ABOUT STACY L. PEARSSALL
Stacy L. Pearsall got her start as an Air Force photographer at the age of 17. During her time in the service, she traveled to over 41 countries, and attended S.I. Newhouse School of Public Communications at Syracuse University. Now combat disabled and retired from military service, Pearsall continues to work worldwide as a freelance photographer, and is an author, educator, military consultant, public speaker and founder of the Veterans Portrait Project.

ABOUT THE VETERANS PORTRAIT PROJECT
Some are smiling. Others gaze at a distant point. All are veterans. The Veterans Portrait Project began while Stacy Pearsall recovered from combat injuries sustained in Iraq. Spending hours in VA waiting rooms surrounded by veterans from every generation and branch of service, Pearsall was compelled to honor and thank them in the only way she knows how, photography. The Veterans Portrait Project totals 3,000 veterans and grows daily. Learn more http://www.veteransportraitproject.com/

COVER PHOTOS
• Sheila C. Berg – Served in the Air Force as a Jet Engine Mechanic (E-8) from 1980 – 2009, Gulf War, Desert Storm, OIF
• Charles Bower – Serving in the Army as a Helicopter Hydraulic Repair (E-4), Oct. 9, 2012 - Present
• George H. Dennison –Served in the Army in Artillery (E-4) in 1966, Vietnam
• Kahmia Johnson – Served in the Army as 71L (E-3) from June 1999 - Jan. 2003
• Jian Hua Liu – Served in the Navy as a Nurse (O-4) from 2000 - 2014
• Wes Moore – Served in the Army as a Captain (O-4) and Infantry Officer (11A) from 1998 – 2009, Operation Enduring Freedom
• Richard T. Robinson – Served in the Army in Aircraft Maintenance (E-6) from 1955 – 1976, Vietnam
• Floyd R. Thomas – Served in the Army as an Infantry, Medic, Airborne (E-4) from Sept. 12, 1944 - Nov. 27, 1946, WWII, Battle of Okinawa, Occupation of Japan
• Jorge R. Torres-Nadal – Served in the Army as a Dentist (O-5) from 1953 - 1956 (Drafted Enlisted, Korean War), and 1965 - 1987
CommonHealth ACTION would like to extend our appreciation to everyone who contributed to this environmental scan. We could not have undertaken a project of this scope without support and guidance from many dedicated individuals and organizations. The opinions and conclusions expressed in this report are solely those of the authors and do not represent the opinions of our funder or collaborators.

This project was generously funded by the Robert Wood Johnson Foundation (RWJF). Thank you to our Program Officer, Maisha E. Simmons, MPA, for your support and guidance. CommonHealth ACTION appreciates RWJF’s commitment to creating a culture of health for America and its investment in our efforts to elevate equitable strategies to better support our veterans’ well-being.

This publication is the collaboration of many CommonHealth ACTION staff and long-time partners. Chanel Barnes-Osula, MA, MHS, Program Associate, and Julia W. DeAngelo, MPH, Program Manager, led the research, writing, and analysis for this project with substantive direction and input from Natalie S. Burke, President and CEO; and Nehanda A.M. Lindsey, MS, MIB, CMP, Director of Program Strategy. Kara D. Ryan, MPP, Senior Program Manager, served as a technical writer and editor for the publication. In addition to Ms. Barnes, Ms. DeAngelo, and Ms. Lindsey, Tiffany R. Boykins, Program Assistant, and Rejane C. Frederick, Assistant Program Manager, contributed to the veteran subpopulation profiles within this report. Nehanda A.M. Lindsey facilitated our Washington, DC focus group and LeKesha L. Perry, MPPA, Senior Program Manager, facilitated our Jackson, MS focus group. Erima S. Fobbs, MPH, Director of Public Health Programs, and Lolita M. Ross, MPPA, PMP, Director of Southern Strategies provided thought partnership to the project team. Finally, CommonHealth ACTION engaged the services of Melody Johnson Morales, PhD, Senior Evaluator, Nexus Research Group, who analyzed data from our national veterans’ survey, and Kimberly Singletary, Creative Director, and Jane Hahn, Senior Designer/Director of Production, Conceptual Geniuses, who designed the layout and prepared this report for publication.

We would like to acknowledge The Chicago School of Professional Psychology (TCSPP) as an invaluable research partner. TCSPP’s National Center for Research and Practice in Veteran and Military Psychology’s charter is to conduct research, advocate, support, and assist those who have served our country and their families. Thank you to Orlando L. Taylor, PhD, MA and Eric M. Morrison, PhD who provided Institutional Review Board oversight as well as resources and expertise. Thank you also to Brittney F. Briggs, MA and Michael Ruiz, who contributed to research on specific veteran populations and facilitated our Chicago, IL and Los Angeles, CA focus groups, respectively.

To our key informants, thank you for your dedication to and support for our veterans. You bring innovative approaches that are necessary to propel us toward an equitable framework for veterans’ mental health. Your willingness to share and connect has been a tremendous asset and we look forward to continued collaboration.

To the U.S. veterans that participated in our focus groups and survey, thank you for sharing your experiences, knowledge, and ideas with us. We hope this report helps to create the space for a
national narrative that is equitable, inclusive, and veteran-led. Ultimately, it is incumbent upon all of us to create the policies, systems, and neighborhood conditions that provide the contexts within which you and your families will live your lives, be healthy, and thrive.
T.J. BREEDEN  
FOUNDER & EXECUTIVE DIRECTOR OF EMERGING ENTREPRENEURS, INC.

Collaboration is the key to advancing social impact. For those of us who dedicate our lives to advocating for change in our society (or are simply consumed with the prospect of seeing our efforts spawn the kinds of positive imprints that produce one small ripple at a time), we have all embraced this way of thinking. Essentially, it is the belief-system that we are more powerful together; and through the exertion of our shared intellectual strength and ambition to be of service to others, we have the capacity to prompt the kind movement that can swell “one small ripple” into a massive wave of resources, stimulus, knowledge, authority, and change. In reading this report, these words of this simple mantra rang true. Through the collective input of researchers, leaders, philanthropists, wellness professionals, veterans, and civilians, CommonHealth ACTION was able to produce a useful and resourceful guide to help address one of our nation’s most disheartening realities: the social, health, and economic disparity that exists within our military community. As a civilian who made a conscious decision to dedicate my young career and ambitions to identifying creative ways to help veterans explore the economic layer of their transition back into society, I have come to recognize the multifaceted complexity of each veteran’s journey home. This report I believe provides a roadmap through the difficult social terrain that our heroes navigate, cluttered by the psychological wounds of war, health disparities, and economic displacement; and provides a pathway through which we as a society can assist our heroes with every possible opportunity to secure the very American Dream they fought to protect.

CHRISTOPHER DEUTSCH  
DIRECTOR OF COMMUNICATIONS, JUSTICE FOR VETS

If the United States is going to live up to the ideal of caring for all those who wear the uniform in its defense, then it is critical that we better understand the myriad of mental health issues affecting our veterans and their families. Much of my work concerns the intersection between veterans and the criminal justice system, a topic about which little is understood. Creating a Culture of Equity for Veterans’ Mental Health draws a critical link between veterans’ mental health and justice involvement.
Building an equity framework for veterans’ mental health will help transform the way the criminal justice system responds to justice-involved veterans, particularly at the crucial intercept point of arrest. Over the past six years, Veterans Treatment Courts have emerged as a solution for veterans in the justice system suffering from substance abuse and/or a mental health condition. These programs hold veterans responsible for their actions while keeping them out of jail and connected to the benefits and treatment they have earned. As we work to expand Veterans Treatment Court to within reach of every veteran in need it is critical that justice professionals understand the correlation between veteran-specific mental health conditions and criminal activity. But it is also critical that quality, veteran-specific treatment is available to serve these veterans.

By effectively identifying, assessing, and responding to all justice-involved veterans appropriately, we can live up to our shared responsibility of leaving no veteran behind. *Creating a Culture of Equity for Veterans’ Mental Health* brings us closer to this goal.

**DENYSE S. GORDON**
VETERAN SUPPORT PROFESSIONAL, CACI
MS. VETERAN AMERICA, EMERITUS

Diversity within veteran populations is a very unique aspect that sets us apart. However, within this diversity there are subgroups and subcultures which may be at greater risk for presenting issues after exiting the military. Service members experience a myriad of issues, ranging from post-traumatic stress due to combat exposure, post-traumatic stress due to military sexual trauma, homelessness, physical ailments – all of which can contribute to how well a veteran assimilates back into society. What I’ve found while advocating for homeless female veterans is that no two stories are the same. The desire to escape the plight of their circumstances overshadows their situation – and I attribute this to their status as having served this great country. Creating opportunities for veteran groups is important. However, creating a framework for veterans’ mental health will address some of the subjects that are still taboo – allowing for those who wore the boots and have military-related experience to tell their story from moving past obstacles, shortcomings, and incompleteness, to a path of success and empowerment.
TIFFANY MANSFIELD
PROGRAM ANALYST, U.S. DEPARTMENT OF STATE
U.S. MARINE CORPS VETERAN

I applaud the CommonHealth ACTION for identifying poignant factors that impact the livelihood of many. This long awaited endeavor invokes change by exploring the need for equity, addressing the need to provide equitable opportunities to ALL Veterans. This groundbreaking project has addressed many overlooked aspects of veterans’ lives. CommonHealth ACTION team made a leap toward social progression through identifying the impact of stigma, labeling, and stereotyping.

While participating in CommonHealth ACTION’s focus group, I was amazed to see that there is a long history of social stigma that pressures women in all aspects of our lives. During the focus group, it became evident that experiences with stigma began early in our military careers. Several other topics were illuminated, including discussions of health care, common stressors, and vulnerability, all of which changed the way I relate to others. I was able to witness this group, break barriers essentially inspiring personal growth.

Through my participation in this project, I have found it possible embrace vulnerability in a space of acceptance, which promotes self-awareness and fortitude, instead of shame and resentment. This fostered a propensity to identify with my very own perceptions, changing the way I relate and connect to others especially while working as a manager in the field of Government Administration. An equity framework for veterans’ mental health will create opportunities within my current workplace by invoking a humanistic approach toward dispelling perceived limitations and encouraging connection through enhancing both individual and collective abilities to empathize.

ERIC MORRISON
DIRECTOR, NATIONAL CENTER FOR RESEARCH AND PRACTICE, MILITARY AND VETERAN PSYCHOLOGY
THE CHICAGO SCHOOL OF PROFESSIONAL PSYCHOLOGY

As an academician and a member of the profession of arms, I have rarely seen such a broad research study on successful Veteran’s programs nationwide. CommonHealth ACTION along with The Chicago School of Professional Psychology has brought attention to successful Veteran’s programs with a positive psychology approach.
The challenge is to network Veteran support resources with the requirement to assist our Nation’s Veterans with the best of care. It is important to note the utility of this research, and increase the efficiency and effectiveness of Veteran support.

CommonHealth ACTION and The Chicago School of Professional Psychology plan to initiate an effort that will develop a network of Veteran programs to link local, state, regional, and national programs. The network will inform Veterans and their families of successful programs with respect to their needs. For example, when a Veteran and his/her family move to another location or state, CommonHealth ACTION can provide them with the most current successful programs for the new location.

It is difficult for Veterans to make the transition from active duty to civilian/Veteran status. Not to mention mental health issues may complicate the transition that may have surfaced while out of the service (i.e., PTSD, suicidal ideations, domestic violence, child abuse, substance abuse, etc.). Our Veterans may still have to overcome many overwhelming problems. Veterans deserve our support. I recommend without any reservation this work of CommonHealth ACTION and The Chicago School of Professional Psychology.

STACY PEARSALL
FREELANCE PHOTOGRAPHER, AUTHOR, EDUCATOR, MILITARY CONSULTANT, PUBLIC SPEAKER AND FOUNDER OF THE VETERANS PORTRAIT PROJECT

I have served with Army infantry units on the streets of Iraq under bullet fire and explosions. I now own a small business and am a respected member of my community. I am a woman. I have PTSD. It seems one is not synonymous with the other and yet it is fact. As a female combat disabled veteran, I am a minority among the 1% of American veteran population; a reality I learned the hard way.

At the time my VA hosted PTSD therapy groups, but only men were permitted – I suppose there were not enough women with combat-related PTSD to have our own group. I was not perceived as a veteran by most VA hospital volunteers, and was denied many benefits afforded my male brethren. I had to explain over and over to VA healthcare providers my history as a combat photographer and how, as a female, my occupation put me on the front lines. I had to recount how I had seen friends die, witnessed human carnage, and how I had been injured too. Essentially, I was fighting another battle – a war for understanding, acceptance, acknowledgment and care. I did not want to be viewed simply as a female, but first and foremost a veteran.
The majority of patrons at my local VA healthcare facility were the stereotypical middle-aged males. I was a young twenty-something woman. One day, while waiting for my neurosurgeon, a World War II veteran leaned over and asked, “Are you taking your grandpa to his doctor’s appointment?” My initial feeling was frustration. I took a long breath and responded, “No sir, I’m the veteran.” His eyes bulged and he half-laughed saying, “We didn’t have many ladies around in my time.”

During our conversation, we talked about his time on the European front, combat, trauma and mental health among other things. He explained to me that men in those days suffered too, but internalized it – came home, got jobs and had families. In his mind, a lot had changed from his generation to mine. Perhaps. Or maybe my generation has just reaped the benefits in a reduction of stigma surrounding combat trauma and mental health and is more open about the subject. There is also the change in diversity of the military community over time too. Creating A Culture of Equity for Veterans’ Mental Health explores all these facets of the veteran experience.

After my conversation with the WWII veteran that day, I decided to embark on a journey of discovery. Each veteran (and those caring for them) has his/her own idea of what typical veterans looks like, about their background, where they are from, and even the reasons for serving. Admittedly, I did too – White, middle-aged-male, Vietnam veteran. However, that is just not fact, to which I can attest.

When I began the Veterans Portrait Project, I started taking portraits of veterans as a way to say “Thank you for your service,” but also to raise awareness. I wanted to show what veterans really looked like: Black, Hispanic, Asian, Caucasian, Native American, male, female, homosexual, heterosexual, young, old, homeless, married, single, disabled, and everybody in between. I made an amazing connection with all of them because we shared a common history: the military. Since starting The Veterans Portrait Project, I have photographed approximately 3,000 veterans nationwide and will continue to do so.

Statistically I may be a minority, but my service to my country should not be marginalized, and I feel that way about all veterans. By reading Creating A Culture of Equity for Veterans’ Mental Health, you too will have a better understanding of how diverse veterans really are, and just how important everyone’s mental health should be to our community.
We have been at war for 13 years. During this time, those who serve our nation have experienced considerable stress and endured significant hardships. Some will transition from the military with mental health issues that must be addressed if they are to continue to lead productive and meaningful lives here at home. Some will come home with post-traumatic stress or traumatic brain injuries. Others bear the psychological wounds of military sexual assault. Some may have entered the service with underlying vulnerabilities that made it difficult to successfully navigate the demands of life in today’s military. In addition, there are an estimated 9.1 million veterans who are 65 and older making up 40% of the total veteran population of 22.6 million. Some of these veterans suffer with mental health challenges that have never been addressed.

As a nation we owe it to our service members, our veterans and their families to provide the best care that we can to ensure their overall health and wellness. We must create a culture of equity that meets the needs of all who serve. This commitment requires that we address the mental health issues that are often a direct result of the mission that our veterans so willingly accept – to protect and defend us.

In the Creating a Culture of Equity for Veterans’ Mental Health report, we are reminded of critical truths that must guide our efforts: our veterans are not a homogenous group and we must recognize that each subgroup has unique strengths and needs; one size does not fit all in terms of mental health care, so our goal must be to develop systems that determine which treatment is best for the veteran who stands before us; and finally, no single effort or agency can address all of the needs of our veterans. We must knit together a comprehensive system of care that brings the best of what our government has to offer with the range of community based efforts that currently exist to serve these men and women. We have made progress, but much remains to be done.
In 2013, CommonHealth ACTION started an environmental scan focused on “vulnerable” veterans and their access to mental health and other services. As a national public health organization, we believe that each person’s health is a production of society. This project gave us an important opportunity to explore the challenges that many of our nation’s veterans face. When we started the work, we hoped to gather information on models, programs, and services to inform veteran-serving organizations and foundations interested in funding work that would improve veterans’ mental health. Although we accomplished the aforementioned tasks (See Appendix), not far into the process we recognized that our initial focus and assumptions needed to expand and change in order to present an accurate and meaningful depiction of the veteran experience.

First and most importantly, we unbundled the words “vulnerable” and veteran in order to see the real contexts of veterans—recognizing that vulnerability could not and should not be a commentary on individual veterans and their mental or emotional state. Instead, we discovered that many veterans experience vulnerabilities (e.g., social, economic, deferential, etc.) when they interact with institutions and systems. Data on access and usage of services and programs; veterans’ health status (inclusive of their mental health status); and our original research through key informant interviews led us to identify 12 veteran subpopulations that experience greater vulnerabilities than the overall veteran population. Those vulnerabilities have significant implications for veterans’ mental health. For each veteran subpopulation profile, we address opportunities for equity which include 1) policies and program recommendations that address inequities; 2) strategies to implement policies and programs; and, 3) research questions to spark further dialogue.

Secondly, we had to adopt the World Health Organization’s definition of mental health: a state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her and his community (2007). This framing expanded our perspective on mental health beyond an initial focus on the presence or absence of mental illness, seeing each veteran in their totality, in relation to their community and family, and throughout the course of their entire life.

Thirdly, we decided to look at the military and its culture as the progenitors of every veteran in our society. Regardless of their branch of service, occupation while serving, combat or non-combat experience, length of service, or era of service, every veteran has certain experiences in common. Many of those experiences are positive; build strength and character; foster resilience; and produce healthy and successful leaders in all walks of life. At the same time, we recognize that the personal sacrifices each service member makes; uncontrollable changes that affect children and families such as moves and deployments; experiencing life-threatening situations and violence; and working in
consistently stressful environments have short- and long-term implications for mental and physical health during and after military service.

Lastly, in what could only be described as a moment of great clarity, we discovered CommonHealth ACTION’s unique approach to this environmental scan—the application of an “equity lens” which is fundamental to how we view the production of the public’s health in America. CommonHealth ACTION defines an equity lens as the “lens” through which you view conditions and circumstances to understand who receives the benefits and who bears the burdens of any given program, policy, or practice. Using that lens, we identified opportunities to create a culture of equity to support veterans’ mental health.

It is our hope that this report’s equity framework and analysis will start a shift in the national narrative about American veterans from one that is focused on basic human needs such as medical care, food, housing, and employment to a more complex and meaningful dialogue. For this to become a reality there must be significant changes to policies and programs. The country has the power to produce health for all veterans but first we must be willing to address issues of privilege and oppression in our institutions and systems, creating equitable opportunities for all veterans to achieve their best possible health.

Be Healthy. Stay Well.

Natalie S. Burke
President and CEO
CommonHealth ACTION
ABBREVIATIONS

- **DOD**: U.S. Department of Defense
- **LGBTIQ**: Lesbian, Gay, Bisexual, Transgender, Intersex, or Queer
- **MST**: Military Sexual Trauma
- **PTS or PTSD**: Post-Traumatic Stress or Post-Traumatic Stress Disorder
- **TBI**: Traumatic Brain Injury
- **VA**: U.S. Department of Veterans Affairs
- **VHA**: U.S. Department of Veterans Affairs Veterans Health Administration

GLOSSARY OF TERMS

- **Equity**: Providing people with fair opportunities to attain their full potential to the extent possible (Adapted from Braveman, 2006)
- **Equity lens**: The “lens” through which you view conditions and circumstances to understand who receives the burdens of any given programs, policy, or practice (CommonHealth ACTION)
- **Oppression**: The exercise of authority or power in a burdensome, cruel, or unjust manner (Merriam-Webster, n.d.)
- **Perspective Transformation**: The process of becoming critically aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about our world; changing these structures of habitual expectation to make possible a more inclusive, discriminating, and integrating perspective; and, finally, making choices or otherwise acting upon these new understandings. (Mezirow, 1978)
- **Privilege**: When one group has something of value that is denied to others simply because of the groups they belong to, rather than because of anything they’ve done or failed to do (McIntosh, 2000)
- **Resilience**: The ability to adapt and adjust despite adversity (CommonHealth ACTION, adapted from CARRI, 2013)
- **Stigma**: Discriminatory beliefs, attitudes, and behaviors toward people with mental illness; self-stigma is the internalization of these attitudes, which can lead to negative outcomes such as avoidance of support or treatment (CommonHealth ACTION, adapted from Collins et al., 2012)
- **Vulnerability**: The degree to which people are susceptible to experiencing oppression or harm during or as a result of their interactions with or feedback from systems, institutions, or entities that affect their health or well-being (CommonHealth ACTION, adapted from CARRI, 2013)
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The men and women who have served our country have been profoundly shaped by their military experiences, including recruitment, training, and socialization. While many of those experiences build valuable skills and leadership abilities that benefit civilian employers and social networks, others are highly stressful, regardless of whether service members have been deployed overseas or seen combat. In many cases, stigma and organizational culture in both civilian and military populations inhibit veterans from seeking support to manage those stressors. In other cases, support services may not be accessible or appropriate for the increasingly diverse veteran population. The U.S. Department of Veterans Affairs projects that while the veteran population will decline from approximately 22 million to 14 million by 2040, the proportion of veterans of color will continue to grow, mirroring demographic shifts in the overall U.S. population (VA, 2013). Policy changes and technological innovation are also diversifying military ranks.

In September 2013, CommonHealth ACTION received funding from the Robert Wood Johnson Foundation to conduct a one-year environmental scan to understand veterans’ historical context, key policies and trends related to mental health, and elevate opportunities to improve equitable mental health outcomes for our veterans. CommonHealth ACTION conducted a literature review and media scan, key informant interviews and a convening of advisors, and collected original data through focus groups and a national survey. This resulting study identifies challenges and opportunities facing all veterans, with a particular focus on 12 veteran subpopulations who, due to their characteristics or circumstances, experience vulnerability when they interact with systems and institutions. CommonHealth ACTION defines vulnerability as the degree to which people are susceptible to experiencing oppression or harm during or as a result of their interactions with or feedback from systems, institutions, or entities that affect their health or well-being.

In the report, two sets of veteran subpopulations are explored: veterans belonging to groups who have been historically oppressed—including veterans of color as well as women, immigrants, and people who identify themselves as lesbian, gay, bisexual, transgender, intersex, or queer—as well as veterans with certain post-military experiences, by choice or by circumstance, who encounter challenges as they interact with systems and institutions designed to support them. These subpopulations include veterans who are disabled, elderly, homeless, incarcerated, other-than-honorably discharged, rural dwellers, students, and the unemployed. For each subpopulation, CommonHealth ACTION identifies opportunities for each of the subpopulations to achieve greater equity through recommending policies and programs, strategies to implement policies and programs, and research questions to spark further discussion.

CommonHealth ACTION provides three call to actions to achieve a culture of equity for veterans mental health:

1) We need a national dialogue that engages veterans and their families as well as military leaders, service organizations, policymakers, and others in order to create the culture change needed to achieve greater equity for veterans’ mental health;
2) We encourage military and veteran leaders to invest in inclusive, veteran-informed policy and culture changes, to address mental health supports and organizational structures at the start of military service rather than shortly before separation; and

3) We need to invest in more research and assessment to understand specific needs and experiences of diverse veteran subpopulations. Better understanding the experiences of different subpopulations during and after their military service is the key to designing effective, responsive interventions.

Creating a Culture of Equity for Veterans' Mental Health provides the foundation for a veteran-led, comprehensive, inclusive, and equitable national narrative that supports a cultural shift in our understanding of veterans' mental health. CommonHealth ACTION’s capacity-building approach is rooted in the belief that perspective transformation is necessary to change these systems so that all people can achieve their full potential. In essence, perspective transformation is about seeing and understanding the world in a new way and acting upon that new knowledge as a result. Perspective transformation involves using both our heads and hearts. The complex and challenging nature of an equity-focused approach requires all people to have a personal understanding and perspective on what equity means to his or her everyday life. This “heart” component, including a commitment to justice, is not sufficient to change outcomes.

