse	33.75	28.51
Illicit Drug Use	4.10	4.06
Alcohol Misuse	9.13	8.85
Tobacco Use	32.18	25.81

VETERAN SPECIFIC SERVICES:

1. American Legion
   5 Posts
2. Disabled Veterans of Americans
   1 Chapter
3. Veterans of Foreign Wars
   2 Posts
4. Priority Veteran
5. Reid State Community College

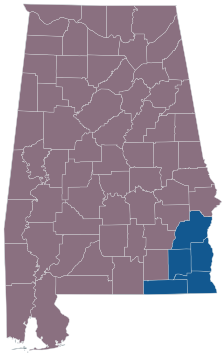
In the Southwest catchment area of Clarke, Conecuh, Escambia, and Monroe counties, the number of available state-funded MH/SU services fell below the state average at 202 total services available to the community versus the state average of 396 total for a four-county area (51%). According to the 2020 census, the population of the counties in the Southwest catchment area is 91,227—averaging 22,806 per county with a high of 36,768 in Escambia County and a low of 11,597 in Conecuh County. Overall, the counties in Southwest are sparsely populated and rural as their rankings in state population range from numbers 33 to 61.

The number of veterans in the Southwest catchment area is 4,773—which in approximately 200 below the state average per county. The number of veterans averaged 1,193 per county with a high of 2,145 veterans in Escambia County and approximately 500 veterans recorded in Conecuh County. This was approximately one-fourth of the state average of 4,927 veterans per county. Overall, the counties in the Southwest catchment area were consistent in the ratio of the county's ranking of total number of veterans to total county population.

Though each county had under the average number of MH and/or SU services per county, the catchment area's average population was congruent with the number of services offered. For example, the Southwest catchment area has 24% of the average population and 51% of the average MH/SU services offered. This makes the population to service ratio 24:51.

This the same across the Southwest catchment area not only for MH/SU services, but also veteran services. In the four counties, there were 34 veteran services recorded that are state and federally funded. This is 61% of the veteran services in a county on average; however the population to veteran service ratio is 24:61, meaning that through the lens of the population of Southwest, the federal and state veteran services are above average as compared across the state. Of the 34 veteran services, twenty of these were attributed to the four respective ADVA offices in the counties. Of these four offices, one is open one day a week, two are open two days, and one is open three days across the catchment area. Despite the hours of these offices, five services were attributed to each. The remaining 14 services come from the VA Community Outpatient Clinic in Monroe County.

Of the 173 community resources recorded, 34 of them were provided by veteran specific organizations in the community including. According to the graph, there are few resources for certain categories such as women resources, medical and dental services, and crisis stabilization—including disaster relief, emergency services, and suicide prevention; however, no state, local, or federal government resources were recorded here. There are services for these categories that are government-funded such as programs provided by the college, state departments, and the local school systems.



SPECTRACARE:
BARBOUR, DALE, GENEVA, HENRY, & HOUSTON

TOTAL NUMBER OF VETERANS: **18,037**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **greater than average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **on par with the average** offered across the state

KEY POINTS

- 20% of all community resources are homelessness prevention or support
- 20% of all community resources supplied by veteran specific organizations
- Barbour: 40th in the state for population; 41st for total number of veterans
- Dale: 28th in the state for population; 20th for total number of veterans
- Geneva: 39th in the state for population; 32nd for total number of veterans
- Henry: 51st in the state for population; 44th for total number of veterans
- Houston: 11th in the state for population; 9th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

242	210	53
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

273 COMMUNITY RESOURCE SERVICES

55 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 15 ORGANIZATIONS

SENIOR SERVICES	35	*UTILITIES AND FINANCIAL AID*	13
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	31	*TRANSPORTATION AND CAR SUPPORT*	8
DISABILITY SERVICES	31	*HOME REPAIR, HOME ITEMS, ETC.*	6
HOMELESSNESS PREVENTION	28	*JOB SUPPORT, TRAINING, AND/OR TRANSITION*	6
GROUPS	24	*WOMEN RESOURCES*	6
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	23	*CLOTHING*	5
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	19	*CRISIS STABILIZATION*	5
FAMILY SERVICES	13	*MEDICAL AND DENTAL SERVICES*	4
FOOD ASSISTANCE	13	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	3

SPECTRA CARE: STATE STATUS

RATES IN SPECTRACARE

	VETERANS	NON VETERANS
Psychological Distress	8.32	11.37
Serious Mental Illness	3.81	3.74
Co-Morbid SMI/SUD	0.78	0.38
Suicidal Ideation/ Planning	4.50	6.20
Opioid Misuse	33.27	28.99
Illicit Drug Use	4.20	4.28
Alcohol Misuse	9.78	8.85
Tobacco Use	32.20	28.30

VETERAN SPECIFIC SERVICES:

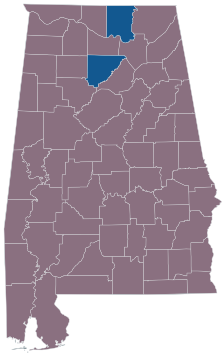
1. American Legion
   6 Posts
2. Disabled Veterans of Americans
   3 Chapters
3. Veterans of Foreign Wars
   3 Posts
4. Priority Veteran
5. George C. Wallace Community College-Dothan
6. Chapter of the Association of the United States Army

In the SpectraCare catchment area of Barbour, Dale, Geneva, Henry, and Houston counties, the number of available state-funded MH/SU services fell below the state average at 209 total services available to the community versus the state average of 396 total for a five-county area (53%). According to the 2020 census, the population of the counties in the SpectraCare catchment area is 225,552—averaging 45,000 per county with a high of 107,200 in Houston County and a low of 17,000 in Henry County. Overall, the counties in SpectraCare averaged 60% of the average state population per county. Houston County alone equaled 142% of the state average population per county, while the remaining four counties averaged 39%. Barbour, Dale, Geneva, and Henry counties ranged from 17,000 to 49,300 people per county—approximately one-third of Houston County's population.

The number of veterans in the SpectraCare catchment area is 18,037. The number of veterans averaged 3,607 per county with a high of over 8,100 veterans in Houston County and approximately 1,200-1,300 veterans recorded in the counties of Henry and Barbour, respectively. This was approximately three-fourths of the state average of 4,927 veterans per county. Overall, the counties' population rankings were similar to their veteran rankings across the state.

Within this catchment area, the veteran specific services are provided largely by common statewide veteran organizations. These veteran specific services include three DAV Chapters, six American Legion Posts, three VFWs, services provided by United Way's Priority Veteran program, and services provided by one institute of higher education. In addition to these organizations, there was one veteran specific organization connected to the Fort Novosel-Wiregrass: the Association of the United States Army. Of the 273 total community resources recorded in the area, 55 of these were provided by these veteran specific organizations. Of the 35 state and federally funded veteran services in the SpectraCare catchment area, 25 were provided by the ADVA through local VSO offices. Of the five offices reported through the VA, two are open one day a week, one for three days a week, and two for four days a week. As these offices provide the same services, five services were attributed to each no matter the posted hours for the office. In addition, twenty-eight services were provided by the VA's community-based outpatient clinics in Houston County and Geneva County respectively.

There was a large presence of homeless prevention resources in the SpectraCare area. These mostly derived from senior service organizations with a specific focus on housing permanency, or other individual resources who bundled the services amongst others within the organization.



WELLSTONE:
MADISON & CULLMAN

TOTAL NUMBER OF VETERANS: **38,958**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **less than average** offered across the state

state-funded ADVA/VA services offered is **less than average** offered across the sate

community resource services offered is **less than average** offered across the state

veteran specific community resource services offered is **less than average** offered across the state

KEY POINTS

- The area includes two non-adjacent counties: Cullman and Madison
- Cullman accounts for approximately one-third of the community organizations from which services were recorded
- Madison accounts for 58 of the 63 state and federally funded veteran services.
- Wellstone has a diverse population demographic as Cullman has one-fourth the population of Madison County.

STATE & FEDERALLY FUNDED SERVICES

142	258	63
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

344 COMMUNITY RESOURCE SERVICES

66 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 19 ORGANIZATIONS

FOOD ASSISTANCE	63	*CLOTHING*	13
SUBSTANCE USE AND MENTAL HEALTH SUPPORT	41	*DISABILITY SERVICES*	13
HOMELESSNESS PREVENTION	36	*FAMILY SERVICES*	13
GROUPS	35	*HOME REPAIR, HOME ITEMS, ETC.*	9
SENIOR SERVICES	22	*MEDICAL AND DENTAL SERVICES*	8
EDUCATION, WELLNESS, AND/OR COACHING SERVICES	21	*CRISIS STABILIZATION*	6
CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	19	*TRANSPORTATION AND CAR SUPPORT*	5
JOB SUPPORT, TRAINING, AND/OR TRANSITION	17	*WOMEN RESOURCES*	4
UTILITIES AND FINANCIAL AID	16	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	3

WELLSTONE: STATE STATUS

RATES IN WELLSTONE

	VETERANS	NON VETERANS
Psychological Distress	7.85	9.64
Serious Mental Illness	3.39	2.42
Co-Morbid SMI/SUD	0.71	0.44
Suicidal Ideation/ Planning	4.19	5.17
Opioid Misuse	32.68	30.61
Illicit Drug Use	4.13	3.88
Alcohol Misuse	10.10	7.49
Tobacco Use	30.42	29.00

VETERAN SPECIFIC SERVICES:

1. American Legion
   4 Posts
2. Disabled Veterans of Americans
   2 Chapters
3. Veterans of Foreign Wars
   3 Posts
4. Priority Veteran
5. Wallace Community College-Hanceville
6. University of Alabama, Huntsville
7. Drake State Community College
8. Saving Forgotten Warriors
9. Alabama Career Center System, Cullman
10. Bearded Veteran
11. Association of the United States Army, Redstone
12. North Alabama Veterans & Fraternal Organizations Coalition
13. Still Serving Veterans, North Alabama

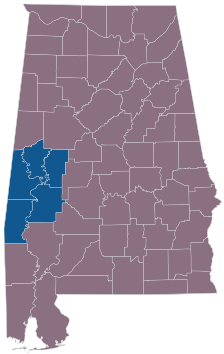
In the Wellstone catchment area of Madison and Cullman counties, the number of available state-funded MH/SU services superseded the state average at 400 total services available to the community versus the state average of 198 total for a two-county area (200%). According to the 2020 census, the population of the two counties in the Wellstone catchment area is one of the largest in the state at 476,011—with a high of 388,154 in Madison County and a low of 87,857 in Cullman County.

The number of veterans in the Wellstone catchment area is one of the few that does not reflect the two-county population. The total number of veterans in Madison and Cullman is 38,958. There are 4,734 veterans recorded in Cullman County and 34,224 veterans reported in Madison County. Madison County is home to seven times the state average number of veterans, and 8% of the state's total veteran population. Madison County supersedes the total number of veterans in Jefferson County by 200 veterans despite a population difference of 286,186.

Despite the difference in population to veteran ratio, there was a below-average number of veteran specific community resources in Madison County. Of the six veteran specific community organizations that are speficic to Wellstone, three were attributed to Cullman County. This indicates that Madison County either does not have the resources for the community-based services (which is unlikely) or does not have the need for the community resources in a way a weaker socio-economic or more rural county could benefit from them. Overall, the Wellstone catchment area is well-resourced as compared to the rest of the state. Regarding MH/SU services, there were 400 total recorded in the Wellstone catchment area—over twice the average across the state for a two-county catchment area. In addition, there were 63 veteran services recorded that are state or federally funded. Ten of these were attributed to the two, full-time ADVA offices in the respective counties, and the remaining 53 were services recorded across the VA care continuum, all in Madison County.

Both counties touted higher-than-average community resources as well, and because there are so many services available to the veterans in Cullman and Madison counties, it is a strength of the region that case management services are abundant. Large numbers of case management opportunities mean the veterans in the catchment area have the opportunity for professional support through all phases of treatment. In rural areas where transportation and frequency of service availability may be lower, or in more population-dense areas where surplus service navigation can be confusing or intimidating to a non-professional, case management is vital. In Wellstone's catchment area, it is likely that any needed service is available if one knows how to find and initiate it.

Within this catchment area, the veteran specific services are provided largely by common statewide veteran organizations It is likely that the number of veteran support services provided by the University of Alabama, Huntsville were not accurately captured.



WEST ALABAMA:
CHOCTAW, GREENE, HALE, MARENGO, & SUMTER

TOTAL NUMBER OF VETERANS: **3,592**

REGION ACCORDING TO POPULATION

state-funded MH/SU services offered is **greater than average** offered across the state

state-funded ADVA/VA services offered is **on par with the average** offered across the sate

community resource services offered is **greater than average** offered across the state

veteran specific community resource services offered is **greater than average** offered across the state

KEY POINTS

- All West Alabama counties are in the bottom fifth in terms of population
- Total population of West Alabama catchment area: 66,857
- Greene: 59th in the state for population; 59th for total number of veterans
- Sumter: 67th in the state for population; 61st for total number of veterans
- Hale: 55th in the state for population; 53rd for total number of veterans
- Marengo: 48th in the state for population; 45th for total number of veterans
- Choctaw: 60th in the state for population; 66th for total number of veterans

STATE & FEDERALLY FUNDED SERVICES

167	124	20
MH SERVICES	SU SERVICES	VETERAN SERVICES

COMMUNITY RESOURCE BREAKDOWN

157 COMMUNITY RESOURCE SERVICES

40 VETERAN SPECIFIC SERVICES DELIVERED ACROSS 11 ORGANIZATIONS

CASE MANAGEMENT (MENTAL HEALTH, MEDICAL, OR SOCIAL SERVICES)	30	*EDUCATION, WELLNESS, AND/OR COACHING SERVICES*	6
HOMELESSNESS PREVENTION	23	*HEALTHCARE AND PRESCRIPTION PAYMENT ASSISTANCE*	6
SENIOR SERVICES	20	*FAMILY SERVICES*	3
DISABILITY SERVICES	15	*SUBSTANCE USE AND MENTAL HEALTH SUPPORT*	3
HOME REPAIR, HOME ITEMS, ETC.	12	*CLOTHING*	1
JOB SUPPORT, TRAINING, AND/OR TRANSITION	10	*FOOD ASSISTANCE*	1
GROUPS	9	*WOMEN RESOURCES*	1
UTILITIES AND FINANCIAL AID	9	*CRISIS STABILIZATION*	0
TRANSPORTATION AND CAR SUPPORT	8	*MEDICAL AND DENTAL SERVICES*	0

WEST ALABAMA: STATE STATUS

RATES IN WEST ALABAMA

	VETERANS	NON VETERANS
Psychological Distress	8.24	10.63
Serious Mental Illness	3.85	3.01
Co-Morbid SMI/SUD	1.03	0.37
Suicidal Ideation/ Planning	4.66	5.91
Opioid Misuse	35.65	30.86
Illicit Drug Use	4.28	4.16
Alcohol Misuse	8.63	7.62
Tobacco Use	38.84	31.21

VETERAN SPECIFIC SERVICES:

1. American Legion
   4 Posts
2. Disabled Veterans of Americans
   1 Chapter
3. Veterans of Foreign Wars
   3 Posts
4. Priority Veteran
5. University of West Alabama
6. Central Alabama Veterans Collaborative

In the West Alabama catchment area Greene, Sumter, Hale, Marengo, and Choctaw counties, the number of available state-funded MH/SU services fell below the state average at 291 total services available to the community versus the state average of 495 total for a five-county area (59%). According to the 2020 census, the population of the counties in the West Alabama catchment area is 66,857—averaging 13,370 per county with a high of 19,325 in Marengo County and a low of 7,731 in Greene County. Overall, the counties in West Alabama are sparsely populated and rural as their rankings in state population range from numbers 48 to 66.