Equity also requires us to engage the more technical aspects of this work (the “head” component) by writing policies, thinking through logistics, and using data to drive our strategies. Yet an equity analysis—assessing who receives the benefits and who bears the burdens of decisions and actions—is not always black and white; rather, equity requires interpreting shades of gray by activating a shared understanding of fair and just outcomes for the work. Using only one of these levers—the “head” or the “heart”—will rarely produce the desired results. It is the connection between the head and the heart that achieves perspective transformation and brings us closer to organizational and community change. A national narrative will engage both heads and hearts, giving people the tools to transform veterans’ mental health from a system of need to a culture of equity.
The men and women who have served our country have been profoundly shaped by their experiences with military recruitment, training, and socialization. While many of those experiences result in veterans with skills and leadership abilities that benefit civilian employers and social networks; some are highly stressful, whether the service members are deployed or serving on U.S. soil. In many cases, stigma and organizational culture in both civilian and military populations inhibit veterans from seeking support to deal with those stressors. In other cases, support services may not be accessible or appropriate for the increasingly diverse veteran population. This section describes the historical and cultural context of the U.S. military, the stressors of military life and their implications for mental health, as well as how population and policy shifts are creating a greater urgency for an equity-focused approach to veterans’ well-being.
A Historical Context for Military Mental Health

The U.S. military force is composed of more than 3.6 million people (U.S. Department of Defense, 2012). Active-duty members make up the largest segment (39%) of military personnel, followed by the Guard and Reserve (36%), and civilians employed by the Department of Defense (25%) (U.S. Department of Defense [DOD], 2012). As of July 2014, active-duty military personnel numbered around 1.4 million, including members of all five branches—the Army, Navy, Marine Corps, Air Force, and Coast Guard (Defense Manpower Data Center, 2014). Each branch serves a different function and has a unique culture. The military structure includes three general categories of rank, including enlisted, warrant officers, and commissioned officers.\(^1\) Approximately 82% of active-duty members are enlisted personnel, with the remainder composed of officers (17%) and cadets/midshipmen in training (1%). Millions more Americans are connected to the military through family ties; an estimated two million children have a parent on active duty or in the National Guard and Reserve and 90,000 children are born to active-duty service members each year (McLanahan, 2013).

The modern military originated at the beginning of the Revolutionary War. American colonies recognized that separate, uncoordinated militias were insufficient to defend against British attack. In 1775, the Second Continental Congress established a Continental Army commanded by George Washington, designating the New England militia as an American army and authorizing recruitment from other colonies, as well as a Continental Navy and Marines. After winning independence, Washington believed that it was necessary to retain a standing Army, although its size was subsequently reduced and the Navy was disbanded (Hogan, 2005). Later, the architects of the Constitution agreed to establish a permanent national military force but ensured civilian control of the armed forces by designating the President as commander-in-chief, enumerating presidential power to call state militias into federal service, and requiring Congress to appropriate military spending (Hogan, 2005). The Department of War was established in 1789; Congress later established the Coast Guard as well as separate cabinet-level departments of the Army, Navy, and Air Force. Since 1947, oversight of the Army, Navy, Marines, and Air Force has been consolidated under the renamed the Department of Defense (DOD). The Coast Guard, formerly under the Department of Transportation, is governed by the Department of Homeland Security in peacetime and the Navy in times of war (DOD, n.d.). For 200 years, the U.S. has engaged in hundreds of military operations abroad, including five wars against foreign nations, as well as domestic protection of people and property (Grimmett, 2010).

Historically, the U.S. military has used intelligence testing and psychological screening to assess potential recruits’ mental fitness for service (Cardona & Ritchie, 2006). Adapted by psychologists from the Stanford-Binet “IQ” test, military cognitive testing was administered to nearly 2 million draftees during World War I.

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1. Enlisted personnel are required to have a high school diploma or are working towards higher degrees. Warrant officers have specialized knowledge in their specific career field and do not focus on increased levels of command, while commissioned officers have a minimum of a four-year bachelor’s degree and are similar to managers or leaders in a company (U.S. Department of Veteran Affairs [VA], 2013).
Military personnel used the tests to disqualify people with low scores and form training groups of new recruits. By World War II, draft boards engaged military and civilian psychologists to assess potential recruits’ fitness to serve, based on interviews and review of historical records. However, examinations were brief—if determinations could not be made within 15 minutes, the draftee was referred for further observation in a hospital setting. Before the U.S. entered the war, the psychiatric rejection rate was 10-15%; after 1942, the military needed to deploy more troops and loosened its restrictions for minor mental health and personality conditions. Following World War II, the military determined that its psychiatric screening processes were too stringent and did not accurately predict service members’ performance once deployed. By the 1950s, the military integrated psychiatric questions into general medical exams and limited grounds for disqualification to “gross psychiatric disabilities.” Subsequently, the rate of applicants screened from service for mental health reasons dropped from 5.5 to 1.9 per 1,000 (Cardona & Ritchie, 2006).

Over the decades, researchers developed screening tools designed to predict new recruits’ military performance, including measures of individual motivation and adaptability. Today, the military uses a combination of intelligence testing (the Armed Forces Qualification Test score) and educational achievement to predict recruits’ successful performance, including completion of the first term of service (Cardona & Ritchie, 2006). There is no additional or comprehensive screening for psychological or personality conditions for new services members (Tritten, 2014). Identifying potential and existing mental health conditions in prospective recruits requires a diagnosis or event to be formally documented in medical records or disclosed personally by the hopeful service member (Nakashima, 2011). Therefore, potential recruits concerned about jeopardizing their enlistment have a disincentive to self-report previous mental health conditions, including depression and attempted suicide, that have not be formally documented. In fact, a recent study of Army personnel estimates that as many as one in four (25%) soldiers had a mental health condition prior to enlistment, about two times higher than the rate (12%) of a demographically similar civilian population (Kessler et al., 2014). Once enlisted, the military does conduct mental and behavioral health assessments, including baseline tests for brain function prior to deployment and upon service members’ return (Defense Centers of Excellence, 2012). Commanders may also refer service members exhibiting behavior changes for mental health evaluation, including assessment of fitness for duty (Nakashima, 2011).

**Military Socialization and Stress**

All branches of the military have basic training that is designed to prepare new recruits for the physical, mental, and emotional demands of service; specialized occupational training then follows. Although each branch has a distinct culture, the military has cross-cutting cultural values to which new recruits are socialized, including uniformity, depersonalization, hard work, teamwork, stoicism, trust, and orderliness (Hsu, 2010). Military socialization may have lasting effects on the cultural values and personalities of all services members, whether or not they were deployed (Jackson et al., 2012). The military also cultivates transferrable technical skills as well as a commitment to organization and mission in its service members.
As a result, upon separation military veterans often take on leadership and entrepreneurial roles (Syracuse University, 2012).

The environments in which members of the military have served—whether they were stationed stateside or overseas—are often high-pressure, with persistent exposure to stress and trauma. Patricia Wilson of the VA’s National Center for PTSD (2013) discusses a number of stressors common to members across all branches of service. The first is life threat, which often occurs in combat and exposure to dangerous, potentially fatal conditions or events such as threat of ambush. Second is loss, including deaths of colleagues and separation from loved ones as well as the loss of bodily function due to injury. Third is inner conflict, which may occur when people conduct or witness actions contrary to their personal morals and values. Next is combat or operational stress, or wear and tear associated with lengthy service under extreme conditions (such as an unfamiliar diet and extreme temperatures) and constant scrutiny. The final common stressor is sexual harassment or abuse, including unwanted sexual attention and contact as well as sexual coercion; it is reported at a higher rate by women but experienced by both genders and may be especially damaging when service members feel pressured to keep quiet or cover up the trauma (Wilson, 2013). The mental and physiological effects of stress can affect cognition and both individual and group performance (Hosek, 2011).

Deployment increases exposure to combat-related trauma, though it does not explain all service members’ mental health experiences. The wars in Iraq and Afghanistan have outlasted other armed conflicts, including World War II and the Vietnam War. Many service members, particularly those of Army and Marine units, have been frequently deployed and had less time between deployments to recuperate, regenerate, and train. According to Dr. Akua Asare, former Resident at the Miami VA Healthcare System, the average length of deployment in the post-9/11 wars in Iraq and Afghanistan is six months to a year. Having shorter more frequent deployments does not provide ample time to acclimate to a civilian mentality and routine, and it increases exposure to possible traumatizing events (A. Asare, personal communication, August 18, 2014). Service members with three or four tours of service report more psychological burden, acute stress, marital issues, medication use, and lower morale than their peers on first or second deployments (Brancu et al., 2011). While combat-related trauma plays a significant role in military mental health, we should not limit our understanding to those who have served overseas. A major longitudinal study that tracked active-duty service members across all branches between 2001 and 2008 found that risk of suicide was not limited to those who were deployed (LeardMann et al., 2013).

Relationship strain and family stress reactions may also contribute to military service members’ stress and mental health management [Figure 1]. Since 2001, more than two million children have been separated from their deployed parents. School age children and adolescents with deployed parents have found increases in problems with peer relationships, physiological signs of stress, emotional and behavioral problems, depression, and suicidal thoughts. Researchers also found that adolescents are more likely than their peers to use drugs or alcohol when a parent or sibling is deployed to war. Symptoms of anxiety persisted in children for up to a year after parents returned home (McLanahan, 2013). In addition to deployment,
Military families must often deal with frequent geographic moves, which can make putting down community roots and establishing local support networks more challenging.

The effects of these stressors may not end with the service member’s military career. Our understanding of the physical and emotional effects of war on the mental health of military service members has evolved over more than a century. During the Civil War, service members who survived combat trauma were often characterized as having “irritable heart,” which included chest-thumping sensations, anxiety, and shortness of breath (Turnbull, 1998). Later, “shell shock” was a common condition among World War I service members, who reported physical symptoms of fatigue, tremors, confusion, nightmares, impaired sight, and inability to eat. World War II described these physical and mental symptoms as “combat exhaustion” and “battle fatigue.” After the Vietnam War, psychiatrists coined the term “Post-Vietnam Syndrome” to describe widespread reports of psychological symptoms, including apathy, depression, and alienation, that developed months after service members returned from deployment (Satal, 2010). In 1980, the broader term posttraumatic stress disorder (PTSD) became an operational diagnosis to describe the physical and psychological symptoms experienced by survivors of traumatic events (Crocq & Crocq, 2000). Not all military personnel develop
posttraumatic stress and PTSD is not limited to the military. However, the estimated prevalence of PTSD in veterans of the current Iraq and Afghanistan wars is approximately 14%, higher than the rate (8%) within the civilian population (Gradus, n.d.). Moreover, about a third of veterans struggle with substance abuse, where veterans aged 21 to 39 involve alcohol as the primary substance of abuse (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

However lengthy or short their military careers, service members who separate from the armed forces transition to veteran status and bring their experiences with them into communities and into their homes. Transition assistance training offered to service members in their final months of active duty is a valuable opportunity for education about veterans’ benefits, services, and programs, including mental health supports. Yet there is currently no comprehensive mechanism to track former services members’ outcomes after they have separated from the armed forces and attained veteran status, particularly if they do not access VA health care services.

**Stigmatizing Veterans’ Mental Health**

As a nation, we have shifted our approach to mental health treatment from institutionalization to community-based and clinical care for mental and behavior health conditions, enacting legislation to remove financial and other barriers to care. President Truman signed into law the National Mental Health Act of 1946, which allocated government funding for mental health research and treatment and created the National Institute of Mental Health. The deinstitutionalization movement advocated for the passage of the Community Mental Health Act of 1963, which closed state psychiatric hospitals and authorized funding for community-based mental health services and programs. In 1996, Congress passed the Mental Health Parity Act, which required health insurers to provide equitable coverage for mental health and medical services in terms of lifetime limits and benefit caps. The Mental Health Parity and Addiction Equity Act of 2008 expanded on this law to include substance abuse treatments, providing protections for mental health and substance abuse treatments, and ensuring that this coverage is no more limited than other medical or surgical services offered under the same large-group health plans with more than 50 employees (U.S. Department of Labor, 2010). In 2010, the healthcare reform law—the Patient Protection and Affordable Care Act—extended mental and behavioral health parity to small group and individual plans established after the law’s passage (SAMHSA, 2014).

Despite these policy and cultural shifts, many Americans are unaware that mental illnesses can be treated and managed, and many barriers to mental and behavioral health supports persist.
While mental health is often conceived as the absence of illness or disorder, CommonHealth ACTION adopts the World Health Organization’s definition of mental health: “A state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her and his community” (2007). This framing is important to understand mental health as a shifting state of well-being experienced by everyone throughout the lifespan, rather than dichotomous mental health “haves” and “have-nots.”

The concept of mental illness as “lack” is reinforced by stigma, both within the military community and the American public at large. Stigma is the “co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised” (Hatzenbuehler et al., 2013). In this context, public stigma refers to discriminatory beliefs, attitudes, and behaviors toward people with mental illness; self-stigma is the internalization of these attitudes, which can lead to negative outcomes such as avoidance of support or treatment. Culture plays a critical role in shaping stigmatizing beliefs (Abdullah & Brown, 2011). Beliefs that people with mental illness are dangerous to themselves and others, prone to criminality, and incompetent have real effects, as people with mental health conditions face discrimination in housing, employment, and other systems (Hatzenbuehler et al., 2013). Military culture has historically perceived people with mental illnesses as weak or unfit for duty, and until recently, there have been career-limiting consequences for service members who have sought mental health care and counseling (Dingfelder, 2009). In at least one study, officers were more likely than enlisted personnel to stereotype service members seeking mental health treatment as weak (Hipes, 2011). The military is taking steps to address stigma, including educational campaigns as well as policy changes, such as implementation of a combat and operational stress control continuum that classifies service members as “ready,” “reacting,” “injured” or “ill” rather than the binary labels “ready” or “ill” (Miggantz, 2012).

In addition to stigmatizing attitudes among both military and civilian populations, veterans in particular have been labeled with a “ticking time bomb” stereotype perpetuated by popular culture and media coverage. During and immediately following the unpopular Vietnam War, public sentiment turned against not only American foreign policy, but also the returning U.S. service members. Popular culture portrayals of the PTS experienced by veterans in media (e.g., Rambo and Taxi Driver) characterized veterans as unstable, desensitized, and prone to violence. As military operations in Iraq and Afghanistan scale down, the U.S. runs the risk of recreating this stereotype of veterans as mentally fragile—and therefore dangerous. Recent media coverage of mass murders committed by veterans on military bases and in community settings—such as the Navy Yard in Washington, DC; Fort Hood in Killeen, Texas; and the Sikh Temple shooting in Oak Creek, Wisconsin—have invoked the “crazy veteran” stereotype. These sometimes sensationalized portrayals undermine efforts to reduce mental illness stigma among both military and civilian populations. An example is the case of residents in a San Diego neighborhood who have opposed siting veteran TBI treatment facilities next to a school (Holt, 2012). In other cases, employers making hiring decisions have expressed reservations about bringing veterans on their teams; in a poll conducted by the Society for
Human Resources Management, two in five (42%) employers reported challenges hiring veterans due to their concerns about potential PTS and mental illness issues (Minton-Eversole, 2012). While mental health challenges should not be minimized, this stigmatization risks labeling and devaluing another generation of veterans in a way that creates lifelong barriers to health and well-being, not to mention limiting the important contributions they could make to their workplaces and communities.

A Diversifying Military Population

In 2012, there were 21.2 million veterans living in the U.S., representing 1% of the total population (U.S. Census Bureau [UCB], 2013). In addition to understanding the role of military culture, socialization, training, and stressors, it is important to recognize the demographic shifts that have led to an increasingly diverse military workforce—and therefore an increasingly diverse veteran community. These veterans may have differing experiences with military service or other social and economic systems that they must navigate to access services and supports critical to their well-being.

While the current veteran population is predominantly composed of older White men, new generations of veterans more closely reflect the demographic shifts in the general population. Already, children of color make up the majority of infants born in the U.S. and by 2043, non-Hispanic Whites will no longer make up a majority of the population (Yen, 2013). About 90% of veterans ages 75 and older are White; however, among veterans ages 18 to 34, about two-thirds (65%) are White, followed by non-Hispanic Blacks (15%), Latinos (14%), and all other races including Asians, Native Hawaiians/Pacific Islanders, and American Indian/Alaska Natives (10%) (UCB, 2013). Researchers project that while the veteran population will decline to approximately 14 million by 2040, the proportion of veterans of color will continue to grow (U.S. Department of Veterans Affairs, 2013) [Figure 2].

Policy changes and technological innovation are also diversifying military ranks. Despite a long history of women’s contributions to war efforts, service members were traditionally men. As the draft came to an end in 1973 and women entered the workforce in greater numbers, new military career options emerged for women. The share of female service members increased from approximately 1% of military personnel in 1970 to 14% in 2012 (Rutgers, 2010). Women have represented a growing share of officers and the Department of Defense further expanded women’s roles by lifted the ban on their participation in direct ground combat (Roulo, 2013). Moreover, since 2010, women and men who are openly gay are able to serve in the military with the repeal of “Don’t Ask, Don’t Tell” (DADT), a Clinton-era policy that had prohibited open service of gays and lesbians in the armed forces (DOD, 2011). The removal of barriers on the basis of sexual identity reflects larger societal trends supporting rights for people who identify as lesbian, gay, bisexual, transgender, intersex, or queer (LGBTIQ). Transgender people—those who identify as a gender that is different from the sex they were assigned at birth—are still prohibited from military service (Cooper, 2014).

These trends underscore the need to assess the current military culture, approach to recruitment, and structures of support for veterans and their implications for health
outcomes. Despite expanding its ranks to different populations, military culture and procedures emphasize uniformity and value masculinity (Hsu, 2010). Subpopulations who have been underrepresented in the military may experience stress and trauma in unique ways—and as veterans they may not have access to appropriate services that would support optimal mental health. Moreover, the life experiences of some veterans after they have separated from service, whether by choice or circumstance, may mean that support programs are more difficult to access.
PART II

USING AN EQUITY FRAMEWORK TO UNDERSTAND HOW VETERANS EXPERIENCE VULNERABILITY

Achieving equity for veterans requires us to understand the experiences subpopulations who may experience vulnerability when interacting with systems and services meant to support their health or mental well-being. Unlike equality, which emphasizes sameness and uniformity, equity is defined as the process of providing people with fair opportunities to attain their full potential to the extent possible (Braveman, 2006). In this report, CommonHealth ACTION applies an equity lens to the veteran community by assessing who is receiving the benefits and who is bearing the burdens of current programs, policies, and practices. This framework informs our approach to understanding veterans’ mental health to create conditions that meet the World Health Organization’s (2007) expansive definition: a state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.
Veteran Subpopulations Who May Experience Oppression and Discrimination

Health is production of society; it is shaped and driven by policy. While our genes and behaviors do have important roles to play in our health outcomes, policies and systems create the context in which people live their lives and make personal health decisions (Centers for Disease Control and Prevention [CDC], n.d.). For instance, families who live in neighborhoods where violence is common and playgrounds are crumbling have a more difficult time engaging in physical activity than people with access to safe, clean green spaces and trails. This approach is aligned the socio-ecological model, which takes into account the complex interplay between individual, organizational, community, and public policy/societal factors (CDC, 2013). For historically disadvantaged and under-resourced communities, improvements in opportunity occur by addressing the social determinants of health (e.g., housing, the environment, transportation, employment, education, structural racism, access to healthcare, and access to technology) by changing policies, practices, and procedures. Intervening at the systems level to ensure that all veterans have access to services and systems is critical to improving veterans’ mental health and well-being.

Many populations within the U.S. have experienced discrimination and oppression. Historically, public policies and private actions created systems and circumstances that advantage some groups while denying benefits to others. Long after legally-sanctioned discrimination has ended, the cumulative social and economic impacts of privilege and oppression may affect current-day populations. For example, public policy and private actions in the first half of the 20th century helped to create neighborhoods of concentrated poverty in hundreds of American cities. Practices of “redlining,” the denial of federally backed mortgages to African American and Latino populations, and restrictive housing covenants in which private homeowners contractually agreed not to sell their properties to people of color, Jews, and other populations, reinforced residential segregation and made it impossible for these groups to move into White neighborhoods where rising property values created wealth, later passed on through generations (Hernandez, 2009). Moreover, communities of color were locked into neighborhoods of disinvestment that, decades later, continue to suffer from poverty, economic crisis, and foreclosure—even after fair housing laws outlawed discrimination. This is an example of how populations that have historically experienced oppression may continue to have interactions with systems and institutions that leave them vulnerable to poorer outcomes.

Finally, while certain populations have been oppressed on the basis of an innate or immutable characteristic, such as race or national origin, other groups—such as students, people experiencing homelessness, and the elderly—have also been the subject of systemic and interpersonal discrimination and prejudice.

It is well-established in scientific literature that when people are repeatedly exposed to stressful environments, hormones that trigger a fight-or-flight reaction are constantly activated, resulting in wear and tear on the body even at a cellular level. Researchers refer to the physiological impact of chronic stress as “allostatic load,” and are able to measure the body and brain to determine an individual’s risk. High allostatic
loads are linked to high blood pressure, stroke, and heart disease as well as illness and early death (McEwen & Gianaros, 2010). Risk factors for high allostatic load include socioeconomic status (e.g., education, income, employment status), race/ethnicity, built environment (e.g. rural/urban infrastructure challenges, poor housing), lack of social support and interpersonal problems, and genetics (Juster et al., 2010). Moreover, a growing body of research has demonstrated a link between discrimination and allostatic load. For example, one longitudinal study of rural African American boys from low-income households found that the young men who experienced racial discrimination and did not receive emotional support from family and friends were more likely to have high allostatic load by age 20 (Brody et al., 2014). In other cases, recent immigrants from Mexico were less likely to have high allostatic load as compared to their non-Hispanic Black, non-Hispanic White, and U.S.-born Mexican American peers; researchers found this advantage disappears the longer that Mexican immigrants lived in the U.S., which may reflect their experiences with discrimination and xenophobia (Peek et al., 2010). Therefore, the stressors of military life may be compounded by the chronic stress effects of belonging to a group or population that experiences overt discrimination or implicit bias.

**Defining Vulnerability and Resilience**

Vulnerability research generally seeks to understand the underlying causes of vulnerability, the scale at which it occurs, and the main actors involved, to identify for risk reduction, coping, and adaptation. The term vulnerability adopts many meanings and is interpreted in a variety of ways across sectors. In this report, CommonHealth ACTION defines vulnerability as the degree to which people are susceptible to experiencing oppression or harm during or as a result of their interactions with or feedback from systems, institutions, or entities that affect their health or well-being. Many people experience both vulnerability and resilience—the ability to adapt and adjust despite adversity—at the same time. Additionally, both resilience and vulnerability are transient. Even among individuals characterized as having a high degree of resilience will experience vulnerability throughout their lifespans.

To experience vulnerability is different from identifying an individual as vulnerable. Traditionally, the term “vulnerable” is used to characterize populations and individuals that are underrepresented, experience mental illness, or are medically underserved. Feedback from veteran communities reveals that to be characterized as vulnerable is to be weak, childlike, and defenseless. However, vulnerability is not an assessment of an individual’s character, strength, will, mental health, or socioeconomic status. Instead, it is an acknowledgment of the contexts within which people with specific characteristics live their lives. It is important to understand that identifying vulnerability does not necessarily mean that populations need to change, but rather systems, institutions, and other entities need to modify their interactions with populations in order to promote optimal outcomes. This is a critical point in understanding and addressing underlying experiences and conditions encountered by an individual that contributes to or creates vulnerability.
Identifying Veteran Subpopulations Who May Experience Vulnerability

In 2014, President Obama awarded the Congressional Medal of Honor to 24 World War II, Korea, and Vietnam veterans who had been wrongly denied this decoration due to racial, ethnic, or religious discrimination; only three were alive to participate in the ceremony and the others were awarded post-humously (Weinstein, 2014). There is evidence that veteran subpopulations who have historically experienced oppression and discrimination disproportionately experience trauma and mental health conditions that affect their well-being. Researchers estimate that rates of PTSD are higher among Black and Hispanic veterans of the war in Vietnam than their White peers, potentially because they were more likely to serve in combat and therefore experience trauma on the battlefield (VA National Center for PTSD, 2014). Discrimination and harassment are also sources of stress. More than half (55%) of women reported experiencing sexual harassment, along with about one-third (38%) of men (VA, 2014).

After service, veterans who experience difficulty accessing housing, employment, and other basic needs may also be at risk for poor mental health outcomes. Despite the fact that veterans make up 1% of the population, they make up approximately 12% of homeless adults—and within the homeless veteran population, about 40% of all homeless veterans are African American, despite these populations only accounting for 14% of overall veteran population. Veterans who experience homelessness are more likely to experience higher rates of PTSD and depression than people with stable housing. Finally, services designed to support health and wellness may be inaccessible to certain populations due to physical or cultural barriers; only about 50% of veterans access Veterans Administration (VA) services, and rates are much lower among certain subpopulations including women and minority veterans (Barbara Ward, VA Clergy Training, November 21, 2013). Among veterans using VA healthcare services, one in four women reported experiencing sexual trauma, compared to one in 100 men (U.S. Department of Veterans Affairs, 2014). Compared to 41% of OEF/OIF veterans who enrolled that were eligible for VA care, one in four (25%) of gay, lesbian, and bisexual veterans reported avoidance of using at least one service at VA that they would like to access due to worry about stigma. One in six (15%) avoided two or more VA services (Seal et al., 2009; Simpson et al., 2013). The experience of accessing VA services may vary depending on the geographic location of where a veteran resides. For example, 91% of veterans living in urban areas are able to drive 30 or fewer minutes to access VA primary care services compared to 38% of veterans living in rural communities (Heisler & Bagalman, 2013).