The number of veterans in the West Alabama catchment area is 3,592—which in over 1,200 below the state average per county. The number of veterans averaged 718 per county. This was approximately 15% of the state average of 4,927 veterans per county. Overall, the counties in the West Alabama catchment area were consistent in the ratio of the county's ranking of total number of veterans to total county population.

Though each county had under the average number of MH/SU services per county, the catchment area's average population was congruent with the number of services offered. For example, the West Alabama catchment area has 18% of the average population of Alabama counties and 59% of the average MH/SU services offered. This makes the population to service ratio 18:59. The MH/SU services provided through ADMH in the West Alabama catchment area are evenly distributed across the counties as the MH services range from 32 to 39 total services, and the SU services range between 16 to 30 total services in the catchment area.

Regarding veteran services, West Alabama fell below the county average of 14 services per county as over the five-county catchment area, there are only 20 state or federally veteran services recorded. These services are attributed to four VSO offices in the West Alabama catchment area. Of these four offices, one is open one day a month, one is open two days a week, one is open three days a week, and one is open five days a week, however serves two counties' veteran populations (the other county is located outside of this catchment area). Despite the hours of these offices, five services were attributed to each.

Of the 157 community resources recorded, 40 of them were provided by veteran specific organizations in the community. There are few resources for certain categories; however, no state, local, or federal government resources were recorded here. There are services for these categories that are government-funded such as programs provided by state departments, and the local school systems. There are also a large number of senior services/support and senior organizations across the West Alabama catchment area. This is significant and a strength of the catchment area as approximately one-third of the population here are over the age of 55.

APPENDIX 1:
BIBLIOGRAPHY

[1] 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

[2] 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] Veterans Affairs. (2021). Trauma-informed care fact sheet. https://www.va.gov/homeless/nchav/docs/Trauma-Informed-Care-Fact-Sheet.pdf

[4] University of Wisconsin. (2024). Mental Health Providers. County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care/mental-health-providers?year=2024

[5] 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

[6] Moore M.J., Shawler E., Jordan C., et al. (2023). Veteran and Military Mental Health Issues. StatPearls. Treasure Island (FL): StatPearls Publishing; 2024. Online.

[7] 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.

[8] American Academy of Nursing. (2023). Intake questions. Have You Ever Served in the Military? https://www.haveyoueverserved.com/intake-questions.html

[9] 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

[10] Deployment Psychology. (2023). Prolonged exposure therapy for PTSD (PE). Center for Deployment Psychology. http://deploymentpsych.org/treatments/prolonged-exposure-therapy-ptsd-pe

[11] Deployment Psychology. (2023). Cognitive Processing Therapy. Center for Deployment Psychology. http://deploymentpsych.org/treatments/cognitive-processing-therapy-cpt

[12] Deployment Psychology. (2023). Cognitive Behavioral Therapy for Insomnia. Center for Deployment Psychology. http://deploymentpsych.org/treatments/cognitive-behavioral-therapy-insomnia-cbt-i

[13] Deployment Psychology. (2023). Cognitive Behavioral Therapy for Depression. Center for Deployment Psychology. http://deploymentpsych.org/content/cognitive-behavioral-therapy-depression-cbt-d-0

[14] Deployment Psychology. (2023). Cognitive Therapy for Suicidal Patients. Center for Deployment Psychology. http://deploymentpsych.org/treatments/Cognitve-Therapy-for-Suicidal-Patients-CT-SP

[15] 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/

[16] Veterans Affairs. (2023). Management of Posttraumatic Stress Disorder and Acute Stress Disorder. (2023, June 3). https://www.healthquality.va.gov/guidelines/MH/ptsd/

[17] Veterans Affairs. (2023). Management of Substance Use Disorder. (2023, June 3). hquality.va.gov/guidelines/MH/sud/VADoDSUDCPGProviderSummary.pdf

[18] Veterans Affairs. (2023). Management of Suicidal Patients. (2023, June 3). https://www.healthquality.va.gov/guidelines/MH/srb/VADoD-CPG-Suicide-Risk-Provider-Summary-2024_Final_508.pdf

[19] State of the Workforce Report XVII: Alabama. (2023). https://www2.labor.alabama.gov/WorkforceDev/WorkforceReports/Alabama State of the Workforce Report.pdf

APPENDIX 2:
PREVALENCE ANALYSIS

BACKGROUND

The purpose of this report is to characterize the current prevalence of serious psychological distress, suicidal ideation and/or planning, opioid use, illicit drug use, alcohol misuse, and tobacco use in Alabama in veteran versus nonveteran populations. The estimates developed for this report were calculated based on predictive models using evidence-based practices. In order to estimate rates of the previously mentioned behavioral health issues, data were retrieved from the 2021-2022 files of the United States National Survey on Drug Use and Health (NSDUH).[1] The NSDUH is an annual survey conducted nationally with representative noninstitutionalized persons aged > 12 years. For purposes of completing the current report, persons aged < 18 were excluded from the analysis.

POPULATION BY CATCHMENT AREA

CATCHMENT AREAS	Population + Veteran Population		
	TOTAL POPULATION	VETERAN POPULATION	PERCENTAGE
Altapointe I	128,725	7,140	5.55%
Altapointe II	661,966	47,763	7.22%
Cahaba	57,569	2,568	4.46%
Carastar	386,062	27,039	7.00%
Central Alabama Wellness	268,049	13,846	5.17%
CED	200,024	10,137	5.07%
East Alabama	309,510	20,757	6.71%
East Central	62,889	3,615	5.75%
Highland	131,498	9,018	6.86%
Indian Rivers	268,468	14,038	5.23%
JBS	824,938	42,286	5.13%
Mountain Lakes	150,190	8,437	5.62%
North Central	260,063	16,728	6.43%
Northwest	148,529	7,502	5.05%
Riverbend	182,906	9,989	5.46%
South Central	123,261	10,250	8.32%
Southwest	91,227	4,773	5.23%
Spectracare	225,552	18,037	8.00%
Wellstone	476,011	38,958	8.18%
West Alabama	66,857	3,592	5.37%
ENTIRE STATE	**5,024,294**	**316,473**	**6.30%**

PREVALENCE RATES BY CATCHMENT AREA: VETERANS VS. NONVETERANS

CATCHMENT AREAS	Psychological Distress		Serious Mental Illness		Co-Morbid SMI/SUD	
	VETERANS	NONVETERANS	VETERANS	NONVETERANS	VETERANS	NONVETERANS
Altapointe I	7.67	10.71	3.52	3.17	0.77	0.38
Altapointe II	7.10	10.64	3.05	3.22	0.79	0.42
Cahaba	7.51	10.40	3.33	3.15	1.03	0.46
Carastar	8.01	10.51	3.54	3.38	0.89	0.45
Central Alabama Wellness	7.66	10.78	3.45	3.02	0.73	0.38
CED	7.35	10.20	3.35	2.72	0.68	0.40
East Alabama	7.67	11.20	3.26	3.63	0.86	0.37
East Central	8.95	10.75	4.23	3.20	0.96	0.45
Highland	6.87	11.39	3.16	3.67	0.81	0.38
Indian Rivers	7.49	10.49	3.05	3.16	0.82	0.43
JBS	7.88	10.21	3.34	2.78	0.66	0.41
Mountain Lakes	7.96	11.27	3.61	3.75	0.61	0.38
North Central	8.21	11.66	3.75	3.74	0.76	0.39
Northwest	7.77	10.43	3.80	2.75	0.75	0.36
Riverbend	6.67	10.33	3.05	2.99	0.73	0.44
South Central	7.93	11.13	3.70	3.50	0.83	0.37
Southwest	8.11	10.44	3.83	3.28	0.80	0.45
Spectracare	8.32	11.37	3.81	3.74	0.78	0.38
Wellstone	7.85	9.64	3.39	2.42	0.71	0.44
West Alabama	8.24	10.63	3.85	3.01	1.03	0.37
ENTIRE STATE	**7.76**	**10.71**	**3.50**	**3.21**	**0.80**	**0.41**

PREVALENCE RATES BY CATCHMENT AREA: VETERANS VS. NONVETERANS

CATCHMENT AREAS	Suicidal Ideation/Planning		Opioid Misuse		Illicit Drug Use	
	VETERANS	NONVETERANS	VETERANS	NONVETERANS	VETERANS	NONVETERANS
Altapointe I	4.34	5.99	35.13	30.63	4.22	4.24
Altapointe II	3.84	5.79	33.74	29.65	4.00	4.15
Cahaba	4.15	5.58	35.79	29.23	4.05	4.11
Carastar	4.30	5.58	33.90	28.37	4.13	4.11
Central Alabama Wellness	4.08	5.98	32.88	30.93	4.06	4.17
CED	3.97	5.58	32.87	30.77	4.03	4.02
East Alabama	3.99	6.10	32.73	29.04	3.99	4.24
East Central	4.78	5.85	34.25	29.70	4.14	4.19
Highland	3.81	6.21	34.28	28.96	4.06	4.27
Indian Rivers	4.14	5.71	34.53	29.72	4.13	4.14
JBS	4.26	5.50	32.95	30.22	4.14	3.97
Mountain Lakes	4.40	6.17	33.14	28.86	4.23	4.29
North Central	4.45	6.33	32.64	29.11	4.24	4.29
Northwest	4.36	5.77	33.83	31.02	4.25	4.06
Riverbend	3.53	5.40	32.63	28.91	3.84	3.93
South Central	4.35	6.03	33.76	29.22	4.21	4.17
Southwest	4.40	5.53	33.75	28.51	4.10	4.06
Spectracare	4.50	6.20	33.27	28.99	4.20	4.28
Wellstone	4.19	5.17	32.68	30.61	4.13	3.88
West Alabama	4.66	5.91	35.65	30.86	4.28	4.16
ENTIRE STATE	**4.22**	**5.82**	**33.72**	**29.67**	**4.12**	**4.14**

PREVALENCE RATES BY CATCHMENT AREA: VETERANS VS. NONVETERANS

CATCHMENT AREAS	Alcohol Misuse		Tobacco Use	
	VETERANS	NONVETERANS	VETERANS	NONVETERANS
Altapointe I	8.76	7.91	36.06	31.60
Altapointe II	9.26	8.32	31.34	28.67
Cahaba	8.20	8.59	36.06	27.89
Carastar	9.54	9.03	32.61	25.98
Central Alabama Wellness	9.80	7.63	29.61	31.61
CED	9.58	7.51	29.96	30.20
East Alabama	9.89	8.74	29.23	28.16
East Central	9.04	8.44	32.89	29.61
Highland	9.05	8.84	33.07	28.69
Indian Rivers	9.11	8.32	34.76	28.93
JBS	9.85	7.74	31.42	28.66
Mountain Lakes	9.76	8.95	32.54	28.41
North Central	10.27	8.83	32.11	28.76
Northwest	9.47	7.43	34.15	31.63
Riverbend	9.43	8.40	27.56	25.48
South Central	9.55	8.52	33.73	27.96
Southwest	9.13	8.85	32.18	25.81
Spectracare	9.78	8.85	32.20	28.30
Wellstone	10.10	7.49	30.42	29.00
West Alabama	8.63	7.62	38.84	31.21
ENTIRE STATE	**9.41**	**8.30**	**32.54**	**28.83**

SERIOUS MENTAL ILLNESS

The model predicting serious mental illness is shown in Table 1. Results showed that serious mental illness was more likely among individuals with younger age, female sex, White race, and living in a suburban or rural county. Additionally, results showed that veterans were more likely than nonveterans to report serious mental illness (b = 0.46, p = 0.002), even after controlling for the aforementioned variables.

Table 1: *Model predicting serious mental illness*

Variable	b	SE	
Intercept	-2.93	0.07	***
Age > 64 Years	-2.31	0.34	***
Male Sex	-0.52	0.06	***
Race			
White	Ref		
Black	-0.42	0.12	***
Other	-0.28	0.08	***
Veteran	0.46	0.13	**
Rurality			
Urban	Ref		
Suburban	0.25	0.07	**
Rural	0.05	0.10	

Note: Ref = category of reference for comparison;
*** p < 0.001,
** p < 0.01,
* p < 0.05;
b = beta coefficient;
SE = standard error

Table 2 presents the predicted probabilities of serious mental illness (SMI) across various sub-populations categorized by veteran status, residential area (urban, suburban, rural), race, sex, and age. In general, veterans exhibited greater odds of SMI compared to nonveterans within similar demographic groups and residential settings. Probabilities of SMI are notably higher in suburban, compared to urban and rural, areas for both veterans and nonveterans, with younger White females exhibiting the highest risk.

Table 2: *Predicted probabilities of serious mental illness (SMI) for sub-populations*

	Veteran			Nonveteran		
	Urban	Suburban	Rural	Urban	Suburban	Rural
Sub-Population Race, Sex, Age	Pr(SMI)	Pr(SMI)	Pr(SMI)	Pr(SMI)	Pr(SMI)	Pr(SMI)
White, Male, < 65 Years	0.04109	0.05215	0.04311	0.02634	0.03357	0.02765
White, Male, > 64 Years	0.00424	0.00543	0.00445	0.00268	0.00344	0.00281
White, Female, < 65 Years	0.06723	0.08471	0.07044	0.04352	0.05520	0.04565
White, Female, > 64 Years	0.00710	0.00910	0.00747	0.00450	0.00577	0.00473
Black, Male, < 65 Years	0.02738	0.03489	0.02875	0.01746	0.02231	0.01834
Black, Male, > 64 Years	0.00279	0.00358	0.00293	0.00176	0.00226	0.00185
Black, Female, < 65 Years	0.04522	0.05732	0.04743	0.02903	0.03697	0.03047
Black, Female, > 64 Years	0.00468	0.00600	0.00492	0.00296	0.00380	0.00311
Other, Male, < 65 Years	0.03137	0.03993	0.03293	0.02004	0.02558	0.02104
Other, Male, > 64 Years	0.00320	0.00411	0.00337	0.00203	0.00260	0.00213
Other, Female, < 65 Years	0.05166	0.06538	0.05417	0.03325	0.04229	0.03489
Other, Female, > 64 Years	0.00538	0.00690	0.00565	0.00340	0.00436	0.00358

Table 3 reveals the prevalence of serious mental illness (SMI) across Alabama catchment areas, stratified by veteran status. Overall, the statewide veteran prevalence rate (3.50%) is slightly higher than the nonveteran rate (3.21%), with significant variability across regions. For instance, the East Central area reports the highest veteran prevalence rate (4.23%), markedly exceeding the nonveteran rate (3.20%). Conversely, Highland shows a higher nonveteran rate (3.67%) compared to veterans (3.16%). Notably, areas like Wellstone and Northwest also show substantial disparities, with veterans experiencing higher SMI rates.

Table 3: *Prevalence of serious mental illness in Alabama catchment areas by veteran status*

CATCHMENT AREA	VETERAN PREVALENCE RATE (%)	NONVETERAN PREVALENCE RATE (%)
Altapointe I	3.516731	3.168992
Altapointe II	3.049001	3.223329
Cahaba	3.326636	3.145903
Carastar	3.539677	3.376752
Central Alabama Wellness	3.446187	3.017198
CED	3.351618	2.719814
East Alabama	3.26163	3.630321
East Central	4.232214	3.200426
Highland	3.162553	3.667183
Indian Rivers	3.054152	3.159713
JBS	3.344306	2.778752
Mountain Lakes	3.612613	3.751545
North Central	3.754147	3.74433
Northwest	3.797549	2.753574
Riverbend	3.046543	2.989998
South Central	3.700356	3.500251
Southwest	3.829427	3.282644
Spectracare	3.805924	3.744613
Wellstone	3.389694	2.418794
West Alabama	3.847015	3.01351
ENTIRE STATE	**3.503399**	**3.214382**

SERIOUS MENTAL ILLNESS WITH CO-OCCURRING SUBSTANCE USE DISORDER

Table 4 presents a model predicting the likelihood of serious mental illness (SMI) co-occurring with substance use disorder (SUD), based on various sociodemographic variables. Being over 64 years old was associated with a significantly reduced likelihood of SMI with SUD (b = -3.21), while being male not significant (b = -0.32). Compared to White individuals, "Other" racial groups show a significant decrease in likelihood of SMI with SUD (b = -0.51), whereas Black individuals did not differ significantly. Veterans were significantly more likely to experience SMI with SUD (b = 0.70). Rural and suburban settings showed no significant differences compared to urban areas, indicating that rurality may not strongly influence this outcome.

Table 4: *Model predicting serious mental illness with co-occurring substance use disorder*

Variable	b	SE	
Intercept	-4.88	0.15	***
Age > 64 Years	-3.21	0.73	***
Male Sex	-0.32	0.17	
Race			
White	Ref		
Black	-0.04	0.30	
Other	-0.51	0.20	*
Veteran	0.70	0.30	*
Rurality			
Urban	Ref		
Suburban	-0.28	0.19	
Rural	-0.27	0.29	

Note: Ref = category of reference for comparison;
*** p < 0.001,
** p < 0.01,
* p < 0.05;
b = beta coefficient;
SE = standard error

Table 5 illustrates the predicted probabilities of serious mental illness (SMI) with co-occurring substance use disorder (SUD) for different sub-populations, based on veteran status, rurality, race, sex, and age. Veterans consistently showed higher probabilities of SMI with SUD compared to nonveterans across all subgroups and geographic settings. Younger populations (<65 years) had significantly higher probabilities of SMI with SUD than those over 64 years, regardless of race or sex. Female veterans exhibited slightly higher probabilities than male veterans in most scenarios, with White and Black females having the highest probabilities among veterans. Among racial groups, individuals categorized as "Other" showed the lowest probabilities, particularly in rural areas. Probabilities are generally lower in suburban and rural settings compared to urban areas for all groups.

Table 5: *Predicted probabilities of serious mental illness with co-occurring substance use disorder (SS) for sub-populations*

	Veteran			Nonveteran		
	Urban	Suburban	Rural	Urban	Suburban	Rural
Sub-Population Race, Sex, Age	Pr(SS)	Pr(SS)	Pr(SS)	Pr(SS)	Pr(SS)	Pr(SS)
White, Male, < 65 Years	0.01099	0.00833	0.00841	0.00549	0.00415	0.00419
White, Male, > 64 Years	0.00045	0.00034	0.00034	0.00022	0.00017	0.00017
White, Female, < 65 Years	0.01507	0.01143	0.01154	0.00754	0.00571	0.00577
White, Female, > 64 Years	0.00062	0.00047	0.00047	0.00031	0.00023	0.00023
Black, Male, < 65 Years	0.01056	0.00800	0.00808	0.00527	0.00399	0.00403
Black, Male, > 64 Years	0.00043	0.00033	0.00033	0.00021	0.00016	0.00016
Black, Female, < 65 Years	0.01449	0.01099	0.01110	0.00725	0.00549	0.00554
Black, Female, > 64 Years	0.00059	0.00045	0.00045	0.00029	0.00022	0.00022
Other, Male, < 65 Years	0.00663	0.00502	0.00507	0.00330	0.00250	0.00252
Other, Male, > 64 Years	0.00027	0.00020	0.00021	0.00013	0.00010	0.00010
Other, Female, < 65 Years	0.00910	0.00690	0.00696	0.00454	0.00344	0.00347
Other, Female, > 64 Years	0.00037	0.00028	0.00028	0.00018	0.00014	0.00014

Table 6 provides the prevalence of serious mental illness with co-occurring substance use disorder among veterans and nonveterans across Alabama's catchment areas. Across all regions, veterans consistently show higher prevalence rates compared to nonveterans. For instance, West Alabama and Cahaba exhibit some of the highest veteran prevalence rates at 1.034% and 1.031%, respectively, significantly surpassing the corresponding nonveteran rates of 0.371% and 0.460%. Even in areas with lower prevalence, such as Mountain Lakes (0.614% for veterans and 0.377% for nonveterans), the disparity persists.

Table 6: *Prevalence of serious mental illness with co-occuring substance use disorder in Alabama catchment areas by veteran status*

CATCHMENT AREA	VETERAN PREVALENCE RATE (%)	NONVETERAN PREVALENCE RATE (%)
Altapointe I	0.770206	0.375661
Altapointe II	0.788367	0.4156
Cahaba	1.031453	0.460309
Carastar	0.889768	0.450285
Central Alabama Wellness	0.728128	0.378405
CED	0.67548	0.404248
East Alabama	0.863515	0.373083
East Central	0.962795	0.445233
Highland	0.811392	0.381145
Indian Rivers	0.819763	0.427988
JBS	0.660039	0.414334
Mountain Lakes	0.613544	0.376605
North Central	0.757155	0.393086
Northwest	0.75283	0.360743
Riverbend	0.730057	0.439874
South Central	0.834294	0.369382
Southwest	0.801166	0.447085
Spectracare	0.775755	0.380236
Wellstone	0.705095	0.435581
West Alabama	1.034231	0.371293
ENTIRE STATE	**0.800252**	**0.405009**

PSYCHOLOGICAL DISTRESS

Psychological distress was measured with the Kessler Psychological Distress Scale ("K6").[2] The K6 is a 6-item self-administered questionnaire that includes Likert-scale response options ranging from 1 (none of the time) to 5 (all of the time). Scores of 13 or more are considered indicative of clinically significantly psychological distress.[3] Therefore, in this report, we categorized individuals as having psychological distress if their scoring pattern resulted in a summative score of 13 or more.

The regression model presented in Table 7 examines factors predicting psychological distress. The coefficients from this model were used in order to generate predicted probabilities of psychological distress among each combination of variables shown in the table. As described earlier, the predicted probabilities from this model were applied to Census population counts for those combinations in each Alabama county. Age over 64 years is associated with significantly lower distress ($b = -1.57$, $p < 0.001$), as is being male ($b = -0.29$, $p < 0.001$). Race does not significantly predict distress, as the coefficients for Black ($b = -0.03$) and Other races ($b = -0.04$) are non-significant. Veterans do not show a significant difference in distress levels compared to nonveterans ($b = 0.07$). Living in suburban areas is associated with higher distress compared to urban areas ($b = 0.22$, $p < 0.001$), while rural living is not significantly different from urban ($b = 0.11$). Overall, the model reveals the impact of age, gender, and suburban residence on psychological distress, while race, veteran status, and rurality are less influential.

Table 7: *Model predicting serious mental illness with co-occurring substance use disorder*

Variable	b	SE	
Intercept	-1.91	0.04	***
Age > 64 Years	-1.57	0.10	***
Male Sex	-0.29	0.04	***
Race			
White	Ref		
Black	-0.03	0.06	
Other	-0.04	0.05	
Veteran	0.70	0.30	*
Rurality			
Urban	Ref		
Suburban	-0.28	0.19	
Rural	-0.27	0.29	

Note: Ref = category of reference for comparison;
*** p < 0.001,
** p < 0.01,
* p < 0.05;
b = beta coefficient;
SE = standard error

Table 8 presents the predicted probabilities of psychological distress (PD) across different sub-populations based on veteran status, urbanicity, race, sex, and age. Generally, younger individuals (< 65 years) have higher predicted probabilities of PD compared to older individuals (> 64 years), regardless of other factors. Females tend to have higher probabilities of distress than males in all sub-populations. Veterans have slightly higher predicted probabilities of PD compared to nonveterans in most cases, particularly in suburban areas. Urban residents have the lowest probabilities of distress across all groups, while suburban residents consistently show the highest probabilities. For example, a White male veteran under 65 years living in a suburban area has a predicted probability of PD of 0.12898, compared to 0.12131 for his nonveteran counterpart. Overall, suburban residency and being younger are associated with increased predicted probabilities of psychological distress across different demographic groups.

Table 8: *Predicted probabilities of psychological distress (PD) for sub-populations*

	Veteran			Nonveteran		
	Urban	**Suburban**	**Rural**	**Urban**	**Suburban**	**Rural**
Sub-Population Race, Sex, Age	Pr(PD)	Pr(PD)	Pr(PD)	Pr(PD)	Pr(PD)	Pr(PD)
White, Male, < 65 Years	0.10716	0.12898	0.11815	0.10065	0.12131	0.11106
White, Male, > 64 Years	0.02436	0.02988	0.02711	0.02275	0.02792	0.02533
White, Female, < 65 Years	0.13823	0.16520	0.15187	0.13010	0.15577	0.14307
White, Female, > 64 Years	0.03229	0.03954	0.03591	0.03017	0.03696	0.03357
Black, Male, < 65 Years	0.10526	0.12675	0.11608	0.09885	0.11920	0.10910
Black, Male, > 64 Years	0.02389	0.02931	0.02659	0.02231	0.02738	0.02484
Black, Female, < 65 Years	0.13587	0.16246	0.14931	0.12786	0.15316	0.14064
Black, Female, > 64 Years	0.03167	0.03879	0.03522	0.02959	0.03626	0.03293
Other, Male, < 65 Years	0.10340	0.12455	0.11405	0.09708	0.11712	0.10717
Other, Male, > 64 Years	0.02343	0.02874	0.02608	0.02188	0.02686	0.02436
Other, Female, < 65 Years	0.13354	0.15976	0.14679	0.12564	0.15059	0.13824
Other, Female, > 64 Years	0.03106	0.03805	0.03455	0.02902	0.03557	0.03230

Figure 1: *Geographic distribution of serious mental illness (SMI) by Alabama county and veteran status*

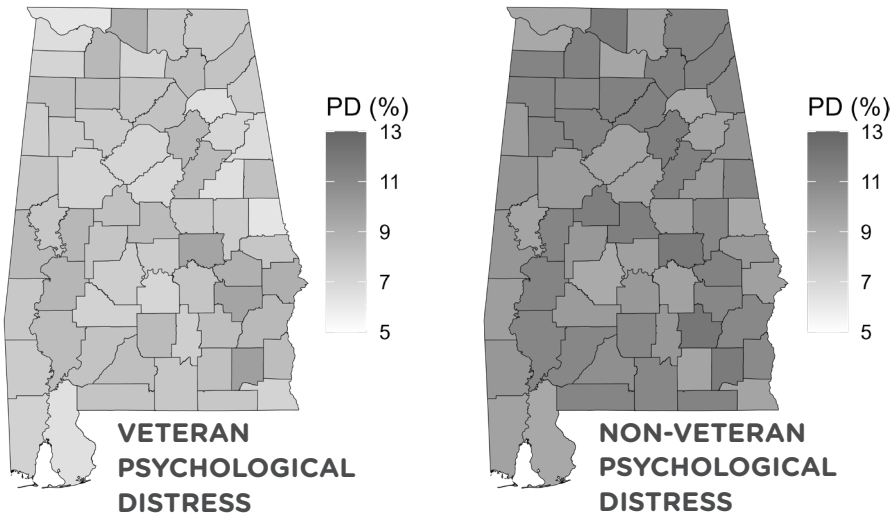


Figure 1 shows the geographic distribution of psychological distress (PD) among veterans and nonveterans across Alabama counties. These predicted rates were established by applied model coefficients to Census population counts for veterans and nonveteran in Alabama counties. For veterans, the percentage of individuals experiencing PD varies significantly between counties, with some counties like Russell (9.02%) and Elmore (9.60%) showing higher levels, while others such as Lauderdale (6.21%) and Baldwin (6.50%) demonstrate lower distress levels. Notably, several counties, such as Bullock, Greene, Lowndes, Perry, Sumter, and Wilcox, exhibited wide confidence intervals, indicating greater uncertainty in these estimates.