In this project, we explored two sets of veteran subpopulations: those belonging to groups who have been historically oppressed—including veterans of color as well as women, immigrants, and people who identify as lesbian, gay, bisexual, transgender, intersex, or queer—as well as those with certain post-military experiences, by choice or by circumstance, who encounter challenges as they interact with systems and institutions designed to support them. These subpopulations include veterans who are disabled, elderly, homeless, incarcerated, other-than-honorably discharged, rural dwellers, students, and unemployed. Assuming longevity, many veterans will belong to at least one subpopulation—e.g., the elderly—at
one point in their lifespans. We focus on these groups because we believe that an equity approach will improve quality of life for all veterans.

**Project Overview and Aim**

This report includes literature and media reviews, key informant interviews, focus groups, and original survey data to understand veterans’ historical context, key policies and trends related to mental health, and elevate opportunities to improve equitable mental health outcomes for our veterans. While our scope is focused on veterans’ mental health, we examine systemic factors that contribute to stress and lead to poorer health outcomes if not addressed (e.g., unemployment, homelessness, etc.). We examine each veteran subpopulation in turn, though we recognize that many veterans belong to multiple groups (for example, a woman of color experiencing homelessness and persistent unemployment). For each group, we make note of opportunities for achieving greater equity, including areas for future exploration: 1) policies and programs that address inequities, 2) strategies for implementation, and 3) culture changes needed to support these interventions. Our recommendations are applicable for today’s returning veterans but do not exclude generations who have served in previous eras.

With this report, we intend to lay the foundation for a veteran-led, comprehensive, inclusive, and equitable national narrative that supports a cultural shift in our understanding of veterans’ mental health. CommonHealth ACTION’s capacity-building approach is rooted in the belief that perspective transformation is necessary to change these systems so that all people can achieve their full potential. In essence, perspective transformation is about seeing and understanding the world in a new way and acting upon that new knowledge as a result. Perspective transformation involves both using our head and heart. The complex and challenging nature of an equity-focused approach requires all people to have a personal understanding and perspective on what equity means to his or her everyday life. This “heart” component, including a commitment to justice, is not sufficient to change outcomes. Equity also requires us to engage the more technical aspects of this work (the “head” component) by writing policies, thinking through logistics, and using data to drive our strategies. Yet an equity analysis—assessing who receives the benefits and who bears the burdens of decisions and actions—is not always black and white; rather, equity requires interpreting shades of gray by activating a shared understanding of fair and just outcomes for the work. Using only one of these levers—the “head” or the “heart”—will rarely produce the desired results. It is the connection between the head and the heart that achieves perspective transformation and brings us closer to organizational and community change. A national narrative will engage both heads and hearts, giving people the tools to transform veterans’ mental health from a system of need to a culture of equity.

In the veteran subpopulation profiles that follow, we incorporate data from multiple sources. Please see Appendix A for a detailed description of our methodology. Appendix B presents a list of key informants interviewed and Appendix C inventories the conferences and events CommonHealth ACTION attended. In addition to the analysis presented in veteran subpopulation profiles, see Appendix D for the Veterans’ Health Survey summary results and Appendix E for a compilation of programs and resources that provide support to the targeted subpopulations and the veteran community as a whole.
In this section, we explore the military experiences of veteran subpopulations who belong to historically oppressed groups: female veterans; immigrant veterans; lesbian, gay, bisexual, transgender, intersex, or queer (LGBTIQ) veterans; and veterans of color.
PROFILE 1: FEMALE VETERANS

Key Highlights

• As a result of their military experience, female veterans suffer from higher rates of depression, PTS and PTSD, and are impacted at a greater proportion of MST leading them to need more mental health services and assistance including securing housing
• Many female veterans do not self-identify as a veteran and are not finding sufficient gender appropriate services at the VA
• More military leadership opportunities are needed and female veterans desire a greater connection to the veteran community

Overview and Historical Context

In the U.S., there are nearly 2.2 million female veterans, comprising nearly 10% of the veteran population (U.S. Department of Labor, n.d.). Characterized as one of the fastest growing veteran groups and having doubled in size since year 2000 (Childress, 2012), this number is expected to grow exponentially in forthcoming years. From 2010 to 2040, the female veteran population is projected to jump from approximately 10% to 17%, respectively (U.S. Department of Veterans Affairs [VA], 2013), suggesting a greater demand to provide effective health care and support services for this group. In addition, female military and veteran populations have increased significantly and females are serving in new roles and greater capacities than before, including combat.

Women have historically been a substantial component of the U.S. Armed forces, but did not officially serve in the military until the Army and Navy Nurse Corps were established in 1901 and 1908, respectively (VA, 2011). Prior to that time, women served with the armed forces as contractors and volunteer nurses, cooks, and laundresses, and even in disguise as soldiers. In World War I, the Navy enlisted nearly 12,000 women as yeomen (i.e., officers who worked as clerks) to serve stateside, and more than 60,000 Army nurses served both stateside and overseas during World War II (VA, 2011). About 7,000 American military women, many of them nurses, served in the Vietnam War. In 1967, restrictions on women’s service—a 2% cap and limits on the rank that women could achieve—were repealed with a Women’s Armed Services Integration Act modification (VA, 2011). In the 1980s, the military opened to women specialties that put them much closer to combat, and their roles expanded during the Persian Gulf War. Today, women serve as pilots and in combat support units that have led to them being directly engaged in the fighting in Iraq and Afghanistan (Roulo, 2013). This involvement has led recently to the lowering of barriers to female service members serving in direct combat positions, such as infantry and special operations. The military is currently studying the most effective ways to integrate females into these positions and recently lifted a ban on women in direct ground combat. Women make up nearly 15% of the U.S. active duty force, 17% of National Guard and Reserve forces, and 20% of all new military recruits (Bean-Mayberry et al., 2010).
However, women’s career progression is often more gradual among female service members compared to their male peers, and women are underrepresented in the military’s senior ranks (Mulhall, 2009).

Women’s experiences in the military may expose them to different stressors that affect their mental and physical health. For example, female service members who were deployed and exposed to combat were 1.78 times more likely to develop eating disorders and 2.35 times more likely to lose an extreme amount of weight when compared with women service members who did not see combat (Bautman et al., 2011). Researchers estimate that between one-quarter to one-third of female service members experience military sexual trauma. This rate is significantly higher than the estimated prevalence of sexual trauma (17%) among civilian women (Brancu et al., 2011). Female service members are also more likely than civilian women to repeatedly experience sexual trauma. MST is four times more likely to result in a PTSD diagnosis than combat-related stress. It also usually results in greater unfavorable consequences when it occurs during military service due to associated psychological and physical issues, reduced safety, challenges reporting a complaint, and other obstacles associated with military life (Brancu et al., 2011). Researchers report that insufficient military health care and high risk of MST have resulted in female service members prematurely discontinuing service (Mulhall, 2009).

Despite these challenges, women in our focus groups reported positive experiences with their military service, which includes traveling around the world to gaining leadership skills and lifelong friends. For instance, a CommonHealth ACTION’s focus group participant stated “There [were] like 5 or 6 of us [female service members] that were in command that were really good friends and we were all runners. The bonding and the friendship went really deep. And so, those friendships have continued on because they were true friendships.” This theme of bonding and connection was also echoed by other female focus group members even when the group explored the challenges of being a woman in a male-dominated occupation.

**Key Trends and Policies**

In addition to experiences during service, when returning home and/or exiting the military, some female veterans encounter additional challenges accessing basic needs. In CommonHealth ACTION focus groups, participants described difficulties upon separating from the military including losing military social support connections, obtaining employment, managing financial responsibilities, and relating to family and civilian friends. In fact, female veterans are at three to four times...
greater risk of homelessness than non-veterans (Washington et al., 2010). Among female veterans, African Americans and women aged 18 to 29 years are at a greater risk of experiencing homelessness than their peers (Fargo et al., 2012). While women make up about one in 20 (5%) homeless veterans, they are often single parents or primary caregivers of children; this circumstance can create greater difficulty finding appropriate housing (Clarke, 2013; U.S. VETS, 2014). Female veterans are at double the risk of developing PTSD (10% for women vs. 4% for men) for reasons ranging from MST to blaming themselves for trauma-related experiences (VA, 2013). Focus group participants discussed the long-term effects of military stress and trauma, including unwanted sexual advances and assault. Yet many female veterans do not access support services.

In recent years, the VA has expanded its medical centers and community-based outpatient services to accommodate female veterans’ health care needs; however, tailored practices and services are still needed. Despite efforts to bolster medical and other support services, this suggests inadequate preparedness to provide services that address this surge of female veterans. Nationwide, nearly one in four VA hospitals does not have a fulltime gynecologist on staff (Daily News, 2014). The Veterans Affairs Office of Women’s Health acknowledges that persistent shortcomings remain in caring for the 390,000 female veterans seen last year at its hospitals and clinics—despite an investment of more than $1.3 billion since 2008, including the training of hundreds of medical professionals in the fundamentals of treating the female body (Daily News, 2014). The Veterans Affairs Office of Women’s Health acknowledges that persistent shortcomings remain in caring for the 390,000 female veterans seen last year at its hospitals and clinics—despite an investment of more than $1.3 billion since 2008, including the training of hundreds of medical professionals in the fundamentals of treating the female body (Daily News, 2014). However, access to mental health services may also vary by age. Younger female veterans (less than 35 years old) were significantly less likely and older female veterans (35 to 54 years old) were more likely to use any mental health services in comparison with their male counterparts (Owens et al. 2009; Batuman et al., 2011).

Opportunities to Achieve Equity

POLICIES AND PROGRAMS ADDRESSING INEQUITIES

On April 23, 2013, the VA launched its new Women Veterans hotline (1-855-VA-WOMEN), an incoming call center that receives and responds to questions across the nation from women Veterans, their families, and caregivers about available VA services and resources (Hayes, 2013). Considering the growing and varied health challenges of the female veteran population and the urgency to address these issues, workforce capacity and coordination needs to increase within the VA, private sector, and community-based organizations. The capacity of the U.S. mental health system is likely not adequate to absorb and address veterans’ issues in terms of the numbers, training, and capacity of the mental health workforce to deliver evidence-based quality care (Terri Tanielian, personal communication, January 14, 2014). These recommendations are especially applicable to female veteran populations, given the inherent male-dominated culture of the military and services have not always been tailored to accommodate the unique needs of female veterans.

IMPLEMENTATION STRATEGIES

Washington and colleagues (2011) recommend that VA after-hours care should be considered, in addition to expanded VA transportation services and tele-medicine alternatives to existing settings for care, to address healthcare access barriers for female veterans. U.S. states
most populated with female veterans, such as California, Texas, Florida, Virginia, and Georgia (VA, 2014), may be characterized as “resource-rich” and barriers to care may not be as great when compared to less populated states. However, it has been recommended that “outreach, education, and expanded VA access, to reduce barriers to entry into VA care, must be coupled with actions to enhance the gender-sensitivity and gender-appropriateness of this care” (Washington et al., 2011) even in locations that provide resources. In the Veterans’ Health Survey, female veterans reported accessing more employment and educational support than their male counterparts, indicating that they may need or are willing to access these types of transitional supports. Female veteran specific resources and provider training in these areas would be helpful.

Outside of VA-related care, it is important to inform other providers, community-based organizations, and families/friends about potential female veteran transition challenges and concerns. This will be helpful to mitigate the gap between civilian and veteran/military cultures. Lastly, it is widely suggested that social support is beneficial to the overall well-being of female veterans, including mental and physical health (Cotton et al., 2000; Crompvoets, 2011; Lehavot et al., 2013). Specifically, emotional support, that is, having someone to communicate with and people who really care, helped females to adjust more easily and adapt to postwar life (King et al., 1995; King et al., 1996; King et al., 1998; King et al., 1999; UVA, n.d.). Indeed, in the focus groups that CommonHealth ACTION conducted, female veterans expressed that they had enjoyed sharing their experiences—positive and negative—with other women who had served. It is important for communities and providers to be educated and understand which types of support work best in helping female veterans to thrive.

Additional research specifically focused on these veterans’ experiences should explore:

- What peer-support and recommendations can female veterans provide to civilian women who are also survivors of trauma?
- How can the civilian business sector offer more employment opportunities for female veterans?
- What types of supports do female veterans need? Are their transitional experiences difference across the different active duty branches and the reserve components?

**INVESTING IN A CULTURE OF EQUITY**

Creating opportunities for women to serve in greater capacity in our armed forces is a significant factor in promoting diversity in the military workforce. A more diverse and inclusive military can improve organizational performance and build more effective teams. The military has taken steps to encourage and accommodate diversity. For example, the Army Diversity Roadmap acknowledges the need to value the potential contributions of its diverse workforce to accomplish its mission through managing differing needs, attitudes, and expectations (U.S. Department of the Army, 2010)

*Women vets are almost not believed to be real vets and [we] are mostly alone with our burdens. Our little FB group has been a small way to connect & inspire. Vet med centers could org[anize] gathering[s]?*  
-Response, CommonHealth ACTION’s Veterans’ Health Survey
PROFILE 2: IMMIGRANT VETERANS

Key Highlights

- Immigrants represent a small but important share of our military and veteran population
- Population projections estimate that they will drive the net growth in the military's recruiting-age population in the coming decades and have important skills to offer including cultural diversity, linguistic fluency, and a commitment to service
- There is inadequate information available about their access to mental health support services as they transition out of service so more research is needed

Overview and Historical Context

The U.S. has long recognized immigrants’ contribution to the armed forces. Noncitizens make up a relatively small share of current veterans; many immigrants who have served eventually become naturalized citizens. Yet the federal government has recently expanded noncitizen eligibility to serve and immigration is driving growth in the recruiting-age population; these trends indicate that many future service members will hail from immigrant families. Despite the nation’s long-standing practice of recruiting and training noncitizens for military service, more information is needed about this group’s experiences with mental health diagnoses and treatment and whether they have access to all the services and programs for which they are eligible.

The foreign-born have served in the U.S. military, often with distinction, since the Revolutionary War. By the 1840s, half of all military recruits were born abroad, and during the Civil War, about one in five Union soldiers were born outside the U.S. (primarily Ireland and Germany) (Batalova, 2008). Dating back to these times, noncitizens have been decorated for their outstanding service during armed conflict, including the distinguished Congressional Medal of Honor (Stock, 2009). Our national policies have also long recognized foreign-born service members’ contributions by expanding or expediting the naturalization process. Between 1907 and 2010, more than 700,000 individuals became naturalized citizens through military service (Barry, 2013). Since the 9/11 attacks, the U.S. has granted citizenship posthumously for more than 100 immigrant service members who were killed in the line of duty (Stock, 2009).

Today, immigrants represent a small but important share of our military and veteran populations. Approximately 24,000 noncitizens are currently serving in active duty and an estimated 5,000 join the military each year (U.S. Department of Defense [DOD], 2012). The U.S. Census Bureau estimates that the foreign-born—including both naturalized citizens and noncitizens—made up about 3% of the total veteran population in 2011 (Lee and Beckhusen, 2012). More than half of all foreign-born veterans hail from 11 countries: Mexico (13%), Philippines, (11.5%), Germany (8%), and Canada (5.8%) round out the top four along with Italy, Jamaica, Korea, England, China, Vietnam, and Cuba (3% or less) (Lee & Beckhusen, 2012). Because most foreign-born veterans
have become naturalized citizens at some point, veterans who remain noncitizens number fewer than 1 million people (about 86,000, or 0.04% of the total living veteran population) (Lee & Beckhusen, 2012).

In addition to the foreign-born veteran population, an additional 9% of living veterans are U.S.-born citizens with at least one immigrant parent (Barry, 2013). It is useful, then, to also explore the experiences of U.S. citizen veterans who hail from “mixed-status” families, where a parent or other family member is a legal or undocumented immigrant. Moreover, it is likely that service members from mixed-status families already number in the thousands and will continue to grow in the coming decades (Contributions of Immigrants to the United States Armed Forces, 2006). The Pew Hispanic Center estimates that in 2010, there were 4.5 million U.S.-born citizen children with at least one undocumented immigrant parent, up from 2.1 million a decade earlier (Passel & Cohn, 2011). Researchers at the Center for Naval Analysis estimate that there are approximately 1.2 million men and women who are eligible for recruitment and project that immigrants will be driving the net growth in the recruiting-age population in the coming decades (McIntosh et al., 2011). As these both noncitizen and citizen children with immigrant families members reach adulthood, some will likely enter the military, serve this country, and eventually transition into veteran status.

As service members, many immigrants have important skills to offer: cultural diversity, linguistic fluency, and a commitment to service. Noncitizens recruits are more likely than their citizen peers to be people of color, women, and have a spouse or other dependent. (McIntosh et al., 2011). The Army notes that its interpreters and translators—many of whom are foreign-born—save lives in the field not only due to their bilingual abilities, but also by their abilities to read the cultural cues such as body language and local customs (U.S. Army, 2008). Foreign-born recruits have lower attrition rates than their U.S.-born peers; researchers analyzing enlistment data concluded that noncitizens are about half as likely as citizens to drop out at the three-month, three-year, and four year marks, a finding that is consistent regardless of race/ethnicity, age, or branch of military service (McIntosh et al., 2011). The researchers note that this finding is consistent with findings from their interviews with recruits in which noncitizens expressed a stronger attachment to the U.S., which they considered to be their home (McIntosh et al., 2011).

Key Policies and Trends

While there is evidence of immigrants’ contributions to the nation’s defense, there is a dearth of information available about their access to mental health and support services as they transition from duty. However, many current and proposed policies have implications—both positive and negative—for these veterans’ access to supports and general well-being. Key themes include: 1) eligibility for military service, 2) naturalization processes, 3) access to programs and services, and 4) deportations and removals.

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2. See page 71 for dialogue between Professor Margaret D. Stock and Senator Lindsey Graham (R-SC).
Immigrant Eligibility for Service

Immigrant eligibility for military service is a matter of national policy. For decades, foreign-born enlistment has been limited to naturalized citizens, legal permanent residents (LPRs, or “green card holders”), and nationals of countries in free association with the United States—the Marshall Islands, the Federated States of Micronesia, and Palau—have been eligible to enlist in the armed forces (Batalova, 2008). Yet most male noncitizens between the ages of 18 and 26—including undocumented immigrants—are required to register with the Selective Service System alongside their citizen peers; they would be eligible for the draft if the U.S. were to reinstate conscription (Selective Service System, 2014).3

In recent years, the DOD has authorized the recruitment of certain legal immigrants who are not yet permanent residents. In 2009, the armed forces began recruiting noncitizens under the pilot program Military Accessions Vital to National Interest (MAVNI); of the initial 1,000 new recruits, about 89.9% served in the Army, 10% in the Navy, and 0.1% in the Air Force (McIntosh et al., 2011). MAVNI is limited to certain noncitizens with cultural backgrounds and linguistic fluency in 44 key languages or medical training for certain healthcare specialties in which the military is currently experiencing a shortfall (DOD, 2012; U.S. Army, n.d.). To be eligible for MAVNI, prospective recruits must have a qualifying immigration status, have been legally present in the U.S. for at least two years (with no absences longer than 90 days), have a high school diploma, and pass other qualifying tests, including proficiency in both English and the strategic language (DOD, 2012; U.S. Army, n.d.). The program, which has been renewed several times, is capped annually at 1,500 placements, and there is a waiting list of hopeful applicants (Preston, 2014). Following the success of MAVNI, the Army also similarly expanded its 09L interpretation and translation program (McIntosh et al., 2011).

While undocumented immigrants are ineligible for the MAVNI program, some policymakers have supported legislative or executive action to authorize military service as a pathway to legal status and/or naturalization. While the proposal has been backed by politicians on both sides of the aisle, it has failed to garner support in a divided Congress. Other policies adopted or proposed by the Obama administration regarding undocumented immigrants and the military are discussed below.

Naturalization Processes

While noncitizens in the armed forces are not required to naturalize, their careers will be somewhat limited, as U.S. citizenship is required to become an officer and to gain the security

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3. Noncitizens who are present in the U.S. on a student or visitor visa and those who are carrying out diplomatic or trade missions are exempted from registering with the Selective Service System. The Selective Service does not collect data on immigration status (Selective Service System, 2014). However, Laurence Romo, Director of the Selective Service System, recently wrote that lack of knowledge or fear of deportation still prevents noncitizens from registering, which can endanger the legal cases of those who are seeking to adjust their statuses or naturalize later in life (Romo, 2011).

4. Eligible immigrants include E, F, H, I, J, K, L, M, O, P, Q, R, S, T, TC, TD, TN, U or V nonimmigrant categories and asylees, refugees, and those with Temporary Protected Status (TPS). Eligible language skills for the MAVNI program are: Albanian, Amharic, Arabic, Azerbaijani, Bengali, Burmese, Cambodian-Khmer, Cebuan, Chinese, Czech, French (limited to individuals possessing citizenship from an African country), Haitian-Creole, Hausa, Hindi, Hungarian, Igbo, Indonesian, Korean, Kurdish, Lao, Malay, Malayalam, Moro, Nepalese, Persian [Dari & Farsi], Polish, Portuguese, Punjabi, Pushru, Russian, Serbo-Croatian, Sindhi, Sinhalese, Somali, Swahili, Tagalog, Tajik, Tamil, Thai, Turkish, Turkmen, Urdu (with citizenship from Pakistan or Afghanistan), Uzbek, and Yoruba (DOD, 2012 and U.S. Army, n.d.).
clearance necessary for many occupations (McIntosh et al., 2011). The Air Force also imposes service limits for noncitizens, although there is no limitation on reenlistment in the Army, Navy, or Marine Corps (McIntosh et al., 2011).

Military service has long been associated with naturalization. During World War II, for example, the Immigration and Naturalization Service—the agency now known as the Customs and Immigration Service—processed more than 100,000 citizenship naturalizations for members of the armed forces, including thousands of people in the first-of-its-kind overseas naturalization campaign (USCIS, Agency History, 2013). Military service has been a fast track to naturalization; while LPRs generally must wait five years before naturalizing, LPRs who have served will wait three years in peacetime and fewer in times of war (Barry, 2013). Naturalizing service members (and eligible spouses or children) must meet all other requirements, including demonstrating good moral character, knowledge of U.S. history and English fluency, as well as taking an oath of allegiance (USCIS, Naturalization through Military Service, 2013).

After September 11, 2001, the Bush administration authorized a series of policies designed to expedite naturalization. Noncitizens are now eligible to naturalize after a single day of active duty. Other policy changes include waivers for physical presence in the U.S., which allowed those deployed overseas to “count” their deployment periods toward residency requirements, as well as application fees waivers to reduce financial hardship (Barry, 2013; Stock, 2009). In 2009, USCIS implemented Naturalization at Basic Training Initiative, conducting naturalization processes on base after basic training concluded; since that time, the program has expanded to include all branches of the military (USCIS, Naturalization through Military Service, 2013). Between 2002 and 2013, nearly 90,000 members of the military were naturalized, with about 10,000 of those naturalizations occurring in one of 28 countries abroad (USCIS, Naturalization through Military Service, 2013). The Center for Naval Analysis found that military recruits who were people of color, women, married, or had some college education were more likely to become U.S. citizens than noncitizens who were White, men, single, or high-school educated (McIntosh et al., 2011).

USCIS has the authority to revoke citizenship for members of the military who have naturalized but separates with a less than honorable discharge before completing five years of honorable service (USCIS, Naturalization through Military Service, 2013). However, the Center for Naval Analysis notes that this authority is likely not enforced and, at the time of publication of this report, did not appear to be an agency priority (McIntosh et al., 2011).

**Access to Services**

Noncitizen veterans, who meet all other criteria, including honorable service requirements, are eligible for veterans’ services. However, there are no data available to assess whether and how noncitizen veterans—or citizen veterans from mixed-status families—are accessing healthcare and other support services during and after their separation from the military. There is also no data available to assess whether immigrant veterans experiences with mental health diagnoses differs in any way from their citizen peers'.
Research profiling immigrants’ access to other federal programs and services raise concerns that are worthy of further investigation. The complex policies governing immigrant eligibility for federal programs have often resulted in confusion among immigrant and mixed-status households and even reluctance to enroll in services for which they are eligible (Fortuny & Chaudry, 2012). Researchers cite multiple reasons—confusion due to complex eligibility rules, fear of immigration consequences, lack of culturally and linguistically appropriate information—for low participation rates among eligible noncitizens in federal programs. While veterans are exempted from some immigrant restrictions, it is not clear that eligible noncitizen veterans and family members are participating in these programs. For instance, a noncitizen veteran whose family is experiencing financial instability may be eligible to apply for work supports such as the Supplemental Nutrition Assistance Program (SNAP, formerly known as the food stamp program) without facing the waiting period that other qualified legal immigrants experience (Fortuny & Chaudry, 2012). Understanding whether and how these families are accessing support programs and services will be important to building outreach and meeting the needs of this group.