In comparison, nonveterans generally report higher rates of PD across all counties, with the highest percentages observed in counties like Pike (12.09%) and Bibb (11.63%). The nonveteran population consistently shows higher psychological distress across most counties compared to veterans. For example, in Bibb County, the PD percentage for nonveterans is 11.63%, significantly higher than the 8.07% reported for veterans. This pattern suggests a potential protective effect of veteran status against PD or differences in the availability or effectiveness of support services across these populations. The consistent pattern of higher distress in suburban and rural counties also suggests geographic factors may play a critical role in shaping mental health outcomes.

Table 9 compares the prevalence of psychological distress between veterans and nonveterans across various Alabama catchment areas. The prevalence of psychological distress is consistently lower among veterans, ranging from 6.67% in Riverbend to 8.95% in East Central. In contrast, nonveteran rates are higher across all regions, with values ranging from 9.64% in Wellstone to 11.66% in North Central. The largest disparity is observed in Highland, where the veteran rate is 6.87%, compared to a nonveteran rate of 11.39%.

Table 9: *Prevalence of psychological distress in Alabama catchment areas by veteran status*

CATCHMENT AREA	VETERAN PREVALENCE RATE (%)	NONVETERAN PREVALENCE RATE (%)
Altapointe I	7.668925	10.70855
Altapointe II	7.099077	10.63911
Cahaba	7.513145	10.39873
Carastar	8.012239	10.51058
Central Alabama Wellness	7.660968	10.77907
CED	7.346878	10.19519
East Alabama	7.66753	11.20436
East Central	8.947993	10.7469
Highland	6.871625	11.39143
Indian Rivers	7.487975	10.49367
JBS	7.879457	10.21271
Mountain Lakes	7.960998	11.27395
North Central	8.211254	11.65803
Northwest	7.769696	10.42875
Riverbend	6.669475	10.3331
South Central	7.928046	11.12941
Southwest	8.114204	10.44174
Spectracare	8.321707	11.36662
Wellstone	7.847163	9.637934
West Alabama	8.238982	10.62719
ENTIRE STATE	**7.760867**	**10.70885**

SUICIDAL IDEATION AND PLANNING

The model predicting suicidal ideation or planning (SI/P), as presented in Table 10, indicates several significant predictors. Age over 64 years is associated with a significant decrease in SI/P ($b = -2.68$, $p < 0.001$), indicating that older individuals are less likely to think about or attempt suicide. Female sex is a significant positive predictor of SI/P, suggesting that women are more likely to consider or attempt suicide. Race also plays a role in predicting SI/P, with the "Other" racial category showing a significant negative association ($b = -0.20$, $p = 0.01$) compared to the reference category, White. Veterans are more likely to engage in SI/P than nonveterans, but this difference was not statistically significant ($b = 0.04$, $p = 0.77$). Geographic factors also influence SI/P, with individuals living in suburban and rural areas more likely to engage in SI/P compared to those in urban areas ($b = 0.27$ and $b = 0.24$, respectively, both $p < 0.01$).

Table 10: *Model predicting suicidal ideation or planning*

Variable	b	SE	
Intercept	-4.88	0.15	***
Age > 64 Years	-3.21	0.73	***
Male Sex	-0.32	0.17	
Race			
White	Ref		
Black	-0.04	0.30	
Other	-0.51	0.20	*
Veteran	0.70	0.30	*
Rurality			
Urban	Ref		
Suburban	-0.28	0.19	
Rural	-0.27	0.29	

Note: Ref = category of reference for comparison;
*** $p < 0.001$,
** $p < 0.01$,
* $p < 0.05$;
b = beta coefficient;
SE = standard error

Table 11: *Predicted probabilities of suicidal ideation or planning (SI/P) for sub-populations*

	Veteran			Nonveteran		
	Urban	Suburban	Rural	Urban	Suburban	Rural
Sub-Population Race, Sex, Age	Pr(SI/P)	Pr(SI/P)	Pr(SI/P)	Pr(SI/P)	Pr(SI/P)	Pr(SI/P)
White, Male, < 65 Years	0.05679	0.07310	0.07109	0.05468	0.07044	0.06850
White, Male, > 64 Years	0.01225	0.01598	0.01552	0.01177	0.01537	0.01492
White, Female, < 65 Years	0.06661	0.08549	0.08317	0.06416	0.08241	0.08017
White, Female, > 64 Years	0.01449	0.01889	0.01834	0.01393	0.01816	0.01764
Black, Male, < 65 Years	0.05315	0.06850	0.06661	0.05117	0.06599	0.06416
Black, Male, > 64 Years	0.01143	0.01492	0.01449	0.01099	0.01434	0.01393
Black, Female, < 65 Years	0.06239	0.08017	0.07799	0.06009	0.07727	0.07516
Black, Female, > 64 Years	0.01352	0.01764	0.01712	0.01300	0.01696	0.01646
Other, Male, < 65 Years	0.04698	0.06065	0.05897	0.04522	0.05841	0.05679
Other, Male, > 64 Years	0.01005	0.01313	0.01274	0.00966	0.01262	0.01225
Other, Female, < 65 Years	0.05520	0.07109	0.06914	0.05315	0.06850	0.06661
Other, Female, > 64 Years	0.01189	0.01552	0.01507	0.01143	0.01492	0.01449

Table 11 presents probabilities of suicidal ideation or planning (Pr(SI/P)) across various demographic subgroups of veterans and nonveterans, classified by race, gender, age, and geographic area (urban, suburban, and rural). For both veterans and nonveterans, younger individuals (under 65 years) exhibit higher probabilities of S/IP compared to older individuals (over 64 years), across all racial and gender subgroups. White females under 65, for example, show the highest probabilities, with suburban areas having the largest values (0.08549 for veterans and 0.08241 for nonveterans). Veterans generally display slightly higher probabilities of SI/P than nonveterans across most subgroups.

Geographical location also seems to influence probabilities of SI/P, with suburban populations often displaying slightly higher SI/P than their urban and rural counterparts, regardless of veteran status. For instance, white males under 65 in suburban areas have higher SI/P (0.07310 for veterans and 0.07044 for nonveterans) compared to urban and rural areas. These patterns hold across racial groups, with Black and "Other" populations showing a similar trend, though with slightly lower probabilities than their white counterparts across the board.

Table 12 shows the rates of suicide ideation and behavior in Alabama's catchment areas, comparing veterans and nonveterans. The data show that veterans generally have lower rates of suicide ideation and behavior compared to nonveterans, based on the predictive models. Veteran rates range from 3.53% in Riverbend to 4.78% in East Central, while nonveteran rates are higher across the board, ranging from 5.17% in Wellstone to 6.33% in North Central. The largest gap is observed in Highland, where nonveterans report a rate of 6.21% compared to 3.81% for veterans.

Table 12: *Prevalence of suicide ideation and behavior in Alabama catchment areas by veteran status*

CATCHMENT AREA	VETERAN PREVALENCE RATE (%)	NONVETERAN PREVALENCE RATE (%)
Altapointe I	4.342895	5.99361
Altapointe II	3.837782	5.786892
Cahaba	4.154382	5.584599
Carastar	4.303511	5.579892
Central Alabama Wellness	4.083878	5.984729
CED	3.968734	5.57747
East Alabama	3.989327	6.104019
East Central	4.778299	5.847461
Highland	3.810388	6.207805
Indian Rivers	4.136424	5.714559
JBS	4.256249	5.502699
Mountain Lakes	4.395641	6.168757
North Central	4.451833	6.333399
Northwest	4.357589	5.772647
Riverbend	3.525383	5.404789
South Central	4.354653	6.034681
Southwest	4.396054	5.525266
Spectracare	4.5021	6.198671
Wellstone	4.186419	5.174026
West Alabama	4.65904	5.910572
ENTIRE STATE	**4.224529**	**5.820327**

OPIOID MISUSE

The model predicting opioid misuse in the past year is shown in Table 13. Results showed that opioid misuse was more likely among individuals with older age, female sex, White race, and living in a rural county. Additionally, results showed that veterans were more likely than nonveterans to report opioid misuse (b = 0.29, p < 0.001), even after controlling for the aforementioned variables.

Table 13: *Model predicting opioid misuse*

Variable	b	SE	
Intercept	-0.89	0.03	***
Age > 64 Years	0.09	0.04	*
Male Sex	-0.21	0.04	***
Race			
White	Ref		
Black	0.08	0.05	
Other	-0.31	0.04	***
Veteran	0.29	0.07	***
Rurality			
Urban	Ref		
Suburban	0.06	0.03	
Rural	0.19	0.04	***

Note: Ref = category of reference for comparison;
*** p < 0.001,
** p < 0.01,
* p < 0.05;
b = beta coefficient;
SE = standard error

Table 14 presents the predicted probabilities of opioid misuse (OM) across various sub-populations categorized by veteran status, residential area (urban, suburban, rural), race, sex, and age. In general, veterans show greater odds of opioid misuse compared to nonveterans within similar demographic groups and residential settings. Probabilities are notably higher in rural areas for both veterans and nonveterans, with older females across all racial categories exhibiting the highest risk. White and Black populations have consistently higher predicted probabilities than those classified as "Other," with women, particularly those over 64, showing the highest odds of opioid misuse.

Table 14: *Predicted probabilities of opioid misuse (OM) for sub-populations*

	Veteran			Nonveteran		
	Urban	Suburban	Rural	Urban	Suburban	Rural
Sub-Population Race, Sex, Age	Pr(OM)	Pr(OM)	Pr(OM)	Pr(OM)	Pr(OM)	Pr(OM)
White, Male, < 65 Years	0.30789	0.32082	0.34978	0.24974	0.26115	0.28700
White, Male, > 64 Years	0.32739	0.34074	0.37052	0.26698	0.27888	0.30576
White, Female, < 65 Years	0.35434	0.36819	0.39891	0.29111	0.30365	0.33181
White, Female, > 64 Years	0.37519	0.38936	0.42068	0.31003	0.32300	0.35206
Black, Male, < 65 Years	0.32300	0.33626	0.36586	0.26308	0.27488	0.30153
Black, Male, > 64 Years	0.34299	0.35663	0.38699	0.28090	0.29318	0.32082
Black, Female, < 65 Years	0.37052	0.38462	0.41581	0.30576	0.31865	0.34751
Black, Female, > 64 Years	0.39174	0.40613	0.43782	0.32519	0.33850	0.36819
Other, Male, < 65 Years	0.24601	0.25731	0.28292	0.19623	0.20587	0.22794
Other, Male, > 64 Years	0.26308	0.27488	0.30153	0.21082	0.22097	0.24416
Other, Female, < 65 Years	0.28700	0.29943	0.32739	0.23148	0.24232	0.26698
Other, Female, > 64 Years	0.30576	0.31865	0.34751	0.24787	0.25923	0.28496

Table 15 presents the prevalence of opioid misuse among veterans compared to nonveterans across various catchment areas in Alabama. The data shows consistently higher prevalence rates of opioid misuse among veterans, with rates ranging from 32.63% to 35.78%, compared to nonveteran rates, which range from 28.37% to 31.02%. The Cahaba catchment area had the highest veteran prevalence (35.79%), while Riverbend had the lowest (32.63%). Similarly, nonveteran misuse rates are highest in the Northwest (31.02%) and lowest in Carastar (28.37%).

Table 15: *Prevalence of opioid misuse in Alabama catchment areas by veteran status*

CATCHMENT AREA	VETERAN PREVALENCE RATE (%)	NONVETERAN PREVALENCE RATE (%)
Altapointe I	35.13321	30.62503
Altapointe II	33.73814	29.64528
Cahaba	35.78997	29.22533
Carastar	33.90134	28.37382
Central Alabama Wellness	32.8767	30.92989
CED	32.87103	30.7695
East Alabama	32.72601	29.04162
East Central	34.24694	29.69703
Highland	34.28433	28.95821
Indian Rivers	34.5335	29.72313
JBS	32.94999	30.22018
Mountain Lakes	33.13725	28.86281
North Central	32.63564	29.10632
Northwest	33.83026	31.02001
Riverbend	32.6266	28.91124
South Central	33.76166	29.2225
Southwest	33.74532	28.50814
Spectracare	33.27184	28.99476
Wellstone	32.6757	30.60553
West Alabama	35.64766	30.86133
ENTIRE STATE	**33.71915**	**29.66508**

ILLICIT DRUG USE

The regression model presented in Table 16 examines predictors of illicit drug use. The results indicate that older age is significantly associated with a lower likelihood of illicit drug use, with a beta coefficient of -0.63 ($p < 0.001$). Male sex is not a significant predictor, as indicated by a non-significant beta of 0.07. Racial differences show that Black and Other racial groups have slightly lower, though

not statistically significant, likelihoods of illicit drug use compared to White individuals. Notably, veteran status is positively associated with illicit drug use (b = 0.11, p < 0.01), suggesting that veterans may have a slightly higher risk of engaging in illicit drug use compared to nonveterans. Additionally, individuals living in rural and suburban areas have marginally higher, though not statistically significant, probabilities of illicit drug use compared to those in urban areas. Overall, age and veteran status were the most significant predictors in this model.

Table 16: *Model predicting illicit drug use*

Variable	b	SE	
Intercept	-3.11	0.07	***
Age > 64 Years	-0.63	0.15	***
Male Sex	0.07	0.07	
Race			
White	Ref		
Black	-0.12	0.10	
Other	-0.22	0.06	
Veteran	0.11	0.11	**
Rurality			
Urban	Ref		
Suburban	0.10	0.08	
Rural	0.13	0.09	

Note: Ref = category of reference for comparison;
*** p < 0.001,
** p < 0.01,
* p < 0.05;
b = beta coefficient;
SE = standard error

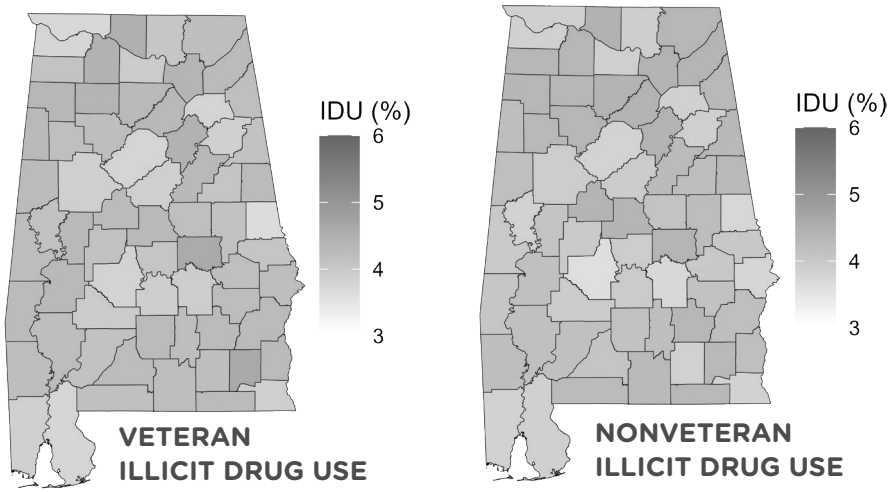
Predicted probabilities of illicit drug use (IDU) for various sub-populations are stratified by veteran status, geographic location (urban, suburban, rural), race, sex, and age in Table 17. Across all categories, veterans generally have higher predicted probabilities of IDU compared to nonveterans, indicating a heightened risk for veterans. For instance, younger White male veterans (<65 years) living in rural areas have the highest predicted probability of IDU at 0.05732, compared to their nonveteran counterparts in urban areas at 0.04565. Similarly, for older individuals (>64 years), the predicted probabilities of IDU decrease across the board, with older White female nonveterans in rural areas having the lowest predicted probability at 0.02634. The model also shows that rural residency tends to be associated with slightly higher predicted probabilities of IDU for both veterans and nonveterans, reflecting a potential vulnerability in rural areas. The differences between racial groups are subtle, with White and Black individuals generally having higher predicted probabilities than those categorized as "Other," regardless of veteran status or geographic location.