Deportation of Veterans and Family Members
In addition to stressors associated with military service or transition, immigrant veterans and citizen veterans from mixed-status families may experience additional worry, concern, or harm due to immigration concerns for themselves or their families. The threat of deportation, and the reality of detention and removal, is highly likely to negatively affect these veterans’ mental health and transition experience.

In 1996, Congress passed the Immigration and Nationality Act, which required that immigrants who commit “aggravated felonies” at “any time” in their lives must be deported (Caldwell, 2014). Yet immigration attorneys explain that an “aggravated felony” is a term that Congress created in 1988 and has defined, over time, to include 30 offenses, including failure to file taxes or appear in court as well as any crime with a maximum sentence longer than one year (Immigration Policy Center, 2012). The law also applied retroactively, so old offenses may become “immediately deportable” if Congress chooses to add to the list of aggravated felonies (Immigration Policy Center, 2012). The provision makes no mention of military service, so noncitizen veterans who separate from the military and commit an offense that falls within this category are subject to immediate deportation (Immigration Policy Center, 2012). The Immigration and Nationality Act also removes judicial discretion in these cases (Sullivan 2013). Although there is no official estimate, immigration attorneys and advocacy groups project that the number of immigrant veterans who have been deported, may be in the tens of thousands (Sullivan, 2013).

This policy has been called under scrutiny. Increasingly, veteran-serving organizations have recognized the need for interventions that divert

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5. This policy brief examines low participation rates among eligible noncitizens in federal programs such as the Supplemental Nutrition Assistance Program (SNAP, formerly known as the food stamp program), Temporary Assistance for Needy Families (TANF, known as cash assistance or welfare), Medicaid, and the Children’s Health Insurance Program (CHIP). Veterans are not subject to the federal “five-year bar” that restricts eligibility for qualified legal immigrants. Many states have been granted waivers for certain programs to cover certain populations (such as legal immigrant children and pregnant women) within the federal five-year waiting period.
veterans experiencing vulnerability, particularly mental health or substance abuse issues, from incarceration. Yet noncitizen veterans may not be afforded these opportunities to treat and rehabilitate; instead, the law calls for their immediate removal and deportation, with little leeway for judicial discretion. Writing commentary in Roll Call, Margaret Stock—an attorney and Retired Lieutenant Colonel in the U.S. Army Reserve Military Police—describes the case of a noncitizen veteran who had lived in the U.S. since childhood and was deported after depositing a bad check, while his U.S.-citizen child now grows up without a father (Stock, 2014). In 2011, Immigrations and Customs Enforcement circulated a memo authorizing greater discretion in detention and removal cases and cites military service as a positive factor in exercising prosecutorial discretion (Morton, 2011). Yet the extent to which this discretion is exercised is not yet clear.

The threat of deportation may also be a serious stressor for military members and veterans with immigrant family members. In mixed-status families, undocumented family members married to a U.S. citizen may be eligible to adjust their status and apply for lawful permanent residence. However, this process often requires waiting periods outside the U.S., including separation from U.S. citizen children and other family, before applications are approved (Immigration Policy Center, 2011). As a result, some eligible immigrants do not apply to adjust their status, fearing being barred from returning to their families. In recent years, the media has profiled a number of active duty service members, deploying or already stationed overseas, whose family members were undergoing deportation proceedings; they feared that their spouses and children would not be home when they returned home (Barbassa, 2007; Gutierrez & Drash, 2007; Eng, 2012). In 2013, USCIS circulated a policy memo citing a commitment to support veterans, reduce the stress of immigration worries, and clarify the appropriate and consistent application of an existing policy, “parole in place,” for noncitizen family members of military personnel and veterans (USCIS, 2013). The policy allows undocumented family members of service members and veterans to stay in the U.S. while they apply to adjust their legal status (Stock, 2013).

There is very limited evidence that undocumented immigrants have been able to enlist in the military; however, recent policy change technically allows for an undocumented veteran who was honorably discharged to apply for deportation relief. In 2012, the Department of Homeland Security announced its Deferred Action for Childhood Arrivals (DACA) policy, in which certain young undocumented immigrants can apply for “deferred action,” which does not adjust legal status but does allow the applicant to live and work in the U.S. on a temporary basis (National Immigration Law Center, 2014). Among other eligibility criteria, applicants must be in school, have a high school degree or equivalent, or be an honorably discharged veteran of the armed forces or Coast Guard (USCIS, 2014). This differs from broader proposals that would allow undocumented immigrants to enlist, serve, and then apply for deportation relief or other status adjustment. For this reason, current DACA policy may not have a direct impact on immigrant veterans (unless a family member is applying under the education criterion). Laura Vazquez, immigration policy analyst at the National Council of La Raza, states that she has not heard of cases in which immigrants were able to apply for DACA on the basis of veteran status (L. Vazquez, personal communication, July 13, 2014).
Opportunities to Achieve Equity

POLICIES AND PROGRAMS ADDRESSING INEQUITIES
There are a number of federal policies and programs shared above that impact immigrant veterans’ ability to serve in the armed forces and access services as a veteran. It is important to note that a veteran’s immigrant status may not be the most defining vulnerability. As described in other profiles of the report, being female, elderly, and a racial/ethnic minority, among other categories, may have a multiplicative effect on a person’s transition experience.

IMPLEMENTATION STRATEGIES
As noted earlier, immigrants represent a small but important share of our military and veteran population that is expected to grow according to population projections. Overall, the U.S. immigrant population is very diverse; therefore, we need to look carefully at the entire spectrum of needs. For example, veterans from mixed status families may require special attention.

INVESTING IN A CULTURE OF EQUITY
Our research indicates that veterans who are immigrants themselves or who hail from immigrant families may need outreach or support for their transition experiences. In CommonHealth ACTION’s Veterans’ Health Survey, a higher proportion of survey participants who identified as immigrants stated that they received family, friend and/or peer support. This indicated that they may need programing support in these areas or are willing to access these support services. Moreover, all of survey participants who identified as an immigrant stated they received support during transition. Although the survey response numbers were low, it might indicate that immigrant veterans are more willing to access and need support.

Additional research specifically focused on these veterans’ experiences should explore:

- To what degree, if any, immigrant veterans experience differences in mental health diagnoses and treatment during and after their separation from the military compared to their citizen peers.
- Whether citizen veterans with immigrant family members (mixed-status families) experience unique stressors that may impact their mental health and well-being during their service and after their separation from the military.
- Whether and how veterans from immigrant and mixed-status families are accessing healthcare, mental health, and other services such as federal means-tested benefits.
- How changes to immigration policy affect recruitment, service, and transition to veteran status for people from immigrant and mixed-status families.

Many of my peers are afraid that seeking mental health will prevent them from reaching their military or civilian career goals. (In response to a question about designing a support program for veterans survey question from a veteran who identified as an immigrant)

– Respondent, CommonHealth ACTION’s Veterans’ Health Survey
PROFILE 3: LESBIAN, GAY, BISEXUAL, TRANSGENDER, INTERSEX, OR QUEER (LGBTIQ) VETERANS

Key Highlights

• Military policy changes over the past century have been very positive for most lesbian, gay, and bisexual servicemen and women; however, there are some individuals within this group whose concerns are not addressed, specifically transgender people.
• Nearly 1 in 4 of gay, lesbian, and bisexual veterans reported avoidance of using at least one service at VA that they would like to access due to worry about stigma.
• Since the experience of an “open” military is still somewhat new, there is still some trepidation from both active and veteran LGBTIQ personnel about discussing issues that would give any indication about their sexual orientation.

Overview and Historical Context

This section explores the experiences of lesbian, gay, bi-sexual, transgender, intersex, or queer (LGBTIQ) service men and women. The military was created to defend our nation's founding principles, particularly democracy and equal rights. It is therefore contradictory to our core values when specific populations are excluded from either serving their country or deterred from living authentically because they are unable to disclose their sexual orientation.

The U.S. Naval Institute (n.d.) has documented key dates in U.S. policy that have affected gay men and women service members. In the American Revolutionary War, the first service member to be discharged due to homosexuality was Lieutenant Gotthold Frederick Enslin in 1778. During World War I, the 1916 Articles of War explicitly cited sodomy as grounds for court-martial. In the decades following, “feminine characteristics,” “sexual perversion,” and “homosexual proclivity” were grounds for potential military recruits’ disqualification from service. In 1950, an Army regulation published guidelines to classify gay service members: aggressive (subject to court-martial), non-aggressive (could avoid court-martial by resigning (officers) or accepting dishonorable discharge (enlisted), and those who “exhibited homosexual tendencies without committing a violation of the sodomy statute” (subject to removal with an honorable discharge).

Since that time, policy change and, incrementally, culture change has allowed gay, lesbian, and bisexual members of the armed forces to be open about their identities during their service (Miller & Cray, 2013). Despite progress, concerns about labeling and fear of documentation have had a significant impact on LGBTIQ veterans’ military experience and ability to access benefits and services. Nearly 1 in 4 of gay, lesbian, and bisexual veterans reported avoidance of using at least one service at VA that they would like to access due to worry about stigma (Simpson et al., 2013). Moreover, these men and women may also identify themselves with other populations (e.g., women, communities of color, people with disabilities, etc.) who may experience vulnerability when interacting with systems and institutions that are meant to support them.
Key Policies and Trends

The military persona has always been represented by masculinity and toughness, while the military policy around LGBTIQ issues is based secrecy and exclusion. For those individuals who do not innately exude these characteristics, they do default to a life of secrecy, and often their legitimacy within the armed forces comes into question.

In the last ten years, the U.S. has experienced a cultural and legal sea change in its recognition of certain key LGBTIQ issues. Since Massachusetts became the first state to recognize marriages between gay and lesbian couples in 2004, federal courts, state legislators, and voters have recognized the legal marriage and spousal benefits for gay couples (Smith, 2013). In keeping with this culture shift, President Obama signed into law the repeal of the DOD’s Don’t Ask Don’t Tell (DADT) policy in 2010, a policy imposed by the Clinton administration in 1993 that forbid open service by gays, lesbians, and bisexuals in the military (Miller & Cray, 2013). In 2013, the U.S. Supreme Court decision to partially overturn the Defense of Marriage Act in 2013 required federal recognition of spousal benefits—including military benefits—for legally married gay and lesbian couples (U.S. Naval Institute, n.d.). Despite this progress, the military’s social and political infrastructure is just starting to grapple with accepting openly gay service men and women in a culture that has traditionally denied their existence among their ranks.

Opportunities to Achieve Equity

POLICIES AND PROGRAMS ADDRESSING INEQUITIES

As noted above, military policy changes over the past century have been very positive for most lesbian, gay, and bisexual servicemen and women; however, there are some individuals within this group whose concerns are not addressed, specifically transgender people [Figure 3]. Their rights are still not covered in military policies and many are faced with the constant threat of losing their military career and benefits (OutServe-SLDN, 2014). However, the VA recently created policy changes to equitably serve these populations. In February 2013, the VA’s Veterans Health Administration (VHA) issued a nondiscrimination directive on health care for transgender and intersex veterans (VA, 2013). The directive explicitly notes that sex reassignment surgery, which is classified a “cosmetic” surgery, cannot be carried...
out by the VHA, but other necessary health care requirements should be met, including hormone treatments and psychological support (Williams, S., 2011). Secretary of Defense Chuck Hagel’s position has recently evolved on LGBTIQ in the military and he is looking into the transgender exclusion policy (Lamothe, 2014). In 2014, The Palm Center published a study that found an estimated 15,500 transgender personnel are currently serving in the military who are unable to disclose their sexual orientation (Pollock, MG, G. S. & Minter, S, 2014). In their findings, they recommend ideal administrative practices for adopting an inclusion policy while maintaining military readiness.

STRATEGIES TO IMPLEMENT POLICIES AND PROGRAMS

It should be noted that there are organizations that have implemented programs and strategies to work with the military and push its leadership to continue the process of developing policies that serve a more diverse population. As noted earlier, the VA has adopted polices to eliminate discrimination towards all LBGTIQ veterans. The VA and community physicians, psychologists, and other providers need training on cultural competency and medical specialization to understand the diverse LGBTIQ needs and types of supports, and the potential dangers of stigma in relationship to accessing services.

This population's reticence to divulge personal information is justifiable, given the trajectory of military policies over the years, despite the fact that DADT is now repealed. There are two major trends that will have to be immediately addressed and rectified in order for LGBTIQ military personnel to finally feel like they are fully vested members of the armed forces.

• **Secrecy:** Although DADT was officially instituted in 1993, the concept had long been a part of military culture, almost from inception of the armed forces. LGBTIQ military personnel had to keep their sexual orientation a secret in order for them to be a part of this community. Many have either not been forthcoming or lied about their private lives in order for them to remain a part of the larger group. This is an extremely difficult position to be in, given the importance the military places on building cohesion among its members. How can these individuals truly feel like a part of the group, if they are not able to open up to their fellow servicemen and women with whom they spend so much time and are expected to support, even until death?

• **Trust:** The issue of secrecy of course begs the question about the level of trust that can be engendered among individuals who are not able to open up about themselves. This is a particular problem encountered by military personnel who need to access services, such as healthcare and mental health services. Many are not open about their sexual orientation - even though it impacts the level of care or service they will receive - because they believe that it will impact their military career and benefits. Results from focus groups have shown that there is a perception that service providers may be biased against them if they open up about their sexuality. There is a fear that these providers will include negative comments/observations in their records that may impact future service needs.

• **Culture:** There are also some military personnel who feel that despite these positive changes in policy, the culture of the military will not fundamentally change. Some feel that these policies were implemented because of pressure from outside the military; however, the social culture and infrastructure will
continue to demonstrate the legacy of policies that once excluded LGBTIQ servicemen and women and forced them into hiding.

As a transgender person, my alcohol abuse stemmed from the depression and anxiety of not being open about my identity. After a suicide attempt and subsequent hospitalization I was subjected to mandatory therapy appointments once a week for a year with an active duty military Mental Health professional. Upon my visit I was instructed that we could not, under any circumstances, discuss the fact that I am transgender but could only attempt to address the symptoms of severe depression and suicidality it caused in that situation.

– Respondent, CommonHealth ACTION Veterans’ Health Survey

INVESTING IN A CULTURE CHANGE TO ACHIEVE EQUITY

With the repeal of DADT, there are new opportunities for the military to develop a more inclusive and open approach to managing the multitude of issues that come with having a very diverse population. Nevertheless, since this experience of an “open” military is still somewhat new, there is lingering trepidation from both active and veteran LGBTIQ personnel about discussing issues that would give any indication about their sexual orientation. Ultimately, we know there is a lot more that needs to be done beyond policy changes. More actions need to be taken to encourage discussion, research, and policy making aimed at leveraging existing resources and creating additional supports for the LGBTIQ military and veteran population.

The information presented in this section is based on limited available data because of the lack of comprehensive data regarding the experiences of both active and veteran LGBTIQ military populations. However, now that there are policies in place for this population to serve openly, there are some questions that should be discussed:

- For both new and old veterans, how can they be reassured that their current benefits will not be impacted by exposing themselves to their service providers? Will they feel comfortable talking with service providers or will the culture still push them to live in secrecy?
- How will LGBTIQ veterans and their families be supported in their transition from active duty to veteran status?
- Now that DADT has been repealed, what will be the status of transgender individuals who want/need to be supported in their transition while in the military? What policies will be put in place to govern their participation in the armed forces?
- How will the non-LGBTIQ members of the military be encouraged to support their LGBTIQ servicemen and women?
PROFILE 4: VETERANS OF COLOR

Key Highlights

- Approximately 20% of the military and veteran population are from people from racial/ethnic minority backgrounds and this proportion is expected to increase.
- Veterans of color experience higher rates of PTSD that is distinctly linked to their cultural and ethnic ties.
- The Military and the VA should provide platforms for these racial and ethnic groups to inform current and future military care structures and health care system.

Overview and Historical Context

People of color have a long history of serving in the armed forces. Today, people from racial/ethnic minority backgrounds make up approximately one in five (20%) veterans [Figure 4] (U.S. Department of Veterans Affairs, 2013). Of that population, Black or African American veterans currently make up the plurality (11%). Hispanic or Latino veterans are the second largest and youngest ethnic cohort (6%). Asian, Pacific Islander, and Native Hawaiian veterans (1.4%) constitute the oldest cohort. The smallest minority veteran

[Figure 4] RACE/ETHNICITY OF U.S. VETERANS (2010)

Source: U.S. Department of Veterans Affairs, 2013
population is American Indian/Alaska Natives (AIAN) (0.6%). Both the Asian and Native veteran populations represent the oldest ethnic groups, with a median age of 57. The VA (2013) projects that through 2040, the Black veteran population will decrease slightly, but it will remain the largest minority veteran group. The share of Latino veterans is expected to rise; all other groups are projected to remain the same.

According to the VA, the current veterans of color population is, overall, younger than their White, non-Hispanic, counterparts. While many factors contribute to this discrepancy, one primary influence is the historical size and entrance of specific racial groups throughout U.S. conflicts. During World War II, there was great fluctuation in the presence of ethnic service members, throughout the different branches, due to varying policies that often segregated and restricted these groups to specific tasks and roles (Department of Defense, 1985). For example, during this time, Black service member participation was limited and also confined to largely combat support services even though there was an overall increased presence of Asian, Native, and Alaskan service members. The Gulf Wars saw the largest number, across the board, of active service members of color. According to the U.S. Department of Labor (2011), racial minorities accounted for 1 in 5 veterans who served during the Gulf War-era, compared to 1 in 10 who served during World War II, the Korean War, and the Vietnam era. Native service participation has been at its highest in the most recent conflicts and their presence is more concentrated in the Navy than any other military branch. Several studies have found that both Black and Latino soldiers have been overrepresented in the enlisted, infantry track of the armed forces. This is an important trend to note when considering the unmet needs of veterans of color as their over-concentration in combat services means a greater risk and likelihood of exposure to traumas sustained through on-the-ground, frontline combat (Segal et al., 2006).

Another significant driver of an increasingly larger and younger veterans of color population is the fact that the U.S. military remains one of the most direct, failsafe vehicles to better socioeconomic well-being in terms of access to quality education, stable employment, health coverage, and higher household income. This is particularly true for Latino, Native, and Black veteran populations. When determining the challenges to coverage and care for these veterans of color populations, it is important to note that those key socio-economic indicators vary greatly among and within the different ethnic populations. Asian veterans have the highest percentage of college and advanced degrees and lowest poverty rate than any other minority veteran cohort (VA, 2013). Asian and Latino veterans are more likely to be employed compared to other minority groups. AIAN veterans have the lowest rate of employment and the highest poverty and uninsured rates (VA, 2013).

Veterans of color experience higher rates of PTSD that is distinctly linked to their cultural and ethnic ties. “Race-related stressors and personal experiences of racial prejudice or stigmatization are potent risk factors for PTSD, as is bicultural identification and conflict when one ethnically identifies with civilians who suffered from the impact or abuses of war” (Loo, 2014). Racial and ethnic disparities are not only visible in health outcomes, but also in veterans’ perception and attitudes towards the VA health system as well as in the types of treatment and medications received by different ethnic groups to treat
behavioral health issues. This dynamic is centrally explained by the convergence of race, stress, lived experience, and health as well as the unique and complicated history each ethnic veteran group has had with both the military and public health field. Asian veterans have the lowest uninsured rate, lowest percentage of service-connected disabilities, and the lowest percentage age of veterans accessing VA benefits and services. On the other hand, the report found that Black and Native veteran populations tended to use VA care services at a higher rate than other groups and that the Black veteran population reported the highest percentage of service-connected disabilities.

Key Policies and Trends

American Indian/Alaska Natives (AIAN) Veterans
Of the approximately 154,305 known AIAN veterans, approximately half live in eight U.S. states (California (12%), Oklahoma (9%), Arizona and New Mexico (7%, respectively), Texas (6%), and Florida, Washington, and Michigan (4%) (VA, 2012). “Native populations in general and rural Native populations in particular suffer significant health care disparities when compared to the general population” (Noe et al., 2011). Rurality plays a significant role in the unmet needs and challenges faced by Native veterans in terms of access to quality care for behavioral health issues. In terms of mental health and behavioral issues, this population experiences “higher incidences and are four times more likely than non-Hispanic White veterans to report unmet healthcare needs” (Noe et al., 2011). Similarly, the “Matsunaga Vietnam Veterans Project, one of the largest surveys of Native American Vietnam veterans found that one third of these veterans lived with full or partial PTSD at the time of the study, more than 25 years after the war, a prevalence more than twice as high as that of White or Japanese American Vietnam veterans” (National Alliance on Mental Illness [NAMI], 2014).

Native veterans rank last in nearly every health and well-being measurement, whether it be employment, educational level, income, or insurance coverage (they are twice as likely to be uninsured than all other races) (VA, 2012). “The proportion of AIAN veterans earning less than $10,000 in annual household income is roughly twice the proportion of veterans in general earning that amount” (Noe et al., 2011). In terms of homeownership, Native veterans are least likely to own a home and are overrepresented in the homeless veteran population; in contrast, according to available data, Asian veteran population has the lowest risk of homelessness than any other racial and ethnic veteran cohort (NAMI, 2007).

A main obstacle to identifying the scope of challenges faced by Native veterans is the sparse available data on the healthcare services used by Native veteran populations. Despite this limitation, recent studies have highlighted that transportation and the difficulty of navigating the healthcare system proves a greater barrier to care than cost for most Native veterans (Noe et al., 2011). In terms of transportation, the majority of native-specific programs are often located within the more densely populated regions, often where the largest, most well-known tribes are located, making it difficult for smaller Native communities to gain access.

Equally important, the traditional approach of broadly grouping Native veteran populations as well as the lack of attention paid to their
diverse tribal makeup and cultural norms has greatly hindered the effort to accurately assess their unmet needs and barriers to care. Of the published research available on Native veteran populations, many note that “access to health care services, lack of cultural competence and culturally appropriate services, lack of collaboration between the various agencies serving Native veterans, and racial misclassification of Native veterans in VHA datasets continue to be significant challenges” (Noe et al., 2011). This research has also highlighted that the diversity of traditional beliefs and cultural practices among the various Native veteran populations plays a central role in how they view and therefore use current healthcare services. Many Native veterans feel that the primary veteran health system is incapable of understanding, and therefore addressing, their unique needs as it relates to their culture and their preference to seek behavioral health care first from traditional healers within their tribal culture.

Traditional healing practices are a fundamental part of health for many Native veterans as it incorporates “a holistic approach encompassing mind, body, and spirit in the healing process. This holistic approach has particular relevance for Native veterans who often have disorders related to trauma” (Noe et al., 2011). The fact that traditional native healing practices and tribal health systems are often categorized as a secondary or alternative form of care by the main healthcare system, and thus lack formal recognition and credentialing, assumes that Native veteran populations ascribe to the Western healthcare model; in actuality, for many Native veterans, it is secondary to their cultural healing practices. Furthermore, the lack of sufficient Native behavioral health caregivers and clinicians in the main healthcare system further complicates the effectiveness of current health programs, given the inherent distrust and disconnect that exists between the existing care structure and many Native veteran communities.

Asian, Pacific Islander, and Native Hawaiian Veterans

To look solely at the VA’s current health and well-being indices for Asian, Pacific Islander, and Native Hawaiian veterans would lead one to assume that the population as a whole is thriving; but, similar to the Native veteran population, the mass grouping of several distinct Asian veteran populations calls into question the data’s accuracy in revealing the unique existing unmet needs and barriers to care that each ethnic group faces. As stated earlier, the VA broadly lumps the following groups under the “Asian veteran” category: Japanese, Chinese, Filipinos, Indian, Korean, Vietnamese, Pacific Islander, and Native Hawaiian. Inconsistency in data reporting amongst the various military branches further hinders the accuracy of assessing unmet needs and barriers to care for these individual groups; for example, the Army does not currently report data on “Native Hawaiian or other Pacific Islander” or “Multi-racial” populations (VA Center for Minority Veterans, 2013).

Studies that have highlighted different PTSD rates amongst Asian Vietnam veterans point to culturally distinct lived experiences within the Asian veteran population. For example, the National Vietnam Veteran Readjustment Study found that Asian and Pacific Islander Vietnam veterans suffered from lifetime PTSD at a much higher prevalence than Japanese Vietnam veterans, which revealed that these two groups experienced the trauma of the Vietnam War in significantly different ways (Loo, 2014). As opposed to Japanese veterans, Pacific Islander Vietnam veterans suffered trauma and stress...
distinctly tied to both their ethnic resemblance and personal identification with their Viet Cong counterparts. The study also found that overall “Native Hawaiians had a higher PTSD prevalence rate than Chinese Americans, who [in turn] had a higher rate than Japanese Americans” (Loo, 2014). Racial identity and racially-linked experiences – such as a Pacific Islander veteran recalling a memory of being shot at by fellow American soldiers as a result of having their loyalty questioned or being mistaken for an enemy combatant – are key components in highlighting and evaluating the discrepancies in trauma between distinct Asian groups; “in fact, research has revealed that failure to assess race-related stressor experiences of Asian and Pacific Islander veterans could result in missing as much as 20% of the Veteran’s PTSD symptoms” (Loo, 2014).

As a result of their closer affinity to the Vietnamese populations, researchers found that race-related stressors were an important predictor of PTSD symptoms amongst specifically Pacific Islander Vietnam veterans (Loo, 2014). The Vietnam-specific studies lead researchers to conclude that veterans of color are at a higher risk of exposure to both immediate life-threatening events and long-term trauma as a result of being stigmatized for being of a similar (if not the same) racial background as the warring opponent.

**Latino and Black Veterans**

Of all the racial and ethnic veteran populations, Latino and Black veterans have had a more similar and closely shared lived experience in terms of disproportionate health risks, prevalence, treatment, and outcomes. Both populations make up the largest racial and ethnic cohort in the military, have been overrepresented in enlisted, combat-support services, and face greater exposure to conflict stressors and predisposing factors than their White counterparts (Segal et al., 2006). According to the most recent VA findings, roughly 35% of all homeless veterans were Black and 7.5% were Latino, despite only accounting for 10.4% and 5.0% of the total U.S. veteran population, respectively (U.S. Department of Veterans Affairs National Center on Homelessness Among Veterans, 2010). Furthermore, across the board, studies have found that Latino and Black veterans were more likely to develop PTSD and had higher prevalence rate than their White counterparts: 28% amongst Latino veterans, 21% amongst Black veterans, and 14% amongst White non-Hispanic veterans (Loo, 2014). In terms of the Vietnam War, like their Native and Pacific Islander counterparts, clinical case studies found that Black Vietnam veterans reported a higher degree of trauma and stress linked to associating the plight of the Vietnamese people with that of African Americans back in the States (Loo, 2014).

In regards to treatment disparities, a 2003 American Journal of Psychiatry study analyzed pharmacy records and discovered that newer antipsychotic medication was less likely to be prescribed to Black and Latino veterans for the treatment of schizophrenia than their White counterparts (NAMI, 2014). Moreover, “a 2002 national study assessing intensive PTSD treatment programs discovered that African American patients showed greater improvement than White patients on one measure of PTSD symptoms and Latino patients were more satisfied with their treatment than White patients although they showed smaller gains” (NAMI, 2014). Overall, the majority of studies found that racial and ethnic veterans’ access to culturally competent care, perceived or otherwise, significantly affected their treatment experience and satisfaction with care. From a coverage
standpoint, a striking correlation was discovered between a veterans’ ethnicity and their chances of getting VA approval for PTSD-related claims in which Black veterans were least likely to have their filed claims approved despite having an overall higher PTSD prevalence rate (NAMI, 2014).

As demonstrated above, while numerous studies noted the cultural similarities between Black and Latino veteran populations—in terms of the incidences of behavioral health issues, diagnosis, treatment, and coverage experiences—there were notable differences as well. For example, PTSD rates are highest within Latino veteran populations, particularly amongst the Puerto Rican Vietnam veterans, and, unlike Black veterans, the disparity remains even when accounting for exposure to combat stressors when compared to their White counterparts (Loo, 2014).

Service providers’ responsibility in supplying culturally-appropriate and equitable diagnosis and treatments must extend to coverage, compensation, and pension benefits. “If clinicians do not evaluate for negative race-related events that may have led to psychiatric problems, the ethnic minority veteran may not be receiving the appropriate disability rating or compensation. Thus, it behooves VA clinicians to be particularly attentive to examining possible race, ethnic, or cultural issues among ethnic minority veterans” (Loo, 2014).

Opportunities to Achieve Equity

POLICIES AND PROGRAMS ADDRESSING INEQUITIES

The fundamental dilemma currently facing the VA, the main healthcare system, and public health field is how to create effective strategies that tailor treatment to the unique needs of each racial, ethnic veteran group while concurrently reducing health outcome disparities (NAMI, 2014). A common thread throughout each racial/ethnic minority veteran population is a shared increased risk for developing behavioral health issues, like PTSD, as a result of being a veteran of color, dealing with a constellation of stresses including a collective history of broad racial marginalization from both the military and civilians. As the research has highlighted, such categorizations obscure the rich diversity within each population, in terms of their ethnic makeup, cultural beliefs, traditions, and practices, all of which profoundly impacts the effectiveness of targeted health initiatives. Therefore, it is incumbent upon these sectors to create and institute both strategies and processes geared towards adapting and aligning policies, programs, collaborations and best practices to a more localized and ethnocentric level.

For example, for Native veteran populations, “further examination of the role of traditional healing for Native veterans’ healthcare, the potential models of collaboration, and the potential use of these practices in the VHA healthcare system is necessary, especially given the high rates of utilization of traditional healing within the Native population” (Noe et al., 2011).

STRATEGIES TO IMPLEMENT POLICIES AND PROGRAMS

From an overall service standpoint, providers must recognize and value the fact that “being an ethnic minority in the military may increase stresses and stress reactions. It is therefore important to assess what the experience of being an ethnic minority was like for that particular veteran” (Loo, 2014) when crafting treatment strategies and programs. Incorporating
“validated measures of race-related stressors and having a conceptual framework by which to understand and interview ethnic minority veterans are [key] steps toward assuring that we are assessing for stressors related to ethnicity, culture, or race” (Loo, 2014).

Research has shown that racial and ethnic veterans are at an increased risk for PTSD and TBI in some part due to their racial and ethnic identity. Often times the data gathered are not capable of highlighting the complexities of the issues these groups face and the reasons why many of these groups are more susceptible to disparate health risks and outcomes. This inability, in turns, results in less-than effective treatments and persistent health outcome differences along racial lines. As racial and ethnic minority groups continue to grow in the armed forces, they will assume a greater portion of the overall active and veteran population. Thus, without tailored initiatives that focus on and address the diverse and unique needs, these populations will continue to experience disparate barriers to securing the right treatment, benefits, and better health outcomes.

INVESTING IN A CULTURE CHANGE TO ACHIEVE EQUITY

The DOD and VA should provide platforms for these racial and ethnic groups to inform current and future military and health care structures so that they may begin to more accurately reflect and account for each group’s unique needs and challenges. Evidence shows that the most successful interventions are those that acknowledge race-related stressors, cultural nuances, and employ veterans who share a common lived experience with those in need. Racial and ethnic minority veterans can contribute their experiences and expertise to inform the design and improvement of treatment programs and protocols geared towards these populations, particularly for populations that made up of many distinct ethnic groups such as Native and Asian veterans. Through additional cultural competency training and education related to diversifying armed services and the veterans’ population, this can also aid in helping the general population’s perspective transformation. Military leadership has a role in allowing and acknowledging the stated challenges and forging career opportunities for veterans of color.

More research can help us understand the unique challenges faced by veterans who are racial and ethnic minorities:

- Why is there such disparate reporting on ethnic and racial service-member groups amongst the different branches within the armed forces?
- What conceptual frameworks are currently being used by the military and VA care systems that serve military populations that take into account race-related stressors?

My supervisor told me I had three strikes against me when I was first class petty officer in a FL base – Black, female, had rank. I said well I’m going to fight. As a woman, I felt like they didn’t want me to be there – it was a problem but it wasn’t as much of a problem as it has been for others – CommonHealth ACTION’s Focus Group Participant Quote
In this section, we explore the military experiences of veteran subpopulations who, due to choice or circumstance, may experience vulnerability as they interact with systems and institutions: disabled veterans, elderly veterans, homeless veterans, incarcerated veterans, other-than-honorably discharged veterans, rural veterans, student veterans, and unemployed veterans. Each of the subpopulation profiles explores opportunities for equity, including 1) policies and programs to address inequities, 2) implementation strategies for policy change, and 3) investing in culture changes that support greater equity among the military and veteran populations.
PROFILE 5: DISABLED VETERANS

Key Highlights

• 1 in 4 veterans have service connected disabilities which includes invisible wounds such as PTSD; advances in modern medicine has led veterans with disabilities to live longer and fuller lives
• Hearing loss is the most widespread injury costing the U.S. government 1.4 billion in veterans disability payments
• There is an opportunity for disabled veterans to use their platform to improve the larger disabled community lives

Overview and Historical Context

According to the U.S. Census Bureau, in 2012 there were approximately 5.6 million veterans (a prevalence rate of 26.7%) with service-connected disabilities out of a total veteran population of 20.1 million [Figure 5]. Of the disabled veterans, 881,907 had a disability rating of 70% of higher.6 Disability compensation is a tax-free monetary benefit paid to veterans with disabilities that are the result of a disease or injury incurred or aggravated during active military service (VA, 2014).

6. A veteran’s level of disability is measured along a scale of 0 to 100%.

[Figure 5] A VETERAN’S WORST WOUNDS MAY BE THE ONES YOU CAN’T SEE

Source: American Psychiatric Association, 2013
The number of disabled veterans is increasing as well as the amount of benefits they require for support. Veterans who have been disabled from the most recent wars have a lower disability rate as compared to veterans from Vietnam and Korea (Tanielian & Jaycox, 2008). This is directly related to the fact that there is less hand-to-hand combat on the ground, as well as today’s advances in both medical technology and body armor. However, the physical injuries are more severe due to the increased destructive capacity of modern military weapons.

There is one physical disability that is on the rise for returning soldiers. Hearing loss and other auditory complications are the most widespread injury for veterans. Soldiers are routinely exposed to extremely loud noises (e.g., shelling, the weapons they operate), and many times they do not protect themselves adequately from auditory injury. In a 2010 spending report, the Department of Veterans Affairs reported that it spent an average of $348 on hearing aids, and that they purchased one out of every 5 hearing aids sold in the United States. It costs the U.S. government more than 1.4 billion in veteran disability payments annually (Miller, 2013). This will be a trend to watch in the upcoming years.

There are also veterans who return home with invisible wounds that many times get either overlooked, misdiagnosed, or just ignored. Unfortunately, this is problematic because these types of wounds tend to hinder the assimilation process for many veterans into civilian life. Additionally, these wounds are the ones that veterans tend not to take care of because they fear being judged. An indirect consequence of mental health illness that goes untreated includes substance abuse, homelessness, and family strain.

Key Policies and Trends

Veterans face several challenges upon their return home that are often complicated by physical and mental issues. The physical challenges are usually addressed immediately and there are usually significant resources and support systems in place to help veterans become acclimatized to their condition. After working in an environment that values physical prowess and mental acuity, military personnel are typically hesitant to seek help because they are concerned about perceptions of the information service providers may document in their records.

The federal government has opened opportunities for veteran hiring through enforcing hiring preferences for disabled veterans (Loughran, 2014). The VA has also been pushing for self-employment for its disabled veterans. Many entrepreneurs with disabilities are often more determined than their typical able-bodied counterparts since they have spent their lives overcoming barriers (Santich, 2011). The National Science Foundation recently

Americans who are severely disabled are also more likely to have other health problems, need Medicaid coverage, receive welfare, and have a household income below $20,000 (Olson, 2006). In 2012, about 56.7 million Americans (19% of the total population) age 21 to 64 with any disability had an employment rate of 41% compared to 79% for those with no disability (U.S. Census Bureau, 2012). For disabled veterans, employment can be even more challenging. In Florida, estimates of the jobless rate among disabled, working-age adults, including large numbers of young, severely injured soldiers returning to civilian life, run as high as 50% (Santich, 2011).
awarded a three-year, $100,000 grant to Maitland-based Blue Orb Inc., parent company of the keyless computer keyboard-maker orbiTouch. The device allows those without fine-motor dexterity in their hands to easily navigate a desktop computer.

The U.S. has dedicated a significant investment in resources and support services for veterans with physical and mental disabilities. Evidence-based treatments have been shown to be effective for both PTSD and major depression, but they are not yet available in all treatment settings. A study estimated that evidence-based treatment for PTSD and major depression would pay for itself within two years, saving as much as $1.7 billion, or $1,063 per returning veteran, which are a result of increases in productivity, as well as from reductions in the expected number of suicides (Tanielian & Jaycox, 2008).

There are several resources, both private and government-funded, that are now in place to help support military personnel address their mental health needs. For example, the Veterans Crisis Line provides free confidential support for veterans in crisis and their families and friends. Since its launch in 2007, it has answered more than 1.1 million calls and made more than 37,000 lifesaving rescues (VA, 2014). A number of advocacy and assistance groups help educate the public about the needs of veterans transitioning home; For example, Disabled American Veterans (DAV) help to empower veterans to lead high-quality lives with respect and dignity.7

Opportunities for Equity

POLICIES AND PROGRAMS ADDRESSING INEQUITIES

Meeting the goal of providing care for these service members will require system level changes, which means expanding the nation’s focus to consider issues not just within DOD and the VA, from which the majority of veterans will receive benefits, but also across the overall U.S. health care system, in which many will seek care through other, employer-sponsored health plans and in the public sector (e.g., Medicaid). System-level changes are essential if the nation is to have the resources it needs to meet its responsibility not only to recruit, prepare, and sustain a military force but also to address Service-connected injuries and disabilities.

STRATEGIES TO IMPLEMENT POLICIES AND PROGRAMS

Policies that can address institutional and culture barriers that inhibit physical and mental health care are needed. For the active duty population in particular, there is a large gap between the need for mental health services and the use of such services. This pattern appears to stem

Captain Luis Carlos Montalván, who in Iraq after September 11, has been a recipient of the 2011 Voice Award and the 2011 Invisible Hero Honors Award for his efforts to educate the public about the trauma and the real experiences of veterans and people with disabilities. His book, Until Tuesday: A Wounded Warrior and the Golden Retriever Who Saved Him, describes the everyday challenges of people with disabilities. A number of service dog organizations exist to improve the quality of life of veterans at little or no cost.

from structural aspects of services (wait times, availability of providers) as well as from personal and cultural factors (Tanielian & Jaycox, 2008). Improving access to mental health services for disabled veterans will require reaching beyond DOD and VA health care systems. Given the diversity and the geographic dispersal of the OEF/OIF veteran population, it is recommended to consider other avenues for providing health services, including Vet Centers, nonmedical centers that offer supportive counseling and other services to veterans, and other community-based providers (Tanielian & Jaycox, 2008).

Disabled veterans are perhaps more concerned with establishing their lives outside of the military and being able to support themselves in the best possible way. This group needs social support and other outlets beyond essential services to help them connect around their shared experiences while serving in the military and as a veteran. The Wounded Warrior Project was created to serve veterans and service members who sustained a physical or mental injury, illness, or wound, co-incident to their military service on or after September 11, 2001. The project also provides veterans and their families services beyond basic essential needs.8

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**INVESTING IN A CULTURE CHANGE TO ACHIEVE EQUITY**

Of all the populations highlighted in this report, disabled veterans are possibly the most recognizable veteran group, because their wounds are a visible and constant reminder of the impact of war. Many disabled veterans’ wounds are not visible and they are often overlooked because of perceptions that they are not as significant as losing a limb or disfiguration. Nevertheless, all types of wounds must be addressed in order for us to truly support veterans through a healthy transition and assimilation into civilian life. With a large number of disabled veterans returning home, there is an opportunity for improvements in services overall for all disabled individuals. Disabled veterans can help further the cause of other disabled citizens by joining forces and bringing to light the specific issues of physically disabled individuals.

Additional research specifically focused on these veterans’ experiences should explore:

- What programs have been effective in helping disabled veterans who experience greater vulnerabilities, including those who are low-income, homeless, and unemployed?
- How are advances in medical technology helping older generations of disabled veterans that served in previous war eras (e.g., Vietnam war)
- How have programs and services geared towards the disabled veterans’ communities benefited the larger disabled community?
- What opportunities exist for the disabled veteran and civilian to form alliances to address current policy, programming, and research needs?

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Ensure that veterans know they are still needed and valuable. Often veterans, especially those who are injured feel like they are broken and wounded and unable to work again. Involve them community service and volunteering in hopes that they can see they are valuable and necessary.

– Respondent, CommonHealth ACTION’s Veterans’ Health Survey

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8. For more information, visit http://www.woundedwarriorproject.org/
PROFILE 6: ELDERLY VETERANS

Key Highlights
• 40% of veterans are age 65 or older, representing service in four different generations of wars.
• In recent polling, 4 in 5 elderly veterans rated themselves as aging successfully both physically and mentally, counteracting negative age stereotypes.
• Elderly veterans can serve as mentors, improve communities through service, and are an important caregiving resource.

Overview and Historical Context

Older veterans make up the fastest growing segment of the VA's patients. They often need comprehensive care and caregiver support, particularly those who have cognitive impairment, increased frailty, and lack social support (Selim et al., 2004). Today, there are an estimated 9.1 million veterans who are 65 and older living in the U.S. and abroad making up 40% of total living veteran population of 22.6 million (U.S. Census Bureau, 2012a; 2012b). These veterans have served in World War II, the Korean War, Vietnam War, and the Persian Gulf War. For veterans blessed with long life, the elderly subpopulation is one to which all will eventually belong.

Most elderly veterans are experiencing overall good health. In a National Health and Resilience in Veterans Study, 82.1% of the 2,025 U.S. veterans aged 60 to 96 years rated themselves as aging successfully when self-reporting of measures of physical, mental, and cognitive functioning (Pietrzak, Tsai, Kirwin, & Southwick, 2014). Celebrating its 27th year, the National Veterans Golden Age Games offers sports and recreational competitive events for veterans 55 years of age and older to make physical activity a central part of their lives and support VA’s comprehensive recreation and rehabilitation therapy programs. The VA's research and clinical experience has found that physical activity is particularly important to the health, recovery, and overall quality of life for older people (VA, 2014).
Complete health care coverage is an important concern for the aging veteran population. They experience higher long-term care expenses having developed service and non-service related disabilities. At age sixty-five, most veterans become eligible for Medicare and receive a higher priority status for the VA health care system. Compared with non-veterans in the same age groups, middle-aged and elderly veterans are less likely to have received treatment for mental health disorders (Kaplan et al., 2012). Despite being more likely to express having a depressed mood more than younger veterans, older veterans’ were reported less likely to seek mental health treatment (Kaplan et al., 2012). One study found that veterans prefer to access one health care system when they had access to more than one even when it required them to wait longer (Pizer & Prentice, 2011). This study also looked at the consequences of long wait time for health care for elderly veterans who are eligible for both the VA and Medicare. The study found that delayed access to healthcare from long wait times led to poor health, especially for older populations who experience greater vulnerabilities.

**Key Policies and Trends**

Late-onset stress symptomatology (LOSS) for aging combat veterans may be one reason that symptoms appear later in life. LOSS is a condition similar to PTSD but without numbing, avoidance, or arousal symptoms. It may come about from changes in social roles (including retirement), physical and cognitive declines, bereavement, and other life-changing events that can serve as reminders of one’s earlier life experiences, leading to increased reminders about military experiences (Davison et al., 2006). The 2013 Military Psychologists’ Desk Reference for mental health providers states that LOSS may provide an opportunity for veterans to engage in a process of acceptance of their role in society and growth later in life (Moore & Barnett, 2013).

There are mental health treatments and therapies for older veterans that have shown promising results. One study found effectiveness in cognitive behavioral therapy for counteracting depression and providing encouragement to older veterans seeking treatment (Karlin et al., 2013). Another Providence VA Primary Care study found improved access to care through using patient-aligned care teams and a medical homes model (O’Toole et al., 2011). Their successes were a result of using a systems design approach tailored to the population’s specific needs and challenges. For example, they found that using telephone care in the geriatric clinic helped elderly patients who could not easily attend clinic appointments, due to a number of reasons such as frailty and caregiver availability. This study recommends looking at access to care from a population-based perspective that addresses competing needs, motivations for seeking care, and strategies for effective treatment engagement.

**Opportunities to Achieve Equity**

**POLICIES AND PROGRAMS ADDRESSING INEQUITIES**

Making up 43 million today, the number of Americans 65 or older could reach 108 million in 2050, which is the same as adding three more Floridas inhabited by seniors (Easterbrook, 2014). How do we prepare our communities and our country to ensure that all people age with dignity, good health, economic security, and social support? This is a particularly important
question for families, policymakers, healthcare providers, and our society given that people in America are living longer than ever before. Government agencies, such as the National Institute on Aging and the AARP Public Policy Institute provide resources, informs the public, and promotes public debate on issues related to aging.

STRATEGIES TO IMPLEMENT POLICIES AND PROGRAMS
An estimated one in five older U.S. veterans is a caregiver (Monin, Levy, & Pietrzak, 2014). When comparing older caregiving veterans to non-caring veterans in terms of health and psychosocial factors, older veterans’ combat exposure may decrease the emotional demands of caregiving, and grandparenting can be rewarding. This suggests that older veterans are an important caregiving resource that deserves resources. Veterans who need caregiver support can find assistance through federal programs. The VA’s Aid and Attendance and Housebound Improved Pension benefit can cover the costs of caregivers in the home or can be used for assisted living or a nursing home.

INVESTING IN A CULTURE CHANGE TO ACHIEVE EQUITY

When asked, “How do younger and older vets returning home differ?” in a panel discussion at the Facing the Invisible Wounds of War event, Koby Langley, Associate Director with the Corporation for National and Community Service, stated “War is war; however the tools [for] how [we] deal to war have changed,” (Volunteers of America, 6/18/13). In addition, he stated that “there are fewer serving [and this] is latent to greater stresses along with higher survivor rates due to better medical care. Vietnam-era veterans can serve as mentors.”

Retirement and aging can be an exciting phase for one’s life that provides one the opportunity to pursue new hobbies, travel, and spend more time with friends and family. Social networks can help aging veterans find purpose and connection. Moreover, elevating aging veterans’ issues can help to renew the discussion about the positive effects of aging and give a voice to Vietnam veterans who may not have had the opportunity to weigh in on their experiences in past years.

More research can help us understand the unique challenges that veterans experience through aging:

- How can Baby Boomer data be analyzed to identify trends, needs, issues around health care, access, and management of co-morbidities for the aging veteran population?
- What future challenges will aging veterans of different eras face with accessing services?
- How can technology be used to help aging veterans access services, particularly those faced with vulnerabilities?

I think that an Outreach effort outside of the VA system is needed to bring forth older Vets that did not receive as much attention as the IRAQ veterans. The system needs to utilize the assistance of Veterans of Foreign Wars (VFWs) as a starting point to bring the VETS together.

– Respondent, CommonHealth ACTION’s Veterans’ Health Survey
PROFILE 7: HOMELESS VETERANS

Key Highlights
- Vietnam veterans remain the highest proportion of our homeless veteran population; however, today, younger, female, and Black veterans are at greatest risk for homelessness.
- The nation’s spotlight on veterans’ homelessness has driven an increase in public and private sector resources, which has led to a significant reduction in veterans’ homelessness despite tough economic times.
- Eliminating veterans homelessness is important but it’s even more vital that homelessness assistance programs are effective in holistically serving veteran populations who are experiencing greater vulnerabilities.

Overview and Historical Context
In the U.S. on any given night, there are approximately 62,000 homeless veterans, a 17.2% decline since 2009 (VA, 2012). Moreover, three times as many veterans are struggling with excessive rent burdens and are at increased risk of homelessness (National Center on Family Homelessness, 2009). National estimates report that approximately 12% of the adult homeless population are veterans, who are mostly single males, reside in central cities, come from poor, disadvantaged communities, and suffer from mental illness and substance abuse problems (Perl 2013) [Figures 6 - 8]. Roughly 35.5% and 8.3% of all homeless veterans are African-American.

[Figure 6] HOMELESS VETERANS: MILITARY PROFILE (%)

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>Post-Vietnam</td>
<td>17</td>
</tr>
<tr>
<td>Stationed in War Zone</td>
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<tr>
<td>Vietnam Era</td>
<td>47</td>
</tr>
<tr>
<td>Received Honorable Discharge</td>
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</tbody>
</table>

Source: National Center on Family Homelessness, 2009
American or Hispanic, despite these populations only accounting for approximately 11% and 5.3% of the U.S. veteran population, respectively (Perl, 2013). Homeless female veterans consist of approximately 3% of the homeless veteran population. They are more likely to be married and experience serious psychiatric illness, but are less likely to have a job and suffer from
substance abuse disorders (National Center on Family Homelessness, 2009). There have been no differences in rates of mental illness or addictions when comparing homeless female veterans to other homeless women (National Center on Family Homelessness, 2009). The growth in the female veteran homeless population may be attributed to factors related to the increased deployment of females in the recent Iraq and Afghanistan conflicts (Byrne et al., 2013).