Table 17: *Predicted probabilities of illicit drug use (IDU) for sub-populations*

	Veteran			Nonveteran		
	Urban	Suburban	Rural	Urban	Suburban	Rural
Sub-Population Race, Sex, Age	Pr(IDU)	Pr(IDU)	Pr(IDU)	Pr(IDU)	Pr(IDU)	Pr(IDU)
White, Male, < 65 Years	0.05069	0.05572	0.05732	0.04565	0.05021	0.05166
White, Male, > 64 Years	0.02765	0.03047	0.03137	0.02484	0.02738	0.02820
White, Female, < 65 Years	0.04743	0.05215	0.05366	0.04270	0.04698	0.04834
White, Female, > 64 Years	0.02583	0.02847	0.02931	0.02320	0.02558	0.02634
Black, Male, < 65 Years	0.04522	0.04974	0.05117	0.04070	0.04479	0.04609
Black, Male, > 64 Years	0.02460	0.02712	0.02792	0.02210	0.02436	0.02509
Black, Female, < 65 Years	0.04229	0.04653	0.04788	0.03805	0.04189	0.04311
Black, Female, > 64 Years	0.02298	0.02533	0.02608	0.02063	0.02275	0.02343
Other, Male, < 65 Years	0.04109	0.04522	0.04653	0.03697	0.04070	0.04189
Other, Male, > 64 Years	0.02231	0.02460	0.02533	0.02004	0.02210	0.02275
Other, Female, < 65 Years	0.03842	0.04229	0.04352	0.03456	0.03805	0.03917
Other, Female, > 64 Years	0.02084	0.02298	0.02366	0.01871	0.02063	0.02125

The geographic distribution of illicit drug use (IDU) in Alabama counties is shown in Figure 2 and shows slight variations between veterans and nonveterans. For veterans, the percentage of predicted IDU generally ranges between 3.78% to 4.63%, with notable counties such as Dale (4.63%) and Limestone (4.51%) reflecting the highest predicted rates. Counties like Lauderdale (3.72%) and Jefferson (3.80%) exhibit lower predicted rates for veterans. However, there is some variation, with counties like Bullock and Sumter showing significant uncertainty, as indicated by the wide confidence intervals (CIs).

Figure 2: *Predicted rates (%) of illicit drug use (IDU) among veteran and nonveterans in Alabama counties (2021-2022)*



For nonveterans, the predicted IDU percentages are slightly lower in some counties but generally follow a similar distribution to the veteran population. The highest predicted rates are observed in counties such as Fayette (4.33%) and Walker (4.37%). Counties like Shelby (3.94%) and Jefferson (3.81%) show lower predicted rates, similar to veterans. The confidence intervals for nonveterans are generally narrower than those for veterans, indicating more precise estimates, particularly in counties with larger populations such as Mobile and Madison. This consistency in the patterns across both populations highlights a broad geographical trend in IDU within Alabama, where both veterans and nonveterans in certain counties may be at higher risk.

Table 18 examines the prevalence of illicit drug use across Alabama catchment areas, comparing rates between veterans and nonveterans. The data reveal minimal differences between the two groups, with veteran prevalence rates ranging from 3.84% in Riverbend to 4.28% in West Alabama, and nonveteran rates ranging from 3.87% in Wellstone to 4.29% in Mountain Lakes and North Central. In most catchment areas, the prevalence rates differ by less than 0.2 percentage points. Notably, JBS and Wellstone are among the few areas where veterans exhibit slightly higher prevalence rates than nonveterans.

Table 18: *Prevalence of illicit drug use in Alabama catchment areas by veteran status*

CATCHMENT AREA	VETERAN PREVALENCE RATE (%)	NONVETERAN PREVALENCE RATE (%)
Altapointe I	4.22335	4.238109
Altapointe II	3.999146	4.149007
Cahaba	4.047946	4.112549
Carastar	4.13068	4.105669
Central Alabama Wellness	4.055731	4.165744
CED	4.031032	4.019622
East Alabama	3.990194	4.236238
East Central	4.142375	4.191417
Highland	4.062203	4.270917
Indian Rivers	4.129812	4.144426
JBS	4.135718	3.973015
Mountain Lakes	4.226614	4.292195
North Central	4.244712	4.290269
Northwest	4.250054	4.061585
Riverbend	3.840028	3.934471
South Central	4.211125	4.174642
Southwest	4.097354	4.059847
Spectracare	4.198108	4.277286
Wellstone	4.13062	3.876448
West Alabama	4.283806	4.163666
ENTIRE STATE	**4.12153**	**4.136856**

ALCOHOL MISUSE

The regression model predicting alcohol misuse shows several significant factors influencing the likelihood of misuse (Table 19). Age appears to be a protective factor, with individuals over 64 years being significantly less likely to misuse alcohol ($b = -0.91$, $p < 0.001$). Males, however, are more likely to misuse alcohol, as indicated by the positive coefficient for male sex ($b = 0.34$, $p < 0.001$). Race also plays a significant role, with both Black ($b = -0.23$, $p < 0.001$) and Other racial groups ($b = -0.29$, $p < 0.001$) being less likely to misuse alcohol compared to White individuals. Although veteran status is associated with a slightly higher likelihood of alcohol misuse ($b = 0.17$), this result is not statistically significant. Finally, rurality has a modest effect, with individuals living in rural areas being less likely to misuse alcohol compared to their urban counterparts ($b = -0.20$, $p < 0.05$), while suburban residence does not significantly differ from urban residence in terms of alcohol misuse.

Table 19: *Model predicting alcohol misuse*

Variable	b	SE	
Intercept	-2.29	0.05	***
Age > 64 Years	-0.91	0.09	***
Male Sex	0.34	0.04	***
Race			
White	Ref		
Black	-0.23	0.06	***
Other	-0.29	0.06	***
Veteran	0.17	0.11	
Rurality			
Urban	Ref		
Suburban	-0.03	0.06	
Rural	-0.20	0.08	*

Note: Ref = category of reference for comparison;
*** $p < 0.001$,
** $p < 0.01$,
* $p < 0.05$;
b = beta coefficient;
SE = standard error

The predicted probabilities of alcohol misuse (AM) for various sub-populations reveal distinct patterns based on veteran status, geography, race, sex, and age (Table 20). Veterans generally have higher probabilities of alcohol misuse across all sub-populations compared to nonveterans. Among the veteran population, younger White males in urban areas show the highest probability of alcohol misuse at 0.1443, with a gradual decrease in risk as the population becomes older, female, or lives in rural areas. White females over 64 years in rural areas have the lowest predicted probability of alcohol misuse at 0.03805 among veterans. For Black and Other racial groups, the trend is similar, with younger males having the highest probabilities and older females the lowest. However, veterans in rural areas consistently exhibit lower probabilities of misuse compared to their urban counterparts.

Table 20: *Predicted probabilities of alcohol misuse (AM) for sub-populations*

	Veteran			Nonveteran		
	Urban	**Suburban**	**Rural**	**Urban**	**Suburban**	**Rural**
Sub-Population Race, Sex, Age	Pr(AM)	Pr(AM)	Pr(AM)	Pr(AM)	Pr(AM)	Pr(AM)
White, Male, < 65 Years	0.14430	0.14064	0.12132	0.12455	0.12132	0.10433
White, Male, > 64 Years	0.06357	0.06180	0.05265	0.05417	0.05265	0.04479
White, Female, < 65 Years	0.10717	0.10433	0.08948	0.09195	0.08948	0.07656
White, Female, > 64 Years	0.04609	0.04479	0.03805	0.03917	0.03805	0.03230
Black, Male, < 65 Years	0.11816	0.11507	0.09886	0.10156	0.09886	0.08471
Black, Male, > 64 Years	0.05117	0.04974	0.04229	0.04352	0.04229	0.03592
Black, Female, < 65 Years	0.08707	0.08471	0.07243	0.07447	0.07243	0.06180
Black, Female, > 64 Years	0.03697	0.03592	0.03047	0.03137	0.03047	0.02583
Other, Male, < 65 Years	0.11205	0.10910	0.09364	0.09622	0.09364	0.08017
Other, Male, > 64 Years	0.04834	0.04698	0.03993	0.04109	0.03993	0.03390
Other, Female, < 65 Years	0.08241	0.08017	0.06850	0.07044	0.06850	0.05841
Other, Female, > 64 Years	0.03489	0.03390	0.02875	0.02960	0.02875	0.02436

Nonveterans generally have lower predicted probabilities of alcohol misuse compared to veterans across all sub-populations. Similar to veterans, younger males exhibit the highest probabilities of alcohol misuse, while older females have the lowest. White nonveteran males under 65 in urban areas have a predicted probability of 0.12455, slightly lower than their veteran counterparts, with probabilities decreasing as they age or reside in suburban or rural areas. For Black and Other racial groups, the trend remains consistent, with younger males at higher risk and older females at lower risk.

The geographic distribution of alcohol misuse among veterans and nonveterans in Alabama counties shows that veterans generally have higher rates of alcohol misuse compared to nonveterans across the state (Figure 3). For instance, in counties like Coffee (10.98% for veterans vs. 8.79% for nonveterans), Lee (10.56% vs. 9.29%), and Madison (10.43% vs. 8.98%), the difference is particularly noticeable, with veterans exhibiting misuse rates significantly higher than their nonveteran counterparts. However, there are also counties where the rates are more closely aligned or the veteran rates are slightly lower, such as Greene County (7.82% for veterans vs. 6.25% for nonveterans) and Wilcox County (7.28% vs. 6.47%).

Table 21 presents data on the prevalence of alcohol misuse in various Alabama catchment areas, comparing veteran and nonveteran populations. The results indicate that veterans generally exhibit higher rates of alcohol misuse than nonveterans, with veteran prevalence rates ranging from 8.63% in West Alabama to 10.27% in North Central. In contrast, nonveteran rates are consistently lower, ranging from 7.43% in Northwest to 8.59% in Cahaba. The greatest disparities between veteran and nonveteran rates are observed in areas such as Central Alabama Wellness and Wellstone, where veterans report significantly higher levels of alcohol misuse.

Figure 3: *Predicted rates of alcohol misuse (AU) among veterans and nonveterans in Alabama counties (2021-2022).*

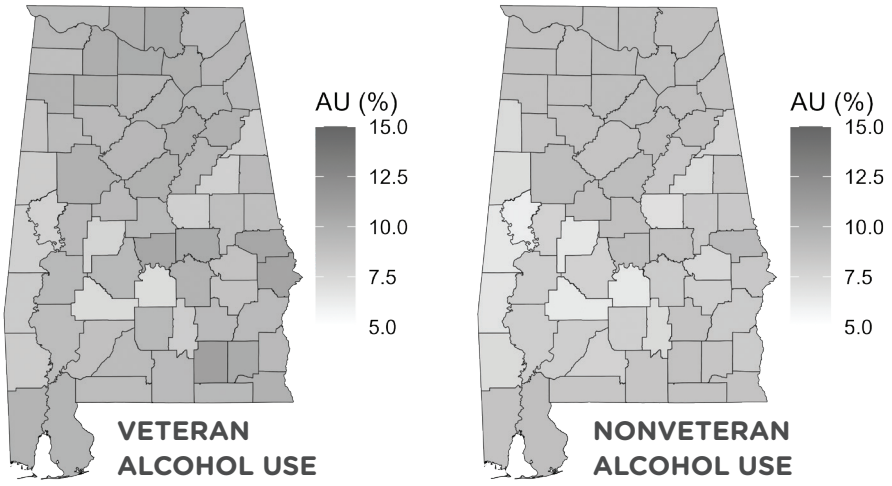


Table 21: *Prevalence of alcohol misuse in Alabama catchment areas by veteran status*

CATCHMENT AREA	VETERAN PREVALENCE RATE (%)	NONVETERAN PREVALENCE RATE (%)
Altapointe I	8.759465	7.905916
Altapointe II	9.264918	8.318002
Cahaba	8.202681	8.588322
Carastar	9.535696	9.031058
Central Alabama Wellness	9.80237	7.62541
CED	9.57672	7.511111
East Alabama	9.887389	8.741746
East Central	9.040487	8.442798
Highland	9.054518	8.843548
Indian Rivers	9.112223	8.315243
JBS	9.853585	7.743271
Mountain Lakes	9.757191	8.948042
North Central	10.26937	8.825598
Northwest	9.472903	7.426225
Riverbend	9.426544	8.400354
South Central	9.553829	8.517251
Southwest	9.133556	8.850793
Spectracare	9.782905	8.854198
Wellstone	10.09998	7.486035
West Alabama	8.626971	7.61775
ENTIRE STATE	**9.410665**	**8.299634**

TOBACCO USE

The model predicting tobacco use, as presented in Table 22, indicates several significant predictors of tobacco consumption. Age over 64 years is associated with a significant decrease in tobacco use (b = -1.08, p < 0.001), indicating that older individuals are less likely to use tobacco compared to younger individuals. Male sex is a significant positive predictor of tobacco use (b = 0.62, p < 0.001), suggesting that men are more likely to use tobacco than women. Race also plays a role in predicting tobacco use, with the "Other" racial category showing a significant negative association (b = -0.47, p < 0.001) compared to the reference category, White. Veterans are more likely to use tobacco than nonveterans (b = 0.21, p < 0.001). Geographic factors also influence tobacco use, with individuals living in suburban and rural areas more likely to use tobacco compared to those in urban areas (b = 0.29 and b = 0.62, respectively, both p < 0.001).