In 2013, the greatest proportion of homeless veterans resided in California (15,179), followed by Florida (5,505) and Texas (3,878), also the top three U.S. states with the highest veterans population (U.S. Department of Housing and Urban Development, 2013). Forty-six percent of homeless veterans were located in major cities including Los Angeles (6,291) and New York City (3,547); together accounting for 17% of all homeless veterans and 37% of homeless veterans in major cities (U.S. Department of Housing and Urban Development, 2013).

Throughout U.S. history, homelessness has been a persistent feature and has been often intertwined with economic hardships. During the Great Depression in 1932, the rate of unemployment was nearly 25%, which resulted in the homeless establishing communities for themselves in temporary shacks called “Hoovervilles” (Dickson & Allen, 2003). On May 21, 1932, a “Bonus Army” of approximately 75 to 100 unemployed World War I veterans marched in Washington, DC demanding a bonus promised eight years before. This number rose to an estimated 25,000 more, many with wives and children, over the next two months; however, compensation was deferred until 1945 due to federal budget constraints. In the 1980s when homelessness reached a high level due to the ailing economy, homeless veterans began showing up in increasing numbers in emergency shelters. In 1987, the VA began initiating support for homeless veteran services (Volunteers of America, 2014).

The current wave of homelessness has not subsided during good economic times, suggesting that the economy is only one factor in a constellation of many other causes (Burt & Aron, 2000). In addition to inadequate income due to lack of employment precipitating homelessness, other contributing factors including poor physical health, mental illness, and substance dependency have contributed to homelessness. A study that aimed to identify specific risk factors for female veterans’ homelessness identified five dominant risk factors that can initiate pathways towards homelessness (Hamilton, Poza, & Washington, 2011). The five risk factors include childhood adversity; trauma and/or substance abuse during military service; post-military abuse, adversity and/or relationship termination; post-military mental health; substance abuse and/or medical problems; and unemployment (Hamilton et al., 2011). The post-traumatic stress caused by a combat experience adds a layer of complexity to the numerous hurdles already facing homeless veterans.

Every wave of homelessness in the U.S. has been associated with negative attitudes and a stigma against homeless people (Leginski, 2007). Following the Civil War, alcohol abuse by the homeless began to receive attention (Baumohl, 1989). Leginski (2007) stated that, “as a result of this attention, this produced more pejorative labels, vagrancy laws, and editorial posturing rather than support services.” A United Nations report describes the causes and consequences of the stigma associated with homelessness;
homeless people and street children are frequently blamed for their homelessness, and labeled as “mentally deficient,” “criminals” or “addicts” (United Nations Human Rights Council, 2012). Consequently, this stigma has lead to a decreased self-esteem and “self-stigma,” caused from the internalization of negative preconceptions in addition to treatment noncompliance and relapses among homeless individuals with mental illness and substance use disorder (Rodrigues et al., 2013).

Key Policies and Trends

Transition out of the military can lead to unanticipated financial challenges and housing instability, particularly when there is a national shortage of affordable housing and employment opportunities (Kotkin, 2013). Debbie Norman, an Outreach Coordinator from United South Broadway Corporation in Albuquerque, New Mexico, stated that the veterans with PTSD with whom she works have a more difficult time following through with housing payments and related responsibilities; predatory lending and payday lending is often a problem for those with lower income (D. Norman, personal communication, April 23, 2014). Affordable housing has been identified as the primary solution for ending episodic homelessness (National Alliance to End Homelessness, 2012).

Over the past two decades, Leginski (2007) described our nation’s actions to address the needs of the homeless as a de facto system of service, which is not driven by specific legislation or theory, but has evolved through a network of organizations that deliver services within a funding and policy context. Instead of an aligned and coordinated system, different approaches have been adopted by federal departments and the advocacy community. In 2009, President Barack Obama launched a coordinated effort to prevent veterans from ever having to experience the desperation of homelessness. He challenged us to have “zero tolerance” for a veteran—any veteran—sleeping on the streets after serving their country in uniform. Since this announcement was made, significant investments and public-private partnerships have been forged:

- **February 2009:** Congress created a $1.5 billion Homeless Prevention and Rapid Rehousing Program (HRPR) and reauthorized HUD’s McKinney-Vento homeless assistance programs following the passing of a landmark housing bill, which resulted in the establishment of a National Housing Trust Fund.

- **June 2010:** The U.S. Federal Government released a comprehensive plan to prevent and end homelessness in America titled, Open Doors: Federal Strategic Plan to Prevent and End Homelessness. The Federal Strategic Plan was released jointly by the U.S. Department of Housing and Urban Development (HUD), the Department of Veterans Affairs, the U.S. Department of Health and Human Services (DHHS), and the Interagency Council on Homelessness. The Federal Plan is based on six integrated pillars: Outreach/Education, Treatment Services, Prevention Services, Housing/Support Services, Income/Employment/Benefits, Community, and Partnerships.

- **December 2011:** The VA and HUD announced a 12% decline in homelessness and that it will make $100 million in grants available to community agencies across the country to prevent nearly 42,000 veterans and their families from falling into homelessness or to quickly return them to stable housing (VA
The funding was offered for fiscal year 2012 through VA’s Supportive Services for Veteran Families (SSVF) program, a homeless-prevention and rapid re-housing program.

- **March 2014**: The VA launched the 25 Cities Initiative in Washington, DC (VA National Center on Homelessness Among Veterans, 2014). This initiative will focus on three key areas: Build an intake system for matching homeless Veterans and the chronically homeless to the housing and specific support services they need; strengthen and integrate data systems for these two groups; and Merge VA’s homeless resources and assets with a broader effort aimed at ending chronic homelessness.

- **June 2014**: First Lady Michelle Obama announced the Mayors Challenge to End Veterans Homelessness as part of the Joining Forces Initiative providing $160 million in funding support (Burns, 2014).

- **Fiscal year 2015**: President and Congress have provided $1.6 billion for ending Veterans’ homelessness, an increase of almost 18% over the 2014 budget level.

Since the implementation of the VA’s five-year plan to end veteran homelessness and the launch of the first ever Federal Strategic plan to end homelessness, there have been additional investments from corporations and other sectors to support nonprofit initiatives, agencies, and innovative projects and housing infrastructure. In addition, newly formed federal and community partnerships and programs have been designed and launched to assist veterans and their families with recovery and reintegration.

**Opportunities to Achieve Equity**

**POLICIES AND PROGRAMS ADDRESSING INEQUITIES**

The nation’s spotlight on veterans’ homelessness has driven an increase in public and private sector resources to address this issue, which has led to a significant reduction in veterans’ homelessness despite tough economic times. Since the Federal Strategic Plan to end homelessness was announced in 2010, there has been nearly a 25% decrease in veteran homelessness (The U.S. Department of Housing and Urban Development, 2013). In 2013, the number of homeless veterans stands at 57,849, an 8% decline from 2012, and a 24% decline since 2010 driven mostly by reductions in the number of unsheltered veterans (National Center on Homelessness Among Veterans, 2014).

**STRATEGIES TO IMPLEMENT POLICIES AND PROGRAMS**

Historically, homeless veterans have been primarily White men who served in the Vietnam War and face significant mental health illnesses. Due to a shift in demographics in the current military and incoming veteran population, we have seen an increase in female veterans of color who return from recent conflicts and continue to experience challenges adjusting back to civilian life. Female veterans and those with disabilities including PTSD and TBI are more likely to become homeless, and a higher percentage of veterans returning from the current conflicts in Afghanistan and Iraq develop these disorders. The Advanced Women’s Program (AWP) in Long Beach, California, a part of the national U.S. VETS initiative, has been shown to successfully help homeless women veterans reintegrate into the civilian sector through addressing mental health needs of women veterans (Kabbara, 2014). The AWP is a gender specific initiative that assists
homeless women veterans with reintegration into the civilian sector through providing assistance with housing and income. However, female veterans with MST did not successfully complete the recovery program. The program evaluators found the following pathways formed a “web of vulnerability”: (a) childhood adversity (b) trauma and/or substance abuse during military service (c) post-military abuse or adversity (d) post-military mental health, substance abuse, or medical problems (e) unemployment. In addition to providing housing vouchers and employment training, we recommended that the VA and community based organizations should target each of these vulnerability junctures. More attention and investment should be made to address the holistic needs for the veteran populations facing greatest vulnerabilities.

A study that utilized a patient-centered medical home for high-risk groups, including homeless veterans, found that access to care and chronic disease management for homeless patients increased by having a fixed site and time of care, eliminating the need for appointments (O’Toole et al., 2011).

As the military continues to downsize and attention is taken away from the armed forces, it is important that the public’s attention to homeless veterans and the funding support does not subside. The National Alliance to End Homelessness, with guidance from their research council, published a Research Agenda to End Homelessness in 2014 to better inform funders about research questions that will help make policy and practice more effective (National Alliance to End Homelessness, 2014).

More research is needed to understand the unique needs and opportunities to help veterans and their families who face homelessness:

- How many of the existing housing programs for veterans are providing holistic care or working in tandem with public and private community support services?
- What local and state comprehensive public and private coordinated services programs that address veterans holistic needs exist?
- Are transitional support and veteran peer-to-peer mentorship programs effective in preventing homelessness?
- What are the short-term and long-term impacts of veterans housing support programs on their quality of life and well-being?
- Where are veteran populations who are not eligible for federal housing support finding support?

I would like to see affordable housing be made easier for vets to acquire. It is a challenge for vets to come home and then deprogram to live up to the expectations of society.

– Respondent, CommonHealth ACTION’s Veterans’ Health Survey

INVESTING IN A CULTURE CHANGE TO ACHIEVE EQUITY

The federal government has moved to make more investments in cost-effective and outcome-oriented programs in an era of higher accountability and stricter requirements for return on investments. Reducing homelessness numbers to zero is important but it is even more vital that homelessness assistance programs are effective, sustained, and holistically serve veteran populations experiencing greater vulnerabilities.
PROFILE 8: INCARCERATED VETERANS

Key Highlights
- More than 140,000 veterans are incarcerated today; the majority are White males that served in the Vietnam War-era; however, Black veterans were 5.6 times and Hispanic veterans were 4.3 times more likely to be incarcerated than White veterans across age groups.
- Within the last two decades, the incarcerated population has seen a significant increase in veterans from the Iraq and Afghanistan conflicts, which may be due to longer deployments, multiple tours of duty, extensive combat exposure, and high occurrences of PTSD and TBI.
- Veteran Treatment Courts (VTCs) have been successful in preventing veteran incarceration through military staff providing peer-to-peer assistance to connect them to untapped military benefits, services, and programs.

Overview and Historical Context
While the number of veterans within State and Federal prisons has steadily declined over the past three decades, there are still more than 140,000 veterans presently incarcerated (Melber, 2014). In one of a few studies to extensively analyze incarcerated veteran data, a 2000 Bureau of Justice Statistics report found that roughly “1 in 6 incarcerated veterans were dishonorably discharged from the military” (Mumola, 2000) highlighting an over-represented population of vulnerable veterans, many of whom are dealing with severe mental traumas sustained while in service and thus are at an elevated risk of becoming homeless and ensnared within the criminal justice system. Disqualified from health care, employment, education, and housing benefits, these vulnerable veterans have very little to fall back on in times of need. This increases concerns that the “less-than honorable” or “dishonorably” discharged statuses, and the subsequent termination of crucial benefits and services, is creating a de facto combat-to-prison pipeline.

Current incarcerated veterans tend to be exclusively male (99%), mostly White, and non-Hispanic. From a proportion standpoint, African-American veterans
- “… were 5.6 times and Hispanic veterans 4.3 times more likely to be incarcerated than White veterans across age groups” (had a lower likelihood of being incarcerated than their non-veteran of color counterparts) (Tsai, Rosenheck, Kaspr, & McGuire, 2013);
- have an approximate median age of 45 (10-12 years older than non-veterans); and
- tend to have a greater level of education, and higher marriage rate. Service-wise, the majority of incarcerated veterans were Army service-members (56 to 57%), 20 to 26% had combat experience, and approximately 80% had been discharged prior to conviction (Blodgett, Fuh, Maisel, & Midboe, 2013).

Broken down at the federal, state, and local (jails) levels, there was notable differences in the conviction patterns amongst the incarcerated veteran population. Among state prisoners, veterans had less extensive criminal histories.
than non-veterans (30% were first-time offenders, compared to 23% of non-veteran state prisoners) but more than half of state-incarcerated veterans (57%) had been convicted of a violent crime as opposed to just under half for non-veterans (47%). Of those violent crimes conviction, “the victims were more likely to be female and more likely to be minors (12 years or younger) for veteran offenders compared to non-veterans” (Blodgett et al., 2013). Additionally, the state-incarcerated veteran population was more likely to be convicted of sexual assault (25%) than the non-veterans (10%). Of state incarcerated veterans with violent crime convictions, 25% were charged with victimizing a family member versus just 10% of the non-veteran violent crime population (47%, in total). These figures highlight an elevated prevalence of domestic abuse found in the returning veteran populations. Within federal prisons, the most common convictions for the incarcerated veteran population were drug-related, although at the federal level, veterans had an overall lower drug conviction rate (46%) than did the non-veteran population (56%) (Blodgett et al., 2013). Like the state prison population, federally-incarcerated veterans had a higher incidence of violent offenses (19%) than non-veterans (14%) despite having an overall lower rate and proportion than their state counterparts. At the local level, the veteran population in jail had similar violent crime and property offenses to their non-veteran counterparts, and also had a “lower rate of drug offenses, but a higher rate of public-order offenses compared to non-veterans” (Blodgett et al., 2013).

Vietnam War-era veterans have historically been the largest incarcerated veteran group—followed by veterans of the Gulf Wars—with their over-representation in the criminal justice system linked to their high combat exposure and the subsequent trauma sustained. “They [Vietnam veterans] are now overrepresented amongst our chronically homeless and incarcerated veteran population, and are presenting in large numbers to the VA for the first time with signs of PTSD, and in many cases, seeking first-ever mental health treatment” (John Mundt, personal communication, December 16, 2013). Within the last two decades, this population has seen a significant increase in veterans from the Iraq and Afghanistan conflicts—OEF, OIF, and OND—and concurrently, amongst this population, unprecedented longer deployments, multiple tours of duty, extensive combat exposure, and high occurrences of PTSD and TBI. Unlike Vietnam and Gulf War-era veterans, the incarcerated OEF/OIF/OND cohort are overall “younger, more likely to be married, more likely to report combat exposure, expected a shorter incarceration, were 26% less likely to have a diagnosis of drug abuse or dependence, and were three times more likely to have combat-related PTSD” (Tsai et al., 2013).

Key Policies and Trends

A number of studies have estimated that “the proportion of inmates with severe mental illness in jails and prisons in the U.S. ranges between 6% and 16% whereas the rate of severe mental illness
in the general population has been estimated at 2.8%” (Erickson, Rosenheck, Trestman, Ford, & Desai, 2008). Research links this disparity to the 1950s nationwide “Deinstitutionalization” movement, which endeavored to close state psychiatric hospitals and transition the severely mentally ill to smaller, community-based treatment programs, but never equitably came to full fruition or wide success. As a result, states saw sharp increases in their homeless and incarcerated populations, generating a crisis that transformed the U.S. prison system into ancillary psychiatric institutions for those suffering from mental illnesses (Torrey, 1997).

In one study, particularly for returning OEF/OIF/OND veterans, as many as one in four reported symptoms of a mental or psychotic disorder and one in six reported experiencing symptoms of PTSD (National Institute on Drug Abuse, 2013). Research on incarcerated populations has consistently identified a “high occurrence of alcohol dependence and drug abuse, particularly among those with mental disorders [uncaused by the substance use]” (Tsai et al., 2013). The presence of both a mental health disorder and substance abuse/dependency increases the risk of violence, unemployment, homelessness, arrest, and incarceration. “Many soldiers, unable or unwilling to get treatment for psychological problems, self-medicating with alcohol and drugs” (Wolfe, 2013). According to a National Institute for Drug Abuse (NIDA) report, “although illicit drug use is lower among U.S. military personnel than among civilians, heavy alcohol and tobacco use, and especially prescription drug abuse, are much more prevalent and are on the rise” (NIDA, 2013). Between 2001 and 2009, NIDA found that pain-reliever prescriptions to veterans had roughly quadrupled (NIDA, 2013).

In terms of treatment, “between 2002 and 2008, fewer than 10% of U.S. veterans of the wars in Iraq and Afghanistan who were newly diagnosed with PTSD received the recommended course of care for their condition at VA health facilities,” according to a study by researchers at the San Francisco VA Medical Center (SFVAMC) and the University of California, San Francisco (UCSF)” (Tokar, 2010). The researchers found several key factors that decreased a veteran’s likelihood of receiving the full, recommended treatment, which included being male, under the age of 25, living in a rural area, and receiving a PTSD diagnosis from a primary care clinic instead of a designated mental health program (Tokar, 2010). According to NIDA, young adult veterans are at a higher risk for developing additional mental health and substance abuse issues. A 2004-2006 report found that “a quarter of 18- to 25-year-old veterans met criteria for a past-year substance use disorder, which is more than double the rate of veterans aged 26-54 and five times the rate of veterans 55 or older” (NIDA, 2013).

The “revolving door” between incarceration and homelessness has long been documented, as has the over-representation of veterans, both male and female. Veterans who experience homelessness are more likely to interact with environments that place them at a greater risk of incarceration. In turn, incarcerated veterans are more susceptible to homelessness, often due to inadequate transitional services upon release, difficulty in adjusting back to civilian life, shortage of community-based reintegration supports, lack of available affordable housing, in addition to certain state policies that prevent released individuals from accessing service benefits (Council of State Governments, 2005). Without support for problems such as addictions and mental health and housing and employment support, the risk of homelessness or prison
re-entry are greatly increased (Gaetz & O’Grady, 2007).

Veterans who have been incarcerated or do not have an honorable discharge are excluded from crucial benefits and access to opportunities and well-paying jobs. The research is clear that these factors, along with long-term treatment supports, are essential in helping these veterans transition into civilian life and remain out of prison.

Opportunities to Achieve Equity

POLICIES AND PROGRAMS ADDRESSING INEQUITIES

As awareness has increased around the plight of incarcerated veterans with severe mental health needs, there have been several concerted efforts, from various sectors to support this vulnerable veteran population. Many of these efforts focus on addressing their unique needs through alternative, more-tailored approaches to care. “In 2007, the VHA created a system-wide outreach program called Health Care for Reentry Veterans (HCRV) to facilitate connection with VHA services among incarcerated veterans upon their release from state and federal prisons” (Tsai et al., 2013) which resulted in a considerable decrease in recidivism.

One of the most successful alternative models for veterans at risk of imprisonment has been the formation of “Veteran Treatment Courts” (VTCs) created in 2008 by the Honorable Robert Russell after he observed a steady increase in the number of drug and mental health-related cases involving veterans. Judge Russell found that by providing peer-to-peer assistance, his military staff was able to connect these veterans to untapped military benefits, services, and programs. This resulted in long-lasting success, which prevented them from entering the prison system. In partnership with the VA, there are now more than 131 VTCs across the nation; these VTCs accept only cases of veterans who have been clinically diagnosed with a mental health and/or substance abuse disorder. These courts have fundamentally changed how the criminal justice system sees and treats veterans, providing a “wrap-around” service that engages mental health and treatment providers, prosecutors, defense lawyers, probation and law enforcement officers, in addition to representatives from the VHA, Veterans Benefit Administration (VBH), and other relevant VA branches (Justice for Vets, 2014). Since homelessness and incarceration are inextricably linked, all veteran anti-homelessness strategies should be aligned, if not adopted, by initiatives focused on decreasing veterans’ involvement with the criminal justice system. “Once veterans go [to] jail for the first time, their chance of going back... increase[s], [which] also applies to the general population; treatment courts are the only successful model to interrupt this [trajectory]” (C. Deutsch, J. Barrow, and M. Fitzgerald, Justice for Vets, personal communication, January 16, 2014).

STRATEGIES TO IMPLEMENT POLICIES AND PROGRAMS

From a philanthropic, non-profit, and community-based approach, it is important that these institutions continue to help design and implement both education and awareness campaigns and trainings for civilians, judges, and the police force on how best to engage veterans and understand the issues they face. Another area where these institutions are well-suited to assist is in addressing the data holes that still exist, and focusing on collecting data on veterans released on parole and probation. Leading data agencies like the U.S. Department
of Justice’s (DOJ) Bureau of Justice Statistics do not currently provide statistics on veterans released under community care. Additionally, the statistics on female veterans are still not well-reported due to a few factors, but primarily because they represent 1% of the incarcerated veteran population.

There has been an intense interest amongst private investors in finding ways in which Social Impact Bonds can be used to fund social programs that bring about revenue-producing positive change. Presently, Goldman Sachs has lent $9.6 million to an educational program geared towards Rikers Island’s 16-18 year old population, aiming to help transform their thinking so as to enable them to make choices that will prevent recidivism (Garrison, 2014). Although the success of such an initiative is still unknown, should this prove effective, it could easily be adapted to assist incarcerated veterans in reintegrating back into society and avoid recidivism. While these innovative approaches and partnerships are to be encouraged and explored, it is equally important to craft programs that focus on a veteran’s environment and ways in which it is impacting their success and how it might be changed to maximize positive outcomes.

INVESTING IN A CULTURE CHANGE TO ACHIEVE EQUITY

Veterans who have experienced incarceration can contribute their lived experiences, expertise, and mentorship to fellow active and veteran service-members struggling with combat-related mental health and addiction issues. This group is also well suited to informing the design and improvement of treatment programs and protocols in order to increase efficacy. Opportunities for this group include employing and empowering them to share their experiences by creating both mentorship programs and occupations that allow this population to counsel active service-members and veterans struggling with similar issues. Moreover, providing platforms for veterans to mentor others struggling with addiction and getting past their time in prison is recommended.

More research can help us understand the unique challenges that veterans experience incarceration:

- Exactly how many veterans are either in the criminal justice system or under its supervision (probation, parole, etc.)?
- How many female veterans are currently in the criminal justice system? What are the exact barriers they face from a social, physical, and psychological standpoint?
- Why do female veterans find it difficult to self-identify as “veterans” and what are the causes for the discrepancies in how they are viewed and treated, externally?

There would be wrap around services and this mentor would know how to access all the services needed (In response to a question about designing a support program for veterans, from a veteran who identified as being formerly incarcerated).
- Respondent, CommonHealth ACTION Veterans’ Health Survey
PROFILE 9: OTHER-THAN-HONORABLY DISCHARGED VETERANS

Key Highlights
• An estimated 100,000 veterans have been less than honorably discharged from the military since 2001; these veterans are excluded from crucial VA benefits, access to opportunities, and civilian employment
• Veterans with an other than honorable discharge have two options for accessing VA-covered health services: 1) apply for a military service discharge status change, or 2) apply to VA facilities for a waiver that will allow access to health care and disability benefits
• A number of non-profits and government agencies have stepped in to provide no-cost mental health services to veterans regardless of discharge status

Overview and Historical Context
Separating from the military is a tremendous process. During this time, service members learn about their eligibility for benefits and how to access health care, education assistance, and other service-connected opportunities. Although the military offers great benefits, the availability of the aforementioned benefits are contingent upon the type of discharge received, which can have a profound impact on how former service members coexist in the civilian world. Upon release from the U.S. Armed Forces, service members are either administratively or punitively discharged, with the exception of retirement. Administrative discharges typically fall under one of the following three categories: 1) honorable; 2) general under honorable conditions; or 3) other than honorable (OTH) (Tully, 2008). OTH discharges can be issued if a service member is convicted by a civilian court for a crime, offense, or participates in a pattern of misconduct comprised of multiple minor offenses (Tully, 2008). Likewise, punitive discharges are also characterized by three categories: bad-conduct discharge, dishonorable discharge, and dismissal (Tully, 2008). These discharges are designations that are issued after a court-martial or a guilty plea in relation to crimes such as drug dealing, assault, rape, murder, robbery, or other serious offenses/patterns of misconduct (Tully 2008). Punitive discharges are often more stigmatizing than administrative discharges and introduce greater post-military service challenges when applying for jobs and educational opportunities.