Table 22: *Model predicting tobacco use*

Variable	b	SE	
Intercept	-1.31	0.03	***
Age > 64 Years	-1.08	0.06	***
Male Sex	0.62	0.05	***
Race			
White	Ref		
Black	0.01	0.05	
Other	-0.47	0.04	***
Veteran	0.21	0.06	***
Rurality			
Urban	Ref		
Suburban	0.29	0.04	***
Rural	0.62	0.05	***

Note: Ref = category of reference for comparison;
*** p < 0.001,
** p < 0.01,
* p < 0.05;
b = beta coefficient;
SE = standard error

The predicted probabilities of tobacco use (TU) across different sub-populations reveal notable variations between veterans and nonveterans, as well as across urban, suburban, and rural settings. For both veterans and nonveterans, tobacco use is generally higher among younger individuals and those who identify as White or Black compared to other racial groups. Specifically, younger White and Black males show higher probabilities of tobacco use across all settings, with rural areas exhibiting the highest probabilities. For instance, White males under 65 years old have the highest predicted probabilities of tobacco use in rural settings (0.53494 for veterans and 0.48251 for nonveterans), while the probabilities decrease with age and in suburban and urban areas.

Table 23: *Predicted probabilities of tobacco use (TU) for sub-populations*

	Veteran			Nonveteran		
	Urban	Suburban	Rural	Urban	Suburban	Rural
Sub-Population Race, Sex, Age	Pr(TU)	Pr(TU)	Pr(TU)	Pr(TU)	Pr(TU)	Pr(TU)
White, Male, < 65 Years	0.38225	0.45264	0.53494	0.33403	0.40131	0.48251
White, Male, > 64 Years	0.17365	0.21926	0.28090	0.14554	0.18543	0.24049
White, Female, < 65 Years	0.24974	0.30789	0.38225	0.21249	0.26503	0.33403
White, Female, > 64 Years	0.10156	0.13124	0.17365	0.08394	0.10910	0.14554
Black, Male, < 65 Years	0.38462	0.45512	0.53743	0.33626	0.40372	0.48500
Black, Male, > 64 Years	0.17509	0.22097	0.28292	0.14679	0.18694	0.24232
Black, Female, < 65 Years	0.25162	0.31003	0.38462	0.21417	0.26698	0.33626
Black, Female, > 64 Years	0.10248	0.13239	0.17509	0.08471	0.11007	0.14679
Other, Male, < 65 Years	0.27888	0.34074	0.41824	0.23867	0.29525	0.36819
Other, Male, > 64 Years	0.11609	0.14931	0.19623	0.09622	0.12455	0.16520
Other, Female, < 65 Years	0.17222	0.21755	0.27888	0.14430	0.18392	0.23867
Other, Female, > 64 Years	0.06599	0.08627	0.11609	0.05417	0.07109	0.09622

In contrast, the probabilities for tobacco use among older adults and individuals from racial groups categorized as "Other" are comparatively lower. Older individuals, regardless of race or veteran status, exhibit lower probabilities of tobacco use, with White and Black males over 64 years old having probabilities as low as 0.14554 and 0.18694 in urban settings for nonveterans. The "Other" racial group also shows lower tobacco use probabilities overall, especially among older adults and females. The data indicates that location and age significantly impact tobacco use, with rural settings and younger age groups being associated with higher predicted probabilities of tobacco use, particularly among veterans.

The geographic distribution of tobacco use in Alabama counties is shown in Figure 4. Generally, veterans exhibit higher percentages of tobacco use compared to nonveterans across the state. For instance, counties like Choctaw, Clay, and Cleburne show high tobacco use among veterans, with rates exceeding 38% and reaching as high as 41.86% in Choctaw County. This trend is in contrast to the lower rates observed for nonveterans in these counties, where the highest tobacco use is about 35.03% in Choctaw County. Rural and less populated areas, such as Wilcox and Sumter Counties, also display elevated tobacco use rates among veterans. In contrast, urban counties like Jefferson and Madison have relatively lower tobacco use rates for both veterans and nonveterans, with Jefferson County's veteran tobacco use rate being around 27.82% compared to 23.66% for nonveterans.

Figure 4: *Predicted rates of tobacco use (TU) among veterans and nonveterans in Alabama counties (2021-2022)*

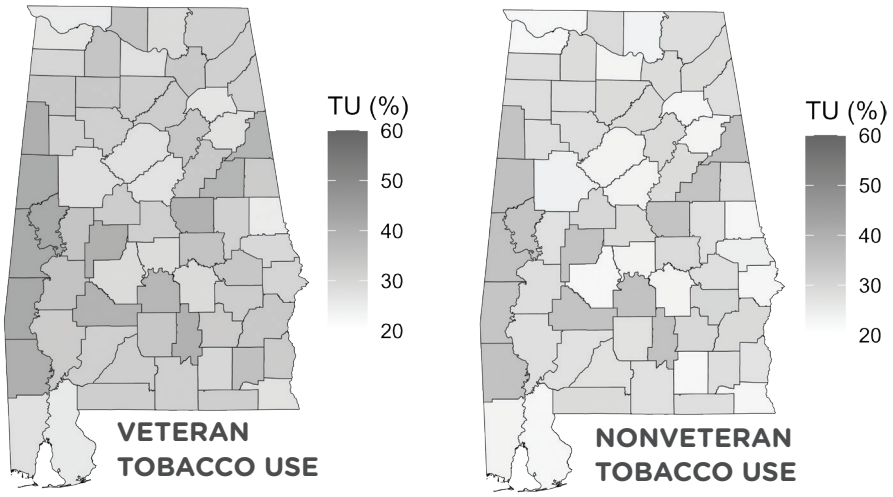


Table 24 shows the prevalence of tobacco use across Alabama catchment areas, comparing veterans and nonveterans. The data show higher tobacco use among veterans in most areas, with rates ranging from 27.56% in Riverbend to 38.84% in West Alabama. Nonveteran prevalence is consistently lower, ranging from 25.48% in Riverbend to 31.63% in Northwest and Central Alabama Wellness. The largest disparity is observed in Cahaba, where the veteran prevalence is 36.06%, compared to 27.89% for nonveterans. Notably, in Central Alabama Wellness and CED, nonveterans exhibit slightly higher tobacco use rates than veterans, suggesting local variations in usage patterns.

Table 24: *Prevalence of tobacco use in Alabama catchment areas by veteran status*

CATCHMENT AREA	VETERAN PREVALENCE RATE (%)	NONVETERAN PREVALENCE RATE (%)
Altapointe I	36.05636	31.60483
Altapointe II	31.33719	28.67275
Cahaba	36.0636	27.88637
Carastar	32.61294	25.97571
Central Alabama Wellness	29.61372	31.61094
CED	29.96044	30.20162
East Alabama	29.22934	28.1648
East Central	32.89407	29.60966
Highland	33.066	28.69193
Indian Rivers	34.76379	28.92993
JBS	31.42034	28.66059
Mountain Lakes	32.53504	28.41243
North Central	32.11065	28.75688
Northwest	34.15129	31.62846
Riverbend	27.56178	25.47868
South Central	33.72639	27.96067
Southwest	32.18481	25.80881
Spectracare	32.20103	28.29501
Wellstone	30.42136	29.00226
West Alabama	38.84084	31.21165
ENTIRE STATE	**32.53755**	**28.8282**

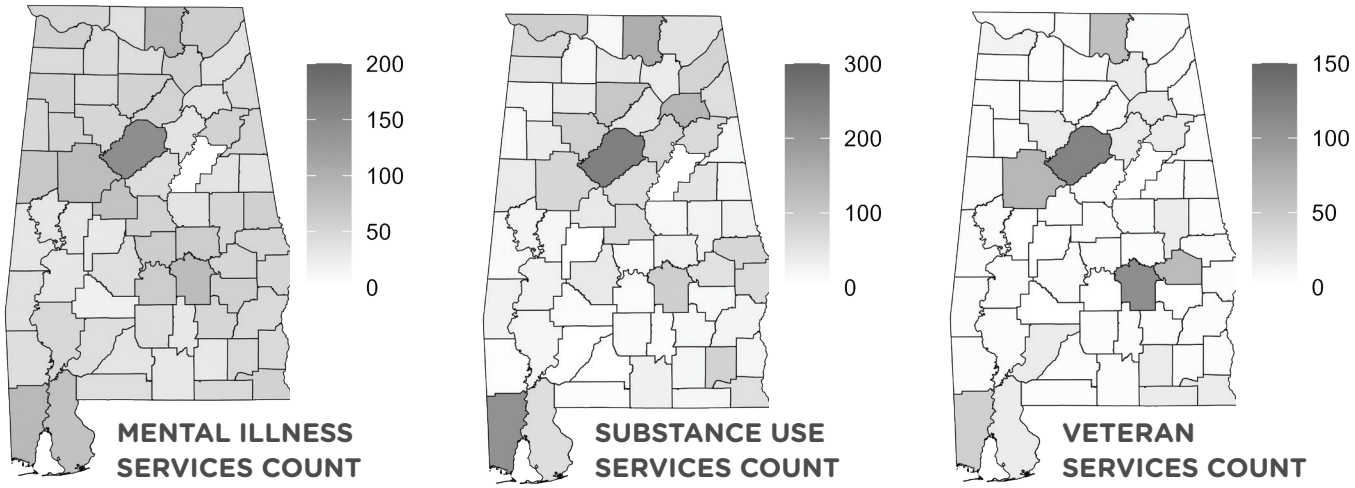
MENTAL ILLNESS, SUBSTANCE USE, AND VETERAN SERVICES

Figure 5 offers an overview of how mental health, substance use, and veteran services are distributed across Alabama's counties. Mental health services show a wide range of availability, with a higher density in urban areas such as Mobile (88 services) and Jefferson (146 services), while rural areas like Wilcox have significantly fewer services (21 services). The data indicates that regions such as JBS and Altapointe II have developed more extensive mental health infrastructures.

Substance use services exhibit similarly uneven distribution patterns. Jefferson County leads the state with 303 services, contrasting sharply with counties like Perry, Conecuh, and Monroe, each of which has only 3 services. This suggests that urban centers may have more robust resources for addressing substance use, while rural areas may face barriers to accessing care.

Veteran services are generally sparse, with many counties reporting just five or fewer services. However, Montgomery and Jefferson counties are exceptions, with 109 and 121 services respectively, suggesting a more substantial support network. The overall pattern reveals considerable geographic disparities, indicating that some areas might be under-resourced in terms of veteran support services.

Figure 5: *Geographic distribution of mental illness, substance use, and veteran services in Alabama*



SUMMARY AND CONCLUSIONS

The analysis of behavioral health issues in Alabama reveals significant geographic disparities in psychological distress, opioid misuse, suicidal ideation or planning, illicit drug use, alcohol misuse, and tobacco use. The geographic distribution of psychological distress shows considerable variation across counties. For instance, counties like Russell and Elmore exhibit higher rates of psychological distress among veterans, whereas Lauderdale and Baldwin report lower levels. Nonveterans generally experience higher psychological distress, with counties such as Pike and Bibb showing particularly high percentages. In general, the results of the predictive modeling exercise show how geographic factors, such as urban versus rural settings, influence mental health outcomes, with suburban areas consistently showing higher levels of distress.

In terms of illicit drug use, geographic disparities are also evident. Veterans tend to have higher predicted probabilities of illicit drug use and opioid misuse. Nonveterans, while showing slightly lower rates, still exhibit notable variation. The differences between veterans and nonveterans are more pronounced in rural areas, suggesting that geographic location may contribute to varying levels of drug and opioid use risk.

Alcohol misuse and tobacco use patterns are also characterized by geographic disparities. Veterans show higher rates of alcohol misuse and tobacco use compared to nonveterans, with rural counties like Choctaw and Clay exhibiting particularly high rates. Conversely, urban counties such as Jefferson and Madison have relatively lower rates for both alcohol misuse and tobacco use. This geographic variation may indicate that regional factors, including access to resources or community support, impact substance use behaviors.

The model predicting suicidal ideation or planning (SI/P) showed that older individuals (over 64) are less likely to engage in SI/P, while women are more likely to do so. Geographic factors also matter, with those living in suburban and rural areas having higher SI/P rates than urban dwellers. While veterans generally show slightly higher probabilities of SI/P than nonveterans, this difference isn't statistically significant. Younger individuals (under 65) have higher probabilities of SI/P across racial and gender groups, with suburban areas showing the highest rates, especially among White females. Some counties, like Bullock, Dale, and Elmore, show higher veteran SI/P rates, suggesting a need for veteran-specific interventions, while other counties, such as Jefferson and Tuscaloosa, show nonveteran rates significantly higher than veteran rates.

Overall, the geographic distribution of these behavioral health issues in Alabama illustrates that both veterans and nonveterans face varied risks depending on their location. Rural areas often experience higher rates of psychological distress, drug use, alcohol misuse, and tobacco use compared to urban areas.

PREVALENCE REPORT: DETAILED METHODOLOGY

The purpose of this report is to characterize the current prevalence of psychological distress, opioid misuse, suicidal ideation or planning, illicit drug use, alcohol misuse, and tobacco use in Alabama based on certain socio-demographic attributes, including age, sex, race, veteran status, and rurality. In order to estimate rates of the previously mentioned behavioral health issues, data were retrieved from the 2021-2022 files of the United States National Survey on Drug Use and Health (NSDUH).[4] The NSDUH is an annual survey conducted nationally with representative noninstitutionalized persons aged > 12 years. For purposes of completing the current report, persons aged < 18 were excluded from the analysis. Topics covered in the survey include, but are not limited to, substance use and mental health.

Several items were extracted from the 2021-2022 NSDUH in order to analyze data for this report. Psychological distress was measured with the Kessler Psychological Distress Scale ("K6").[5] The K6 is a 6-item self-administered questionnaire that includes Likert-scale response options ranging from 1 (none of the time) to 5 (all of the time). Scores of 13 or more are considered indicative of clinically significantly psychological distress.[6] Therefore, in this report, we categorized individuals as having psychological distress if their scoring pattern resulted in a summative score of 13 or more.

Past year illicit drug use was based on an NSDUH calculated index, borrowing DSM-5 criteria for substance use disorder, from survey questions about all known illicit drugs (e.g., cocaine, heroin, methamphetamine), excluding alcohol and marijuana. Opioid misuse was defined as (a) misuse of prescription drugs, including use in any way not directed by a doctor, including use without a prescription of one's own medication, use in greater amounts, more often, or longer than told to take a drug, or use in any other way not directed by a doctor; or (b) heroin use. Past year alcohol misuse was based on an NSDUH calculated index, borrowing from DSM-5 criteria for alcohol use disorder, from questions about the consumption of five or more drinks on one occasion and heavy consumption throughout the week. Past year tobacco use was based on an NSDUH calculated index which combined responses on questions about cigarette use, cigar use, pipe use, or smokeless tobacco use. Past year suicidal ideation or planning (SI/P) was based on an NSDUH calculated index combining responses to questions about whether a person thought about, planned, or attempted suicide. Several socio-demographic measures were used to characterize the sample, including age (< 65 years, or ≥ 65 years), sex (male or female), race (white, black or other race), veteran status (no or yes), and rurality (urban, suburban, or rural).

Data were analyzed using procedures from Albright et al.'s paper[7] published in the journal, "Public Health." That is, fixed effects linear regression models were fit to the national data to obtain predicted probabilities of the outcomes for all combinations of the independent variables (e.g., the probability of psychological distress among urban-dwelling veterans who are white, female, and < 65 years). Probabilities were applied to Census population counts in Alabama counties that matched the model independent variable combinations.[8] Predicted counts of persons likely having the outcome of interest were summed across demographic

groups to obtain a numerator for a particular county's prevalence rate. The denominator in the estimated prevalence rate was based on the total population in that county aged > 17 years. Choropleth maps with graduated symbols were created in order to visually display the results.

PREVALENCE REPORT: BIBLIOGRAPHY

[1] United States Substance Abuse and Mental Health Services Administration. (2024). National survey on drug use and health (NSDUH). 2024. [Internet]. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

[2] Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., ... Zaslavsky, A. M. (2003). Screening for serious mental illness in the general population. Archives of General Psychiatry, 60(2), 184-189.

[3] Prochaska, J., Sung, H-Y., Max, W., Shi, Y., & Ong, M. (2012). Validity study of the K6 scale as a measure of moderate mental distress based on mental health treatment need and utilization. International Journal of Methods in Psychiatric Research, 21(2), 88-97.

[4] United States Substance Abuse and Mental Health Services Administration. (2024). National survey on drug use and health (NSDUH). 2024. [Internet]. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

[5] Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., ... Zaslavsky, A. M. (2003). Screening for serious mental illness in the general population. Archives of General Psychiatry, 60(2), 184-189.

[6] Prochaska, J., Sung, H-Y., Max, W., Shi, Y., & Ong, M. (2012). Validity study of the K6 scale as a measure of moderate mental distress based on mental health treatment need and utilization. International Journal of Methods in Psychiatric Research, 21(2), 88-97.

[7] Albright, D. L., Lee, H. Y., McDaniel, J. T., Kroner, D., Davis, J., Godfrey, K., & Li, Q. (2019). Small area estimation of human papillomavirus vaccination coverage among school-aged children in Alabama counties. Public Health, 177, 120-127.

[8] Modeled rates were based on NSDUH data and Alabama Census data from 2022 (5-year estimates). Sociodemographic data for veterans from the Census files were similar to estimates from the Purdue University Military Family Research Institute (MFRI). For example, veteran population counts in Alabama counties based on Census data were similar to veteran population estimates for Alabama counties from the MFRI ($r = 0.98$, $p < 0.001$).

APPENDIX 3:
DEFINITIONS OF COMMON COMMUNITY RESOURCES

Behavioral Health Care: The prevention, diagnosis, and treatment of mental health conditions, substance use disorders, and behavioral health crisis.

Benefit Navigation: A specific type of case management in which a professional assists the veteran, the veteran's dependents, and/or survivors in applying for all benefits available to them.

Care Coordination: Care coordination is a system-wide approach to the deliberate organization of all Veteran care activities between two or more participants or systems to facilitate the appropriate delivery of health care services. It can include, but is not limited to, care management and case management. Within the VHA level of care coordination framework, care coordination falls within the basic level.

Case Management: Case management (CM) is a proactive and collaborative population health approach to longitudinal care coordination focused on chronic disease and acute condition management. Case management includes systems collaboration and the linking of Veterans, families, and caregivers with needed services and resources, including wellness opportunities. Case management includes responsibility for the oversight and management of a comprehensive plan for Veterans with complex care needs. Within the VHA level of care coordination framework, case management falls within the complex level.

Care Management: Care management is a population health approach to longitudinal care coordination focused on primary or secondary prevention of chronic disease and acute condition management. It applies a systems approach to collaboration and the linkage of Veterans, their families, and caregivers to needed services and resources. Care management manages and maintains oversight of a comprehensive plan for a specific cohort of Veterans. Within the VHA level of care coordination framework, care management falls within the moderate level.

Co-Occurring Disorders: When a person has two or more disorders at the same time as the other. This occurs frequently with mental and substance use disorders. Co-occurring disorders frequently exacerbate the symptoms of the corresponding disorders.

Community Resources: Any community service (i.e.: volunteer or nonprofit) organization that can be called on to take care of the identified need(s) of an individual.

Comprehensive Plan: The comprehensive plan established pursuant to Act 2024-358, to address the behavioral health needs of veterans as a supplement to services already offered in Alabama.

Homeless Prevention: Any service provided to an individual or family who is at imminent risk of homelessness including emergency funds, home items, and home rental/ownership support.

Inpatient Services: Healthcare services that require a patient to stay in a licensed facility overnight or for an extended period.

Integrated Case Management: A specialized, collaborative practice among multiple interprofessional health care teams. Integrated Case Management (ICM) provides structure and standards to support collaboration throughout the continuum of care and optimal utilization of health care resources. Its focus is on program intersections, care transitions, and provider and patient match. ICM emphasizes the importance of patient stratification by acuity, risk, and intensity into an appropriate level of care coordination. Within the VHA Care Coordination & Integrated Case Management (CC&ICM) framework, ICM services correspond with a complex level of care coordination. Because of this, ICM services are higher in intensity and frequency, and delivered to Veterans with greater complexity, as compared with basic and moderate levels of care coordination. A comprehensive description of the CC&ICM framework is contained within the CC&ICM Portal on VA SharePoint and is beyond the scope of this directive.

Outpatient Services: Healthcare services that do not require a patient to stay in a licensed facility overnight or extended period. A clinic where an individual receives mental health therapy, and then leaves the same day, is an example of an outpatient service.

Prevention Services: Services across the mental health, substance use, and/or healthcare continuum that serve to stop diagnoses before they start.

Post Traumatic Stress Disorder (PTSD): A mental health condition that is caused by an extremely stressful or terrifying event – either being a part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts and behaviors in response to the event.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Traumatic Brain Injury (TBI): An injury to the brain caused by a forceful bump, blast, or jolt to the head or body, or from an object that pierces the skull and enters the brain, which can be the result of external forces, including, but not limited to, assault or motor collisions.

Veteran: Any current resident of the state who served in the active military, naval, air, or space forces of the United States who was discharged or released under conditions other than dishonorable; is or was a member of the Army National Guard or Air National Guard who was discharged or released from service under conditions other than dishonorable; or is or was a member of the reserve component of the Armed Forces who was discharged or released from service under conditions other than dishonorable.

COMMUNITY RESOURCES

Case Management: Any service that connected a member of the community to an appropriate, solution-focused service in the venue of mental health, social service navigation, medical service assistance/support, and/or benefit navigation.

Clothing: Services that provided free clothing for adults or children.

Crisis Stabilization: Services related to human trafficking, suicide prevention services, mental health crisis training opportunities, domestic violence crisis hotlines and outreach, emergency/disaster support and relief.

Disability Services: Any community service specifically stated and geared towards supporting individuals with disabilities and their families and/or caregivers.

Education, etc.: Services provided with an education element such as nutrition classes, gardening classes, financial coaching, budgeting, etc. These also include adult education and GED classes.

Family Services: Any service—educational or material—that dealt with parents, marriage, childcare, development, etc.

Food Assistance: Services in which an organization provided a hot meal, take-home or frozen meal, food pantry or emergency food services to the community or an individual.

Groups: These services include group meetings of a non-clinical nature. Meetings such as those provided by Celebrate Recovery and social groups for specific populations were recorded here.

Healthcare, etc. Assistance: These are community-based services that specifically aided an individual in paying for healthcare and/or dental procedures, medical devices, and/or prescriptions.

Home Repair, etc.: Any services dealing with community-based home repair services, home accommodations, furniture, kitchen items, bedding, or other items used in the home.

Homelessness Prevention: Services that included home repair, housing support, home financial literacy programs, home loan education services, and temporary shelters.

Job Support, etc.: All services that included specialized training or education opportunities, transition services for persons experiencing homelessness, substance use, mental health, and/or incarceration.

Medical and Dental Services: Any service provided in the community that was medical in nature and provided at free or majorly reduced cost to the community.

Senior Services: Any service provided specifically to community members aged 55 and older.

Substance Use and Mental Health Support: Services in the community available to the general public that assist an individual in MH/SU treatment or recovery such as SU groups (Alcoholics Anonymous) or MH/SU education services (psychoeducation).

Transportation and Car Support: Include any services that provide free transportation, access to vehicles, gas support/vouchers, and/or car repair.

Utilities and Financial Aid: Community services available for utility assistance payment, or emergency need payments such as mortgage assistance, etc.

Women Resources: Community-based resources that serve women specifically in pregnancy and women's health resources and/or services.

APPENDIX 4:
SB135

SB135 ENROLLED

SB135

GQHQCCC-3

By Senators Jones, Chesteen, Butler, Kelley, Stewart,

Coleman-Madison, Coleman, Barfoot

RFD: Veterans and Military Affairs

First Read: 20-Feb-24

First Read: 20-Feb-24

Enrolled, An Act,

Relating to the Alabama Department of Mental Health; to add Chapter 58 of Title 22, Code of Alabama 1975; to require the Alabama Department of Mental Health to work collaboratively with the Alabama Department of Veterans Affairs to develop a comprehensive plan to address Alabama veterans' behavioral health needs and to provide funding of certain programs addressing specific behavioral health needs.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Chapter 58 is added to Title 22, Code of Alabama 1975, to read as follows:

Chapter 58

§22-58-1

As used in this chapter, the following terms have the following meanings:

(1) ADMH. The Alabama Department of Mental Health.

(2) ADMH COMMISSIONER. The Commissioner of the Alabama Department of Mental Health.

(3) ADVA. The Alabama Department of Veterans Affairs.

(4) ADVA COMMISSIONER. The Commissioner of the Alabama Department of Veterans Affairs.

(5) BEHAVIORAL HEALTH CARE. The prevention, diagnosis, and treatment of mental health conditions, substance use disorders, and behavioral health crisis.

(6) COMPREHENSIVE PLAN. The comprehensive plan established pursuant to this chapter, as may be amended from time to time, to address the behavioral health needs of veterans as a supplement to services already offered in Alabama.

(7) PTSD. Post traumatic stress disorder.

(8) RECOVERY. A process of change through which individuals improve their health and wellness, live a

self-directed life, and strive to reach their full potential.

(9) TRAUMATIC BRAIN INJURY or TBI. An injury to the brain caused by a forceful bump, blast, or jolt to the head or body, or from an object that pierces the skull and enters the brain, which can be the result of external forces, including, but not limited to, assault or motor vehicle collisions.

(10) VETERAN. Any current resident of the state who:

a. Served in the active military, naval, air, or space forces of the United States who was discharged or released under conditions other than dishonorable;

b. Is or was a member of the Army National Guard or Air National Guard who was discharged or released from service under conditions other than dishonorable; or

c. Is or was a member of the reserve component of the Armed Forces who was discharged or released from service under conditions other than dishonorable.

§22-58-2

The Legislature finds the following:

(1) ADMH is the state's lead agency for this act, as well as the expert in the following areas:

a. Knowledge and expertise in behavioral health care services.

b. Certifications and implementation of the Certified Community Behavioral Health Clinic (CCBHC) model.

c. State and national standards of behavioral health care, treatment, and services.

d. Infrastructure and best practices needed to implement behavioral health care treatment, recovery, and prevention services.

(2) ADVA is the state's expert in the following areas:

a. Military experience and culture.

b. Relationships and trust with Alabama veterans.

c. Knowledge of veterans' state and federal benefits

and resources.

d. Types of support needed for veterans to reintegrate into civilian life.

§22-58-3

(a) The Veterans Mental Health Steering Committee is established. The purpose of the committee is to develop a comprehensive plan to address the behavioral health needs of Alabama veterans.

(b) The committee shall include the following individuals:

(1) The ADMH Commissioner, or his or her designee. The ADMH Commissioner shall chair of the committee.

(2) The ADVA Commissioner, or his or her designee. The ADVA Commissioner shall vice-chair the committee.

(3) The Alabama Department of Rehabilitation Services Commissioner, or his or her designee.

(4) The Adjutant General of the Alabama National Guard, or his or her designee.

(5) During their tenure as legislators, the lead sponsor for House Bill 197 and the lead sponsor for Senate Bill 135 from the 2024 Regular Legislative Session, who, upon leaving the Legislature, shall be replaced by the respective chairs of the Senate and House Veterans and Military Affairs Committees, or their designees.

(6) Representatives of two veterans service organizations with expertise in mental health, substance use, peer support, and other culturally competent care, appointed by the ADVA Commissioner, who shall serve for initial terms of one year and three years, respectively.

(7) Representatives of one other veterans support organization, appointed by the ADVA Commissioner, who shall serve for an initial term of four years, respectively.

(8) Three mental health and substance use providers

certified by ADMH who also serve veterans, appointed by the ADMH Commissioner, who shall serve for initial terms of one, two, and three years, respectively.

(9) The Associate Commissioner of the ADMH Division of Mental Health and Substance Abuse Services shall serve as an ex-officio, non-voting member of the committee.

(10) The Veterans Well-Being Program Manager of the ADVA shall serve as an ex-officio, non-voting member of the committee.

(11) The Governor or his or her designee.

(12) The Lieutenant Governor or his or her designee.

(13) The Speaker of the Alabama House of Representatives or his or her designee.

(14) The President Pro Tempore of the Senate, or his or her designee.

(15) The minority leaders of the House of Representatives and the Senate, or their designees.