Military personnel discharged under OTH conditions are not characterized as veterans under federal law, and are consequently ineligible for the health care, employment, housing, and education benefits afforded by the Department of Veterans Affairs (Carter & Kidd, 2013). During the Vietnam War, nearly 3% (roughly 260,000) of the 8.7 million who served were discharged under OTH conditions (Carter, 2013), suggesting that this population had little or no access to military-connected benefits. The lack of VA benefits were potentially compounded by challenges associated with the American public’s insensitivity and respect for Vietnam veterans due to anti-war sentiments and the
prevalence of untreated mental illness on account of stigma, along with the incapacity or lack of available services to aid this population. Since the advent of OEF/OIF conflicts, recent studies indicate that more than 100,000 veterans have been OTH discharged from the military (Lawrence & Peñaloza 2013) and similar to Vietnam veterans, they experience loss of VA assistance, disability compensation, GI Bill benefits, and difficulty when applying for jobs (Lawrence & Peñaloza 2013). While it is not clear how many OTH discharged veterans suffer from PTSD or whether the condition influenced behaviors that resulted in their discharge, studies have demonstrated a strong correlation between untreated or under-treated PTSD and misconduct charges (Toney, 2014). Due to lack of VA healthcare access and limited job opportunities, many veterans with OTH discharges are at greater risk of suffering from health and family challenges along with being among the nation’s homeless or incarcerated populations.

**Key Policies and Trends**

A number of service members who experience combat or other military-related stressors are faced with legal and/or military disciplinary challenges upon release from their military duties. Those administered OTH discharges become the responsibility of the community support system, since the VA and other federal entities cannot always help due to legal issues (Carter & Kidd, 2013). By administering OTH discharges as a disciplinary action, the armed forces contributes to mentally ill populations at risk for harming themselves and the public, due to lack of access to treatment (Markowitz, 2011). Eric Highfill, who served five years in the Navy, received an Iraq campaign medal, an Afghanistan campaign medal, in addition to a good conduct dismissal. However, the OTH discharge he received overshadowed the honors he earned while in the military. This former Navy service member was discharged after battling an addiction to pain medication resulting from a knee injury, and later received a driving under the influence (DUI) charge. “They want nothing to do with you. They won't give you a job, they won’t take care of you, they don’t want to help you out. The jobs I get are usually hard, hard-labor jobs,” said Highfill (Lawrence & Peñaloza, 2013).

Most OTH discharged veterans are not aware that they have two options for accessing VA-covered health services: 1) they can apply for a change in their military service discharge status, or 2) they can individually apply to VA facilities for a waiver that will allow them to access health care and disability benefits (Carter & Kidd, 2013). Veteran advocacy programs such as the Homeless Advocacy Project in Philadelphia, PA have been spreading the word that veterans with dishonorable discharges may often qualify for VA medical care (Carter & Kidd, 2013).

There are numerous OTH discharged veterans who qualify for VA medical care, but do not apply, due to the assumption that their discharge status renders them ineligible, or that their VA rejections may be appealed (McCarthy, 2012). Fortunately, the U.S. military has a mechanism to fix unfavorable administrative discharges, but the approach is time-consuming and veterans often require legal help to navigate through this bureaucratic and difficult process (Carter, 2013). If an individual creates an application for VA-connected health care benefits and has an OTH or bad conduct discharge, s/he can register and be placed in a Pending Verification
Subsequently, to determine eligibility for VA benefits, an administrative decision request regarding the individual’s service character would need to be made at a local VA Regional Office (VARO) (VA, 2013). Appeals are granted on a case-by-case basis. Fortunately, some veterans have been able to upgrade their OTH discharge, which allows them to receive benefits through the VA.

Savage and colleagues (2014) reported that a number of Vietnam veterans who received OTH discharges presented a class action lawsuit against the U.S. Army, disputing that they were suffering from PTSD during the time they received OTH discharges (Savage et al., 2014). They are trying to have their OTH discharges reassessed and upgraded for health care access (Savage et al., 2014). Swords to Plowshares (a San Francisco-based veterans’ rights organization) and Brave New Films (a media company dedicated to addressing justice issues in the United States) partnered to launch a petition calling for Congressional oversight of DOD discharge practices and VA eligibility guidelines to ensure veterans get the healthcare and benefits they need (McFarland, 2014). “This is a decades-old problem that just has to get fixed,” said Michael Blecker, Executive Director of Swords to Plowshares. “Veterans are still being denied life-saving care they earned for injuries and illness sustained in service and Congress has not held hearings to address this injustice since 1971” (McFarland, 2014).

Opportunities to Achieve Equity

POLICIES AND PROGRAMS ADDRESSING INEQUITIES

There are a number of policies and programs that address inequities in accessing health care and legal services among veterans with other than honorable discharge statuses. In 2008, the Los Angeles County Department of Health’s Discharge Review Board (VA), changed its policy to allow any veteran, regardless of discharge status, to be seen at mental health clinics. Give an Hour, a nonprofit organization that provides no-cost mental health services, extends these services to Iraq and Afghanistan veterans, regardless of discharge status. In addition, The National Alliance on Mental Health, The Soldiers Project, Disabled American Veterans...
(DAV), and the National Veterans Foundation are a few of the many support programs, services, and resources available to address the unique challenges of veterans with other than honorable discharges. Additional advocacy organizations representing this group include Yale Law School’s Veterans Legal Services Clinic, where students have represented Connecticut veterans in litigation before administrative agencies and courts, on benefits and discharge upgrade. The Mayer Law Group offers veterans and service members experienced and high-quality legal representation for military law cases.

**STRATEGIES TO IMPLEMENT POLICIES AND PROGRAMS**

According to Jason Hansman, Senior Program Manager at the Iraq and Afghanistan Veterans of America (IAVA), there is clearly a growing recognition that regardless of veterans’ administrative discharge or character, they deserve access to services. “Stakeholders are witnessing a change in the approach of organizations that provide care to those who receive unfavorable discharges” (J. Hansman, personal communication, January 17, 2014). A veteran’s discharge status should not be a barrier to seeking and obtaining adequate health care. Although a number of veterans organizations are working with OTH discharged veterans across the country, this is an issue around which there needs to be more recognition and support. The lives of these veterans and their ability to successfully transition into civilian life are severely impacted by this designation, especially those who require mental and other health services from the VA. While the military has every right to establish consequences for those who do not conform to its regulations or break the law, it should be noted that sometimes these OTH discharges are a result of combat-related illnesses or the stress of being a part of the military (i.e., PTSD and TBI). Those veterans will need—and should receive—additional support and coordination of efforts from the military, VA, and veteran organizations in order for them to move beyond this difficult time in their lives.

*Change the name of mental health to something without the word mental or behavior (In response to a question about designing a support program for veterans, from a veteran who identified with OTH)*
- Respondent, CommonHealth ACTION’s Veterans’ Health Survey

**INVESTING IN A CULTURE CHANGE TO ACHIEVE EQUITY**

Veterans with OTH discharges are likely to rely on public services in the community (T. Tanielian, personal communication, January 14, 2014). We are unaware of how many veterans have this classification because most non-VA health care systems do not track veteran status (T. Tanielian, personal communication, January 14, 2014). A better system is in need of implementation to identify veterans with OTH discharges and ensure that they have access to healthcare and support services.

Additional research specifically focused on these veterans’ experiences should explore:

- What awareness do community-based organizations have about OTH veterans?
- What methods, including policies and programming, have been effective in reaching and providing resources to OTH veterans?
- Have OTH veterans found mental health and other support resources from communities to be effective and culturally sensitive?
- What social networks exist for OTH veterans?
Key Highlights

- There are nearly four million rural veterans comprising over 10% of the total U.S. rural adult population.
- Veterans in rural areas face different challenges than their urban and suburban counterparts. Representing 40% of the VA’s health care enrollees, they travel long distances to access VA services, and they have lower rates of health insurance, limited finances, lower education levels, and overall poorer health.
- The federal government will need to adjust policies and programs to accommodate the needs of a shrinking but more diverse rural veteran population who is aging rapidly and experiences more disabilities.

Overview and Historical Context

In recent conflicts, U.S. soldiers have been drawn more from rural areas; therefore, veterans living in rural communities will require greater services from the Department of Veterans Affairs (VA) than their urban counterparts (VA About Rural Veterans, 2014). Many men and women serving in the military grew up in rural counties and return home after completing tours of duty, which is often a reflection of a strong family and community commitment to the country that is passed on through generations (Farrigan & Cromartie, 2013). According to the U.S. Department of Agriculture (USDA) Rural Veterans At-A-Glance report, there are nearly four million rural veterans that comprise over 10% of the total U.S. rural adult population (Farrigan & Cromartie, 2013). While rural Americans make up 16% of the general population, rural veterans make up a higher portion of all U.S. veterans (19%) (Farrigan & Cromartie, 2013).

On average, rural veterans are older than the general U.S. population, making up 3% of rural young adults and 25% of rural retirees (Farrigan & Cromartie, 2013). The military has shown increasing diversity in recent service periods, resulting in a more racially and diverse rural veteran population. In 2011, racial and ethnic minorities made up 4% of WWII veterans, 5% of Korean War veterans, 8% of Vietnam-Era veterans, and 16% of Gulf War I and II veterans (Farrigan & Cromartie, 2013). In addition, over 40% of rural female veterans served during Gulf Wars I and II, compared with less than 5% of rural male veterans (Farrigan & Cromatie, 2013). National population projections imply that there may be as many as one-third fewer rural veterans by 2030 (VA Office of the Actuary, 2013). Given these data trends, the federal government will need to adjust policies and programs to accommodate the needs of a shrinking but more diverse rural veteran population that is also aging rapidly.

As a result of this population aging, some veterans return to their rural communities with serious physical and psychological health-related challenges. According to the VA Office of Rural Health, a U.S. Department of Health...
and Human Services (DHHS) study estimates that half of adults living in rural areas suffer from a chronic health condition, and some rural veterans experience additional health complications from combat exposure such as PTSD, depression, or TBI (VA VHA, 2013). Over 20% of rural, working-age veterans report disability compared with 11% of nonveterans (Farrigan & Cromatie, 2013). In addition, rural veterans require a higher demand of healthcare services. They rate themselves as having sicker psychiatric disorders (as measured by lower health-related quality-of-life) compared with urban veterans, despite having an overall lower prevalence of most psychiatric disorders (VA About Rural Health, 2014). Since 2010, there has been a 15% increase in rural veterans’ health care enrollment, and this trend is expected to continue (Skupien, 2012). Over 40% of veterans enrolled in the Veterans Health Administration (VHA) are considered “rural” by the U.S. Census definition, with 39% having served recently in Iraq and Afghanistan (VA VHA, 2013).

Key Policies and Trends

Although rural veterans tend to have greater health care needs, they are less inclined to seek care than their urban counterparts (Heisler & Bagalman, 2013). One major barrier to accessing care that is being addressed by the VHA’s Office of Rural Health is the need to travel long distances to health care facilities. Ninety-one percent of veterans living in urban areas are able to drive 30 or fewer minutes to access VA primary care services compared to 38% of veterans living in rural communities (Heisler & Bagalman, 2013). Without adequate personal or public transportation, rural veterans are less likely to receive preventive care or primary care and have greater challenges when managing

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9. ‘Rural’ encompasses all population, housing, and territory not included within an urban area. The Census Bureau identifies two types of urban areas: Urbanized Areas (UAs) of 50,000 or more people; Urban Clusters (UCs) of at least 2,500 and less than 50,000 people (Washington Post, 2013).
chronic disease. In 2013, understanding the mental distress of rural veterans in Arizona, U.S. Rep. Ann Kirkpatrick introduced a bill that would strengthen mental health services for rural veterans and their families. Kirkpatrick’s bill, the Rural Veterans Mental Health Care Improvement Act, would subsequently reduce, if not eliminate, the overarching challenges in rural areas, such as inadequate mental health care professionals, funding restrictions that hinder information technology systems and medical equipment, and the inability to use telemedicine services for a variety of reasons (Mares, 2013).

Improving access to high-quality medical care in rural areas is an ongoing federal policy concern that draws special attention for the VA, starting with the establishment of its Office of Rural Health in March 2007 (Farrigan & Cromartie, 2013). In addition to addressing healthcare, the Office of Rural Health announced it would provide support for rural veterans and their families who are transitioning from military to civilian life. In 2014, they announced that they would fund five Rural Veterans Coordination Pilot grants sites totaling $10 million, in order to support veterans and their families residing in rural and/or underserved areas of the country (VA Office of Public and Intergovernmental Affairs, 2014).

Opportunities to Achieve Equity

POLICIES AND PROGRAMS ADDRESSING INEQUITIES
The Office of Rural Health is improving access and quality of care for rural veterans through creating telehealth programs, expanding healthcare access through opening outpatient clinics, and piloting a program for faith-based leaders on how to support veterans and their families with the readjustment process. Since 2009, the Office of Rural Health has implemented 1,000 projects, from setting up new community-based outpatient clinics, funding more outreach clinics, and reducing the need for veterans to travel long distances by increasing the use of telehealth technology (VA VHA, 2013). Dr. Mary Beth Skupien, Director of the Office of Rural Health, reflects on VA’s efforts to address rural veterans challenges: “We spent about 95 million dollars in the last two years improving access to care with the use of telehealth services, such as telerehabilitation services, primary care telehealth services, telemental health, teledermatology, and the Tele-MOVE weight loss support program” (VA VHA, 2013). There are currently more than 800 VA community-based outpatient clinics (CBOC’s) and almost half of them are in rural areas. In 2012, the VA announced plans to open 13 new CBOC’s throughout the country in nine states, including eight clinics in rural areas. (VA VHA, 2013).

A 2013 study found that 47% of veterans with depression and PTSD were open to seeking help from clergy and 12% had sought clergy assistance (Bonner et. al, 2013). Through the Office of Rural Health, the National VA Chaplain Service is hosting one-day education and training events to address veterans readjustment challenges for local clergy from all faith groups as well as veteran service organizations (VA Rural Clergy Training Program, 2014).

STRATEGIES TO IMPLEMENT POLICIES AND PROGRAMS
The U.S. government has over 15 definitions for the word “rural” which has largely been tied to federal programs funding eligibility (Washington Post, 2013). In August 2014, the VHA announced it was changing its definition...
of urban, rural, and highly rural land areas

Rural-Urban Commuting Areas (RUCA) system, which had been based on the U.S. Census Bureau criteria (VA Office of Rural Health, 2014). The RUCA system was developed through partnership with the USDA and the DHHS and takes into account population density and how closely a community is socio-economically linked to larger urban centers. Through improved understanding of locations where veterans live, it can make policy and program implementation more effective and improve outcomes by wasting fewer resources. Wayne Farmer, formerly with Give an Hour, a non-profit organization that provides veterans and their families over 140,000 hours of free remote mental health support, points out how technology can help fill service gaps for rural populations. “How do we use existing structures to provide better service and how do we market it to those who need it? The use of telehealth can be a game changer, where a provider in Virginia can treat someone in Tennessee.” (W. Farmer, personal communication, January 9, 2014).

**INVESTING IN A CULTURE CHANGE TO ACHIEVE EQUITY**

Veterans in rural communities face greater challenges, such as experiencing higher rates of disabilities and having longer distances to access health services. However, veterans are well situated to contribute to struggling rural communities’ economic growth since they possess high education and skill levels from their military training and leadership experience (Farrigan & Cromartie, 2013). As the U.S. military has become younger and more racially and ethnically diverse, it is expected that these populations will replace older White male veterans who are overrepresented in rural populations in the coming years. This will have implications on how rural programs and policies should be tailored to meet veterans’ needs. As one Veterans’ Health Survey respondent stated, “there are sub populations, including rural and homeless veterans, that face different challenges and needs.” It is important that resources provided meet the needs of veterans from all eras so that they can obtain adequate healthcare. The U.S. government and veteran service providers should look closely at the changing demographic trends, monitor the veteran population’s diverse needs, and lift up the assets that veterans can bring to all communities.

Additional research specifically focused on these veterans’ experiences should explore:

- How do we leverage existing technology infrastructure to provide better service to veterans living in rural communities and how do we market it to those who need it the most?
- How have current telehealth services benefited veterans and what shortcomings need to be addressed (e.g., broadband access)?
- What transportation policies or programs have been implemented that have been effective?

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**I would have more support groups located where Veterans could access them instead of 90 miles away. I would have more shelters/beds available for the homeless Female population. I would not treat veterans from different eras in different ways. All should have the same benefits. I am a Cold War veteran, we are treated as if we are not even veterans...**

- Respondent, CommonHealth ACTION’s Veterans’ Health Survey
PROFILE 11: STUDENT VETERANS

Key Highlights

• Today’s student veteran population is 73% male and 27% female. Female student veterans are overrepresented in postsecondary education with only 10-12% of military service members being women.
• Student veterans are often older, are more likely to have disabilities and caregiver needs, feel disconnected in higher education, and desire interactions with other veterans on campus.
• Colleges and universities need to provide effective services to accommodate the academic, social, and cultural challenges of today’s student veterans, given that they are more likely to transfer between schools or enroll part-time.

Overview and Historical Context

The U.S. student veteran population has grown tremendously over the past 10 years. More than 2.3 million veterans have sought higher education opportunities through the Veterans’ Educational Assistance Act of 1984, commonly known as the Montgomery GI Bill (McGrevey & Kehrer, 2009). To date, there are nearly 450,000 U.S. military veterans who use military education benefits to attend colleges and universities across the nation (Alfred et al., 2014; Sewall, 2010). As OEF/OND operations end and the military decreases its total active force, there will be increased reliance on Post-9/11 GI Bill education benefits (officially known as Post 9/11 Veterans Educational Assistance Act of 2008) [Figure 9], and greater enrollment in postsecondary academic institutions since World War II (Vacchi, 2012). Within the next five years, the student veteran population is expected to nearly double (Reynolds, 2013), commanding a greater demand on higher learning institutions’ staff, faculty, and administrators to adequately prepare and comprehend the unique experiences of this population.

Of today’s student veteran population, 73% are male, while females make up 27% (National Center for PTSD, 2014). With only 10-12% of military service members being women, female student veterans are overrepresented in postsecondary education (National Center for PTSD, 2014).

On average, veterans do not begin postsecondary education endeavors in the same manner as traditional college students. Traditional students typically go directly from high school into a full-time program for four or more years and then graduate. Conversely, as a result of their commitment to the Armed Forces, student veterans often enter higher education programs later on due to breaks between high school and college. Additionally, student veterans are often older than their traditional counterparts. Only 15% of student veterans are traditionally-aged college students (18-23 years of age); most are between the ages of 24 and 40 years (National Center for PTSD, 2014). This is a notable difference that colleges and universities with student veteran populations should take into consideration, since student veterans report lower levels of sense of belonging (Durdella...
...and pre-college characteristics such as age may play a role. In addition, a high percentage of student veterans are married and have their own families (47% with children; 47.3% are married) (Contera, 2013), all of which may have an impact on academic success. Notably, veteran status alone has an impact on academics and belonging (Durdella & Kim, 2012).

In addition, 66% of student veterans are first generation students (Wurster, Rinaldi, Woods, & Liu 2013). In civilian populations, first-generation students are more likely to have weaker academic preparation, lower educational ambition, and less knowledge about navigating college environment prior to matriculation (Durdella & Kim, 2012). Student veterans also experience these challenges (Wurster et al., 2013), which are compounded by the burden of lack of support, social class disparities, and economic cultural differences. Among student veterans, isolation, frustration, and stress are common challenges. As a result of their unique experiences (e.g., deployment) and different demographic characteristics, student service members and veterans often feel disconnected in higher education and desire interactions with other veterans on campus (Strickley, 2009). Student veterans report lower college GPAs despite having higher levels of academic participation and interaction, academic time, and collaborative work, compared to their non-veteran counterparts (Durdella & Kim, 2012).

According to the National Center for Veterans Studies and Student Veterans of America, 46% of student veterans think about suicide, 20% have a plan, and 7.7% make an attempt (Rudd, Goulding, & Bryan 2011). This is much higher than the general population. A reported 3.7% of the U.S. population had thoughts of suicide...
in the past year, 1.0% developed a suicide plan, and 0.5% attempted suicide (Emory University, 2014). Female student veterans may be at increased risk for mental health obstacles, and their emotional impairments may differ from their male counterparts (Whitley, Tshudi, & Gieber, 2013). High rates of MST in female veterans will increase the chance that female student veterans will develop PTSD from a sexual assault (Sander, 2012). Female student veterans can experience isolation symptoms at even higher rates than their male student veterans, considering they are less likely to participate in veteran-related activities (Sander, 2012; O’Herrin, 2011; Whitley et al., 2013). In addition, some female student veterans do not identify or acknowledge their veteran status while on campus, making it difficult to provide assistance (Sander, 2012; Whitley et al, 2013).

Key Policies and Trends

The GI Bill has provided U.S. military veterans the opportunity to afford and enroll in colleges and universities for nearly seventy years. Starting with the Servicemen’s Readjustment Act of 1944 (Radford, 2009), the U.S. government provided financial support to over 6.6 million World War II service members and veterans (Weber, 2011; Breedin, 1972). Between the 1940s and 1950s, as a result of college-attending veterans, the U.S. attained thousands of new health professionals, scientists, engineers, and educators, in addition to transforming service members into community-oriented citizens that substantially contributed to the leadership of the nation (Reynolds, 2013; O’Herrin, 2012). “The percentage of Americans with college degrees increased from 4.6% in 1945 to 25% in 1970,
primarily due to the original GI Bill (Garcia, 2009)” (as cited in Weber, 2012, p. 7). The Bill is often credited as a "contributor in creating America’s middle class (O’Herrin, 2013), in conjunction with other cultural factors (Batten, 2011), resulting in a perceptional paradigm shift that college education is afforded to individuals other than cultural elitists.”

Throughout the years, modifications to the original GI Bill were introduced through the Veteran Readjustment Assistance Act of 1952 (Korean GI Bill), Veterans’ Readjustment Benefits Act of 1966, the Post-Vietnam Era Veterans’ Educational Assistance Act of 1977, and the Veterans’ Educational Assistance Act of 1984 (Montgomery GI Bill) (Weber, 2012). Although a number of service members search for careers within the military, many men and women who serve in the Armed Forces seek employment elsewhere, and recognize the value of the GI Bill as a tool to help propel their career goals. Some are able to continue educational endeavors when they enlisted in the military; others are enrolling in college for the first time. Either way, the GI Bill helps to provide tremendous benefits to military personnel and veterans.

Opportunities to Achieve Equity

POLICIES AND PROGRAMS ADDRESSING INEQUITIES

In 2008, the Post-9/11 GI Bill started helping a new generation of student veterans pay for post-secondary education and earn degrees and certificates. The “New GI Bill”, combined with a competitive work force and weak global economy, has led to an increase in student veteran enrollment in recent years. However, knowing how to navigate the GI Bill may be challenging for veterans, compounded by having delays in benefits. Many student veterans who used certain on-campus services reported receiving academic benefits; however, several barriers to using on-campus services were reported.

STRATEGIES TO IMPLEMENT POLICIES AND PROGRAMS

Overall, student service members and veterans report adjustment difficulties ranging from personal (e.g., developing and maintaining relationship) to educational (e.g., institutional support, infrastructure, and policies). Research demonstrates that providing social support is an effective method for curtailing mental health issues in student veterans. Therefore, college and universities need to provide effective services to accommodate the academic, social, and cultural challenges of today's student veterans. In August 2013, President Obama announced that 250 community colleges and universities signed on to implement the Department of Education and VA’s Eight Keys to Success (Baker, 2013). This initiative includes eight concrete steps that higher education institutions can take to help veterans’ and service members’ transition into the classroom.

In addition, cultural sensitivity trainings have been developed to orient faculty and staff to military culture, including how to manage classroom discussions around veteran-sensitive topics, and to identify or refer veterans in need for mental health and other support services. Establishing communities for student veterans, and providing online resources and tailored mental health support services are necessary to supplement federal educational benefits.
INVESTING IN A CULTURE CHANGE TO ACHIEVE EQUITY

Colleges and universities across the country need to be prepared to upgrade their veterans’ service centers to respond to the increased number of veterans expected to take advantage of the GI Bill. It is vital for higher education institutions to develop partnerships with veteran community organizations and provide veterans benefit and financial planning support. A CommonHealth ACTION focus group participant recommended one strategy to help this population: hiring a full-time student veteran representative to help veterans navigate benefits and student resources. Lifting up the challenges and opportunities that student veterans face could become a vehicle to discussing mental health in the general student population.

Additional research specifically focused on these veterans’ experiences should explore these topics:

- Have designated Veteran Friendly Campuses been effective in supporting student veterans, including creating opportunities for social connection?
- What strategies have higher learning institutions used to promote awareness of veteran student resources and services?
- Have all veteran sub-populations been reached through student veteran associations? Which populations have not been reached?
- Do the leave of absence policies support students’ ability to prioritize their health over their return to campus?
- Are physical and mental health services and resources integrated on campus and are they part of orientation?
- How can we define and measure a culture of health on campus and the impact of this culture and climate on student veterans?