(c) All appointing authorities shall coordinate their appointments so that diversity of gender, race, and geographical areas are reflective of the makeup of this state. To the extent practicable, appointing authorities are encouraged to prioritize appointments of service members, veterans, and family members of veterans. The designee of a committee member shall not be a health care provider or mental health care provider.

(d) Meetings of the committee shall be held no less than on a quarterly basis, or upon the call of the chair or a majority of committee members. Appointments to the committee shall be made by July 1, 2024, and the first meeting of the committee shall be held by September 1, 2024. All meetings shall comply with the Open Meetings Act.

§22-58-4

(a) ADMH shall work collaboratively with ADVA,

leveraging each other's roles, relationships, and expertise.

The committee shall develop a comprehensive plan in response to a review of the following:

(1) The current state of Alabama veterans' mental health and rates of substance use.

(2) Mental health, substance use, recovery, and other veteran support services in Alabama.

(3) Needs assessments previously conducted for the purpose of identifying gaps in services and support. The review of needs assessments shall include qualitative and quantitative feedback of post-9/11 veterans in Alabama, as well as the need for additional services and coordination of existing services.

(b) The review shall be completed by January 1, 2025.

(c) The committee shall consult with others, to include the United States Department of Veterans Affairs and the Substance Abuse and Mental Health Services Administration, as appropriate, during the development of the comprehensive plan.

(d) ADMH shall align the comprehensive plan with state and national behavioral health standards.

§22-58-5

(a) ADMH may establish pilot projects utilizing existing evidence-based services certified by ADMH or organizations which agree to become certified by ADMH. Pilot projects shall be awarded funding by ADMH through a fair and transparent request for proposal process. Pilot projects may begin upon the appropriation of funds and certification of projects.

(b) The pilot projects may include any of the following:

(1) Eye movement desensitization and reprocessing therapy as an evidence-based treatment for PTSD.

(2) TBI screenings integrated into behavioral health

services.

(3) Integrated behavioral health and primary care models.

(4) Agencies that have successfully met the SAMHSA criteria for the CCBHC model of care as certified by ADMH.

(c) Pilot projects shall be based on the findings of the comprehensive plan.

§22-58-6

ADMH and ADVA shall present the proposed comprehensive plan to the respective Veterans and Military Affairs Committees of the Alabama House of Representatives and the Alabama Senate for their review and input no later than April 1, 2025. ADMH shall then submit the proposed comprehensive plan to the Governor by June 30, 2025, for review and approval. The Governor shall act on the comprehensive plan no later than August 31, 2025.

§22-58-7

(a) Upon approval of the Governor and subject to sufficient appropriations, ADMH shall implement the comprehensive plan with continued input from ADVA.

(b) ADMH shall contract with multiple entities to implement pilot projects as described in Section 22-58-4 and provide services under this chapter. Contracts for the procurement of services shall be awarded on a competitive basis through a request for proposal process. Both ADMH and ADVA shall work collaboratively in the review and selection of the proposals in a fair and transparent manner.

(c) ADMH and ADVA shall comply with federal ethics laws in regard to its role in this chapter.

(d) Implementation of this chapter shall be contingent upon new funds appropriated by the Legislature. Nothing in this

SB135 ENROLLED

act shall require existing resources to be diverted for this

purpose.

(e) All pilot projects and services implemented under this act shall comply with all requirements, including data reporting and certification standards, set out by ADMH. If a recipient of funds fails to meet those requirements, ADMH may demand recovery of the full amount of funds awarded. Upon notification of any demand, ADMH shall also notify the committee outlining the rationale for taking that action.

(f) During the committee's regular meetings, ADMH shall update the committee on the progress of the comprehensive plan's implementation.

(g) The committee shall conduct an annual review and may make formal recommendations regarding the comprehensive plan. ADMH shall align these recommendations to state and national behavioral health standards and submit them to the Governor for approval.

(h) To inform this annual review, ADMH shall report annually to the committee the approximate number of veterans served through the pilot projects, the services provided by pilot projects, and the amount of funding expended for this purpose, as well as other available datapoints as determined by the committee.

(i) Nothing in this act shall supersede or diminish the existing powers enumerated to ADMH.

Section 2. This act shall become effective June 1, 2024.

_____

President and Presiding Officer of the Senate

_____

Speaker of the House of Representatives

SB135

Senate 30-Apr-24

I hereby certify that the within Act originated in and passed the Senate, as amended.

Patrick Harris,

Secretary.

_____

House of Representatives

Passed: 08-May-24

By: Senator Jones

2025 Alabama Veteran Behavioral Health Literature Review

CREATED BY

VitAL Improving Wellness in Alabama

ADMH Alabama Department of Mental Health

Created by VitAL

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

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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

FIGURES

TABLES

NEEDS ASSESSMENTS: Alabama Veterans

SOUTHWEST ALABAMA VETERAN NEEDS ASSESSMENT[1]

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 ALABAMA[2]

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 ASSESSMENT[3]

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 ALABAMA[4]

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 ANALYSIS[5]

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

ACCESSIBILITY MATTERS	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 *behavioral health* provider, dissatisfaction due to cultural incompetence, lack of education regarding available services).
THE IMPORTANCE OF INTEGRATED CARE	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.
THE WHOLE VETERAN: HOLISTIC APPROACHES	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 *Social Determinants of Health* (SDoH)—should be assessed in turn with standardized diagnostic assessments.
COMMUNITY SUPPORT	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).
STIGMA REDUCTION IS CRUCIAL	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.
PROVIDER EDUCATION IS IMPERATIVE	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.

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.	Recommendations include: 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.	Recommendations include: 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.	Recommendations include: 1. Support the development of community-based resources directed to develop and improve lives of veterans, specifically regarding: 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.	Intrinsic barriers to care include concerns regarding stigma, career impact, negative attitudes toward treatment, and lack of support. 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). Increasing mental health service utilization can also be supported through community awareness and education programs centered around benefits available to veterans, specifically.
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.	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. Financial support for veteran caregivers, food support, and housing support is also recommended.

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

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

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.

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: 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: 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: 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 incongruencies.

CONFLICT WITH MILITARY CULTURE AFTER SERVICE

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 States[6] (SAES)	Veteran-nonveteran Differences in Alcohol and Drug Misuse by Tobacco Use Status in Alabama SBIRT[7] (VNVAD)	Behavioral Health Outcomes in Veterans Compared to Nonveterans by Rural and Urban Areas in Alabama, 2015–2018[8] (BXHVA)
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.	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.	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: 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: Recommendations & Problems

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]

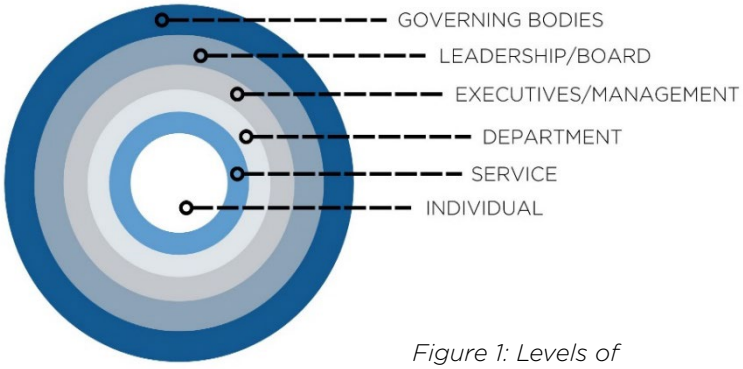

Figure 1: Levels of organizational structure

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]

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

SERVICE IMPLEMENTATION: ONE-ON-ONE SERVICES

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

This understanding starts with establishing veteran status.[5,10] Over the last two decades, there has been a

push in medical and behavioral health settings to identify and explore an individual's veteran status in a way that is non-invasive and conducive to treatment. Establishing veteran status should be a common part of physical and behavioral health histories. In addition, screening for commonly veteran-associated behavioral health diagnoses—such as substance use disorder, depression, and/or post-traumatic stress disorder—or suicidal ideation should be also an intentional part of gathering a patient's history.[11] In order to accurately capture the needs of veterans an organization is serving, a specific, intentional line of exploratory questions needs to be integrated into intake processes. Such a line of questioning includes those provided by the *Have You Ever Served in the Military?*[12,13] initiatives and assists healthcare providers in establishing a foundation of treatment that a veteran is more likely to participate in and complete.[7,9]

While some veterans express a preference for providers with military experience, research shows that 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[198,20]

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.

INSOMNIA[21]

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[199,24]

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.

PROVIDERS[27]

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://theinstitutecf.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-

[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
[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/artcles/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.
- By race:
  - White: 76%
  - Black: 13%
  - Hispanic: 9%
  - Other: 2%
- Veterans comprise roughly 6% of the nation's population.
- By gender:
  - Male: 16,180,913
  - Female: 2,086,057

ALABAMA VETERANS[1,2]

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

**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]

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

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]

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,

> 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.

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

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 Queri 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 family[2]—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 2014[2] 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: • 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 pain[12] 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]

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%

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 of threatened sexual violence* via firsthand experience

(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 & TREATMENT[16]

TREATMENT STAGE	DESCRIPTION
Assessment	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: 1. The Primary Care Screen for PTSD (PC-PTSD-5) • Self-report; twenty items 2. The Clinically-Administered PTSD Scale for DSM-5 (CAPS-5) • 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) • 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 • 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) • Self-report; eight items • Can be used for diagnoses assessment or symptom monitoring over time 6. The Trauma Screening Questionnaire (TSQ) • Self-report, ten items • Designed to be used with all survivors of all types of traumatic stress
Therapy	The VA/DOD recommends psychotherapy for the treatment of PTSD.[15] Strongly recommended EBP therapy modalities included: - Cognitive Processing Therapy (CPT). - Eye Movement Desensitization and Reprocessing (EMDR). - or Prolonged Exposure (PE). There was also sufficient evidence for delivering these psychotherapies over e-based modalities such as teleconferencing.
Social Support & Case Management	EBP care for PTSD regarding social support and case management includes recommendations such as: 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	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. 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.
Maintenance	Maintenance of PTSD diagnoses includes:[15] 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	• Veterans are more likely than active-duty personnel to engage in illicit drug use.[18]
OPIOID AND PRESCRIPTION DRUG MISUSE	• 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	• 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	• 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 relationships[21]

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	• 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	Across all SUDs, when withdrawal symptoms are present, there is recommendation of medication assisted withdrawal. • 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	At times, medication assisted treatment is recommended depending on the severity and/or the type of SUD. • 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	Each SUD has common psychosocial and therapeutic intervention EBPs. Common interventions include: • 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 disorders[23] 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 of 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 diagnoses[23]: 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 theses 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]	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. 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. 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.
Acceptance and Commitment Therapy for Depression[29,32]	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.
Behavioral Therapy and Behavioral Activation[29,32]	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. Both BT and BA engage the veteran in problem-solving, reflection, mood tracking and emotional intelligence, and interpersonal skills practice.
Interpersonal Psychotherapy[29,32]	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.
Problem-Solving Therapy[29,32]	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.
Non-directive Supportive Psychotherapy[32]	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.
Short-term Psychodynamic Psychotherapy (STPP)[32]	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.

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	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. 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.
Medication	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.
Therapeutic Interventions	For both bipolar disorder and schizophrenia, non-pharmacological interventions such as the following have been proven to decrease symptoms and distress: • 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 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. Specifically for schizophrenia, other EBP interventions include: • 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	For both bipolar disorder and schizophrenia, support in the maintenance phase of treatment includes: • 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]	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: • 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]	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).
Mental Health Case Management	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]

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	Peer specialists exist to: • 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. 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: 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 Support provided by peer specialists services are considered an EBP for behavioral healthcare within and outside of the veteran population.

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.

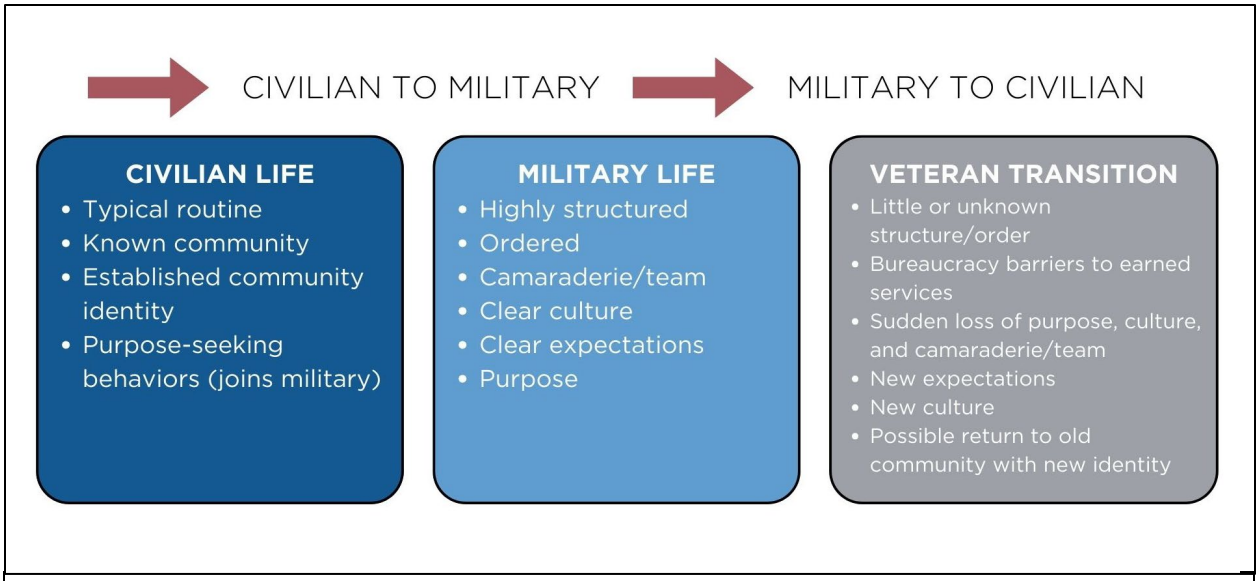

Figure 3: Considerations in Civilian to Military to Veteran Transitions

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	1. Available 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 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, 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 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	1. For each veteran, individual support plans should be created through the identification of individual needs.[16] a. Special attention paid to ensuring non-White and women veterans' transition support is individualized[16] and based on assessed need—not a model created for majority veteran populations.[17]
Support in Healthcare Venues	All healthcare venues should, 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. 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 venues[9] and higher treatment engagement/treatment rates[11] 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 situation[22]. 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., Spoont, 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/VADODmTBICPGProviderSummaryFinal508.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.

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