I think there should be more peer support after leaving the military. I found it a very lonely transition because I didn’t have any friends in the community I lived in (In response to a question about designing a support program for veterans, from a veteran who identified as a student)

- Respondent, CommonHealth ACTION Veterans’ Health Survey
PROFILE 12: UNEMPLOYED VETERANS

Key Highlights
• Since the economic depression began in 2008, Iraq and Afghanistan veterans experienced greater unemployment compared to civilians, 12.1% to 8.7% in 2011; Younger veterans aged 18-24 experienced the highest rate of unemployment compared to their civilian counterparts, 30.2% to 16.1% in 2011
• 1 in 5 veterans of Iraq and Afghanistan suffer from PTSD or major depression, which can make it more difficult for them to secure a job and make bill payments
• One comprehensive employment database is needed to list opportunities in every state across the nation and abroad, where veterans can also connect and exchange job searching and interviewing tips, list job postings, and share employment resources

Overview and Historical Context
In a May 2014 Gallup poll, 20% of Americans stated that unemployment is the country’s top challenge today (Riffkin, 2014). Currently, one in five veterans in the U.S. are unemployed (Thresholds, n.d.). Over 2.3 million Iraq and Afghanistan veterans that left the military in recent years face the worst job market since the Great Depression (Berlin, 2011). Joblessness has affected all veterans, despite the majority of recent military service members being drawn from the National Guard and reserve units; many of whom had full-time jobs and college degrees (Giegerich, 2011).

Since the recent economic downturn from 2007 to 2011, the unemployment rate of non-White veterans increased from 5.5 to 11.7% while the rate for White veterans increased from 3.5 to 8.1% (U.S. Department of Labor, 2010). Veterans between the ages of 35 and 64 continue to make up nearly two-thirds of all unemployed veterans, who have greater financial obligations and fewer available VA education and training options (VOW to Hire Heroes Act of 2011). From 2008 to 2011, the rate of veterans’ unemployment increased at a rate higher than civilians, particularly for veterans aged 18-24 [Figure 10]. Jobs also remain scarce for female veterans. In 2012, their unemployment rate increased slightly from 12.4 to 12.5%, resulting in an increase of 35,000 to 37,000 out of work (Zoroya, 2013).

The veterans’ population makes up a tremendous talent pool and has an extraordinary set of skills; however they have recently struggled to secure employment due to a number of reasons. A Harvard study on Confidence in Leadership found that our society has above-average confidence

"Understand the Reservist and National Guardsmen have had a major transition. We come back to a totally different environment than active duty personnel and we don’t get the same treatment from the VA or active duty personnel”
– Respondent, CommonHealth ACTION’s Veterans Health Survey
in military leadership (Rosenthal, Moore, Montoya, & Maruskin, 2009), but this does not lead to veterans gaining more employment. Veterans are undervalued in the labor market due to veterans finding it difficult to translate military experience to jobs. A Military Benefit Association study (2013) revealed that more than 70% of hiring managers admit having a difficult time making sense of military experience. Once employed, veterans lack satisfaction after transition to civilian employment. In many cases, veterans are hired below their skill level. Civilian employers do not recognize and understand veterans’ leadership potential and how their skills transfer to civilian jobs. “There is a growing need for programs that help veterans build skills – not through ‘a fake job,’ where veterans, for example, are placed as greeters, but jobs in which veterans can develop and put leadership skills to use,” said Tony Dale, Director of Military Initiatives at Points of Lights. Veterans find that certain jobs are not accessible to them, although they have leadership skills and qualifications (Cole McMahon, Points of Light Veteran Leader Corps, Serve DC Forum on December 18, 2013).

In a 2012 Veterans’ Employment Challenges study, 58% of respondents said they were worried about translating their skills to a business environment; nearly 50% were concerned that civilian supervisors who are not veterans do not understand military culture; and 44% of veterans said they were not ready to make the transition to civilian life (Vogel, 2012). Moreover, one in five veterans of Iraq and Afghanistan suffer from PTSD or major depression, which can impose professional limitations and make it more difficult for them to secure a job and make bill payments (Berlin, 2011). As a worst possible outcome, author and veteran Wes Moore stated that veterans’ suicide has been tied directly to veterans’ unemployment in Coming Back with Wes Moore, a documentary aired on PBS in May 2014.

T.J. Breeden, Founder & Executive Director of eMerging Entrepreneurs, Inc. states that, “It’s true that 20% of veterans who return suffer depression symptoms, but stigma or negative perception of post-traumatic stress inflates that statistic. So essentially because of how society grossly incorrectly categorizes the social
impacts of PTSD, those with hiring authority will assume that (for instance) one in every two veteran applicants is medically suffering from the psychological wounds of war, as opposed to one in five, and as a result the interview becomes more of a discussion about the veteran’s combat record.”

**Key Policies and Trends**

In recent years, large corporations such as Starbucks, Walmart, Goodwill, and Home Depot have made commitments to offer more job opportunities to veterans. The 100,000 Jobs Mission has grown to more than 160 companies and represents almost every industry in the American economy that is committed to hiring of 200,000 veterans by 2020. The federal government has also opened opportunities for veteran hiring through enforcing hiring preferences for disabled veterans, veterans of certain military operations, as well as enacting a federal law barring discrimination against veterans, including the Uniformed Services Employment and Reemployment Rights Act (Loughran, 2014). The 2011 VOW to Hire Heroes Act provides tax credits for employers who hire veterans who have been unemployed for six months or more (VOW to Hire Heroes Act of 2011). In addition, numerous federal agencies, private companies, and public organizations have supported veterans’ job searches through job fairs, online job search services (e.g., DOL’s Career OneStop program), and connected service members to employers prior to exiting the military (e.g., Army Partnership for Youth Success).

Despite major progress in creating more jobs for veterans’, there is an insufficient pool of jobs available in smaller communities. “Large companies have less employment opportunities in smaller, rural communities,” said an anonymous source. Moreover, even though job fairs and career expos for veterans have become more abundant, they are not helping all veterans find jobs. Donald Brooks, a veterans’ Outreach Specialist at Pathways to Housing DC stated, ”Most job fairs are full of crap. They want veterans with technical skills, security clearances, and require criminal background checks and credit checks; meanwhile, many of the jobs are offered to high-ranking officers. If I get locked up, there goes my security clearance” (D. Brooks, personal communication, July 2, 2014).

Non-governmental and private organizations have supported veterans through connecting them to employment opportunities. “If you type in ‘veteran jobs’ into Google, 195,000,000 results show up in 0.36 seconds – this is very overwhelming to returning veterans. At Unite US, we help streamline searches through facilitating organization to organization and peer to peer connections” (Mike Liguori, Unite US, 2014 “Champions Speakers Series and Leadership Conference,” on January 31, 2014). Developed by eMerging Entrepreneurs, Inc., the “Champions” Speakers Series and Leadership Conference aims to bring together leaders from across the country to explore public, private partnerships, and creative alignments that promote social and economic change.

**Opportunities to Achieve Equity**

**POLICIES AND PROGRAMS ADDRESSING INEQUITIES**

According to the Bureau of Labor Statistics, the U.S. economy added 288,000 jobs in June 2014, resulting 1.4 million jobs in the first six months
of the year, the strongest job growth since 2006. President Obama’s administration welcomed the report, but also stated that more work needs to be done to address stagnant wages and long-term unemployment (Kurtz, 2014).

STRATEGIES TO IMPLEMENT POLICIES AND PROGRAMS

Below, we discuss opportunities that could make a significant impact to support and sustain veterans’ employment.

• Help veterans secure and maintain stable employment: Job fairs and career expos have been offered in cities across the nation to provide information to veterans on employment opportunities. Numerous training centers and employment and resource clearinghouses have also become available online. The availability and accessibility of these resources are critical; however, more comprehensive educational training is needed to connect other support services to veterans and their families and help veterans identify and follow through with educational and employment opportunities. Veterans also need support leveraging their leadership skills and experiences gained in military service and accruing new skills and knowledge gained after services to secure and maintain long-term employment. The Institute for Veterans and Military Families at Syracuse University and VetAdvisor launched a Veterans Job Retention Survey in 2014 to collect information about veterans’ first-hire experiences, with the ultimate goal to improve the retention of veterans in the workplace (VetAdvisor, 2013). This survey will produce a number of recommendations for hiring organizations so that they can optimize the structure of veteran hiring programs.

• Support veterans & military spouse

entrepreneurs and businesses. Providing platforms for veteran business owners to share successes and challenges, collaborate, and engage with one another can help veterans establish a support network and promote economic growth through innovation. A number of online networks have been established to help people find over 3 million veteran businesses including:

• Provide veterans greater opportunities to find employment. Each military branch has their own Transitional Assistance Program, which provides information on job searching and other support services, but the information delivered is not consistent and not sufficient as veterans’ may experience unemployment well after their service period ends. One comprehensive employment database should be developed that has jobs listings in every state across the nation and abroad, where veterans’ can also connect and exchange job searching and interviewing tips, list job postings, and share employment resources.

• Provide opportunities where veterans can help veterans. Upon exiting the military, veterans want to continue their mission of service, through supporting other veterans, through their jobs, but also through continuing to engage with fellow veterans in community service. Mission Continues, a national veterans’ service organization, provides opportunities for veterans to serve their country through two action-oriented programs. The Mission Continues’ Fellowship harnesses veterans’ strengths, skills, and compassion, and empowers them to volunteer with non-profit organizations in their community. The Mission Continues’ Service Platoons brings teams of veterans who are working together with partners at the local level to build stronger communities and tackle pressing issues.
INVESTING IN A CULTURE CHANGE TO ACHIEVE EQUITY

Political leaders, businesses, and communities all have an important role in providing employment opportunities to veterans and recognizing the strengths and assets they bring to improving the economy and enhancing communities. The military should train its workforce to meet the demands of their military position while being prepared for their future civilian career path.

Additional research specifically focused on these veterans’ experiences should explore:

• How do veterans’ experiences exiting the military differ based on their branch, rank, position, and demographics (e.g., age, gender, and racial and ethnic background)? How can this information be used to provide tailored job searching support upon transitioning out of the military?
• What steps can the DOD take to restructure military job roles to help service members develop skills that are more compatible to the civilian sector jobs?
• How will younger veterans, female veterans, and other veterans who experience greater stressors’ and poorer mental health outcomes be impacted in the short and long term by experiencing a higher rate of unemployment today?
• What can we learn from the experiences of veterans’ who have been successful in securing employment upon exiting the military?
At CommonHealth ACTION, we believe that health is a production of society. Policies, systems, and institutions—including employment, education, income and wealth, housing, transportation, healthcare, neighborhood infrastructure, democratic participation, and others—create the context in which we live our lives. These social determinants of health have implications for both our physical and mental health outcomes. For example, people living in a neighborhood prone to street violence may at times feel unsafe going outside, deterring physical activity and making it more difficult to maintain a healthy weight; they are also more likely than residents of safe neighborhoods to be affected by mental trauma if they personally experience or witness a violent event. While individual choice and hard work have a role to play, the determinants of health are factors outside of our personal control that powerfully influence our health behaviors and outcomes.
Veterans’ Mental Health as a Production of Military Life

Much in the way that health is a production of society, veterans are a product of the U.S. military. Many aspects of the military experience—including recruitment, training, socialization, and work environment—are designed to shape and mold service members to achieve military goals and missions, with limited consideration for the impact on individual Soldiers, Sailors, Airmen, Marines, and Coast Guardsmen. Their service is often stressful, whether service members are deployed abroad or serving on American soil, and some are exposed to trauma related to combat, loss, moral injury or inner conflict, wear-and-tear, and/or unwanted sexual contact. Military service members also often have little personal control over major decision points, such as redeployment dates or base relocation. Moreover, members of the armed forces who belong to historically oppressed groups—including women, people of color, immigrants, and LGBTIQ—may experience additional stress due to discriminatory actions or beliefs, whether overt or implicit.

The effects of chronic stress on physical and mental wellness are well-documented in the scientific literature. The “fight-or-flight” reaction that is critical to military job performance takes a toll on the body at a cellular level and can impact processes such as metabolism and cognition. High allostatic load—a measure of chronic stress—is associated with increased risk for illness and premature death, as well as depression, anxiety, and mental illness. However, mental illness stigma—both in American culture generally and military culture specifically—is a profound barrier to identifying, treating, and managing the detrimental impact of stress and trauma. Active-duty service members who may be interested in mental health care may be deterred by real and perceived negative impact on their reputations and careers. While the military is changing its policies to encourage service members to seek treatment for symptoms of mental illness and PTS, informal barriers may still persist until this treatment is fully normalized both in the armed forces and society.

The U.S. military is in the business of creating warriors who succeed on the battlefield. Its socialization and acculturation processes emphasize hierarchy, uniformity, and depersonalization, which are necessary for efficient and effective missions. However, the military has limited support for service members’ successful transition and reintegration into civilian institutions, structures, culture, and life. Instead, the preparation for transition and separation is often addressed only during the final months of service. Many veterans leave a highly regimented and controlled environment—where housing, medical care, food, and other basic needs are accessible and available—to civilian life that has far less structure and assistance. As a result, veterans are often in the position where they are in need of support for basic human needs, such as shelter, food, and employment. This issue is compounded when veterans experience a choice, challenge, or circumstance that creates vulnerability in their interactions with systems and institutions; for example, the unemployed veteran who has an encounter with the criminal justice system may then have even greater difficulty finding a high-quality job. In response, some veteran-serving organizations target their assets and resources to meet basic needs and address coping behaviors such as substance abuse or self-harm. While these services are
critical and often life-saving, if we do not address the institutional and structural contexts that perpetuate these needs, programs will never be sufficient.

**An Equity Framework for Veterans’ Mental Health**

While the nation’s resources are often committed to meeting veterans’ basic needs, we are unable to leverage them to create opportunities and conditions that promote mental health as defined by the World Health Organization (2007): *a state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community*. By its nature, this definition requires us to not only meet, but also to transcend basic human needs for every veteran. One promising solution is to address the environment in which veterans are produced: the U.S. military. While it will always be critical for the armed forces to create warriors, it is possible to envision an approach that better manages stressors, imparts education, and supports developing skills that service members will need to thrive when they reenter civilian life.

CommonHealth ACTION proposes a new framework to create a culture of equity for veterans’ mental health. It will require us to understand that veterans from specific subpopulations experience vulnerabilities as

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**VETERANS’ VOICES ON SUPPORTING A HEALTHY TRANSITION TO CIVILIAN LIFE**

“I was able to find a job that allowed me to use my military skills to make a living. Without the interview training that focused on changing military jargon to civilian terminology, I wouldn’t have been able to get jobs so easily.”

~Respondent, CommonHealth ACTION’s Veterans’ Health Survey

“Veterans are walking around looking for a new mission, including myself – everything in the military we did in the military was important – we need to teach veterans to come up with their own mission and goals, which they are used to receiving in the military.”

~Respondent, CommonHealth ACTION’s Veterans’ Health Survey

“A support program for transitioning families should include an individual case worker who will sit down one on one with each member/family and go over everything that they qualify for, help them apply for benefits, and guide them through the whole process ... The case worker would even stay in contact with the member/family periodically after discharge to check in with them for at least the first year.”

~Respondent, CommonHealth ACTION’s Female Veterans Focus Group

“There is no one size fits all solution. Veterans can be male/female, retire[d]/separate[d], single/married, [two] parents/single parent, etc. ... all of these identities affect their lives differently.”

~Respondent, CommonHealth ACTION’s Female Veterans Focus Group

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they interact with systems and institutions that may not be designed or prepared to interact with an increasingly diverse veteran population in meaningful ways. This approach will require a shift from equality (sameness) to equity—providing all people with fair opportunities to achieve their potential, to the extent possible. Opportunities for equity include: 1) designing policy solutions that address needs of specific subpopulations, including people experiencing mental illness or disabilities as well as people from historically oppressed groups, 2) ensuring that those policies are implemented effectively, 3) fostering culture change that supports those policies, and 4) creating accountability, such as metrics, to assess progress. Finally, the civilian population must better understand and support the military’s efforts to produce healthier veterans.

Such a sea change in the ways that we understand veterans’ mental health requires better communication and collaboration between military and civilian populations. As the wars in Iraq and Afghanistan are scaled back, we are in danger of repeating our disservice to Vietnam veterans: portrayed in popular culture as dangerously unstable, this stereotype had a real and lasting impact on their access to employment, housing, healthcare, and other civilian systems and institutions. To acknowledge and support the stress and trauma experienced by this generation of veterans, we will need a common language to discuss issues of equity, privilege, oppression, discrimination, opportunity, stress, health, and mental health. To create a culture of equity and fair opportunity, both the military and civilian populations must support the development of “bicultural” veterans—service members who not only function, but thrive while serving their country and contributing to their communities.

Recommendations

CommonHealth ACTION envisions an America where all people have equitable opportunities to achieve their best possible health. To achieve this goal, we believe that we must bring together public health and other sectors—including the military personnel as well as educators, counselors, planners, elected officials, entrepreneurs, artists, and others—to build their capacity to examine their own policies, programs, and practices that produce opportunities for health in communities. Understanding the historical and cultural contexts for inequities and vulnerability is a necessary step to chart a path to a more inclusive future.

In addition to the opportunities that we have identified to achieve greater equity for subpopulations of veterans, our overarching recommendation is to foster a veteran-centered and veteran-led dialogue to create a language and vision for an equity framework for veterans’ mental health. These are the tools necessary to achieve perspective transformation and foster culture change. A national dialogue provides a platform for different subpopulations to discuss their military and civilian experiences, including how they have coped with trauma, stress, and stigma. It requires engaging veterans and their families as well as policymakers, military leaders, philanthropy, healthcare and public health professionals, community-based organizations, and businesses. And it asks all of us to understand whether our policies, programs, and practices perpetuate vulnerabilities for veterans from different subpopulations or bring us closer to equitable outcomes.
CommonHealth ACTION gathered and qualitative and quantitative information from primary and secondary sources through an environmental scan. Our approach to an environmental scan included the following components: completed a full literature and media scan; interviewed and convened the key informants in an advisory meeting; attended local and national meetings and trainings related to veterans’ mental health (Appendix C); and collected original data through focus groups and a national survey. The scope of the scan was intended to be broad in obtaining information on veterans of recent war eras since World War II.

Literature and Media Scan: Information was retrieved from peer-reviewed journals, reports (e.g., White papers, grey literature, unpublished dissertations), presentations, conference and meeting proceedings, news, blogs, and commentary articles. Articles and sources of information were also retrieved through social media sites, including Facebook and Twitter. We used Google alerts to monitor and receive updates on relevant resources, articles, and current events related to veterans’ mental health issues. A list of veteran and military search terms, key words, and Boolean phrases were created.

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Key Informant Interviews: CommonHealth ACTION identified a list of potential key informants from professional networks at the beginning of the project (Appendix B). Additional key informants were identified through a press release announcement distributed to CommonHealth ACTION’s organizational contacts on October 2, 2013; through stakeholder recommendations; suggestions from the literature and media scan; and identified at local and national events.

From November 2013 through July 2014, we reached out to over 80 individuals representing organizations across various geographic locations and sectors, including academia, government, non-profit, and private sectors. Forty-seven key informants were interviewed in-person or by phone. Prior to the interview, key informants were provided background information on the project scope and a list of research questions. A semi-structured interview guide was constructed around the research questions and tailored to accommodate each expert’s background and experience. Interviews ranged from 30 minutes to one-hour in length. One or more members from the research team attended the interview, and responses were typed or hand-written.

Interim Report: CommonHealth ACTION finalized an interim report of literature review, media scan, and key interview findings. The purpose of the interim report was to summarize a cross-section of findings captured from our national environmental scan from the start of the project. The report identified challenges and opportunities, in addition to lifting up innovative models that had potential or demonstrated success for veterans and their families in accessing mental health care and other support resources. The report also explored efforts to ameliorate veterans’ mental health today and in forthcoming years, along with acknowledging innovative practices to address behavioral health issues. CommonHealth ACTION identified nine themes regarding the challenges and opportunities related to veterans’ mental health. The report was shared among CommonHealth ACTION’s internal research team and select key informants. Key Informant Advisory Meeting: On February 26, 2014, CommonHealth ACTION held a half-day meeting at its national office with nine key informant advisors representing multiple sectors within the field of veterans’ mental health. The purpose of this meeting was to review preliminary findings to help set the direction for the focus groups, the
national survey, and prioritize additional research areas to investigate. Participants provided input on the challenges and opportunities for vulnerable veteran groups through a small group activity. Participants had an opportunity to network with professionals in the field and share information about their work.

Female Veterans’ Focus Groups: Based on findings obtained from the literature and media scan and recommendations, from the key informant advisory meeting, and the CommonHealth ACTION research team, the scope for the focus groups was narrowed to focus exclusively on female veterans. To learn more about the barriers faced by female veterans, CommonHealth ACTION conducted focus groups consisting of female veterans in partnership with the Chicago School of Professional Psychology. The objectives of the focus groups were to learn and understand:

- types of support they have received;
- any challenges they have encountered;
- any unmet needs or service gaps that you have experienced;
- their ideas about potential solutions to ensure all veterans are supported in their transition.

Preparation: On March 17, 2014, CommonHealth ACTION received notification of IRB approval from TCSPP’s IRB committee for a proposed study of female veterans through focus groups. In March 2014, the CommonHealth ACTION research team completed focus group moderation trainings to develop knowledge, skills, and obtain information on best practices for focus group moderation specifically for veteran populations. Recruitment: Recruitment of focus group participants began in March 2014 upon receiving IRB approval using a snowball-like method for promotion. CommonHealth ACTION’s networks and contacts received an email with messaging that included information about sharing focus group information, a basic overview of the project, the focus group purpose, and a link to an online eligibility survey. Focus groups were also promoted on social networking sites including Facebook and Twitter, and CommonHealth ACTION’s website. Eligibility: Potential participants were required to complete a brief online eligibility survey, including questions regarding demographics and focus group location preference. Participants had to be: adults (18+); female; have an ability to speak and understand English fluently; a U.S. veteran who has served on active duty, in any job capacity, while a member of the Army, Navy, Air Force, Marines or Coast Guard active components, or of the National Guard or Reserves, regardless of discharge status. Participants were notified regarding eligibility via email or by phone. Implementation: In April 2014, focus groups were conducted in Jackson (MS), Chicago (IL), Los Angeles (CA), and Washington (DC). Locations were selected based the location of CommonHealth ACTION and TCSPP office locations while considering geographic regions where veterans live. A trained moderator presented structured questions for discussion and provided instructions for informed consent. Two notetakers were present to capture key themes, quotes, and record discussion. Each focus group was structured to be 90 minutes in length. Parking reimbursement, a $20 gift card incentive, and a list of local and national veterans’ mental health and other support programs, resources, and services were provided to participants. Participants were given the opportunity to complete a follow-up note card indicating interest to obtain additional support resources and services and the full transcript for their focus group session. In the event of an
inadvertent psychological trigger from focus group discussion, trained mental support professionals were onsite at the focus groups with connections to mental health, medical, housing, employment, legal services, and other social support resources and services available. Mental health professionals were obtained through the Give an Hour network, TCSPP, and other local behavioral support organizations.

**National Survey:** A national survey of 29 questions targeting all 50 U.S. states and territories was launched via Survey Monkey in July 2014. The objective of the survey was to gather additional input from U.S. military veterans to learn and understand: types of support they have received, any challenges they have encountered, any unmet needs or service gaps that you have experienced, and their ideas about potential solutions to ensure all veterans are supported in their transition. CommonHealth ACTION submitted an addendum with the national survey and received approval from TCSPP’s IRB committee on May 27, 2014.

**Recruitment:** A snowball-like method was used to promote the online survey. Similar to the focus groups, CommonHealth ACTION’s networks and contacts received an email with messaging that included instruction on sharing focus group information, a basic overview of the project, the purpose of the survey, and an online survey link. Survey was also promoted on social networking sites including Facebook and Twitter; CommonHealth ACTION’s website, and websites and social networks of project contacts. **Eligibility:** The same criteria as the focus groups were used except for allowing all veterans to complete the survey. Survey directions and an Informed Consent were provided on the survey home page prior to the start of the survey. **Implementation:** The survey was opened on June 10, 2014 and closed on August 4, 2014. Three-hundred and fifty-four participants completed the survey. As an incentive for participation, $50 gift cards to Amazon.com were raffled to two participants and provided a list of national resources related to mental health support, housing, education, employment and other supports were shared for those who request to receive them.

**Focus Groups & Survey Data Analysis:** Focus group recordings were compiled and transcribed by Exceptional Transcription & Business Solutions. Key themes from each focus group were identified. Transcriptions were shared with focus group participants upon request. Melody Johnson Morales, PhD, Senior Evaluator, Nexus Research Group, completed survey data cleaning and analysis. Data from Survey Monkey were up uploaded into a Microsoft Excel spreadsheet and then cleaned to ensure consistency and recoded for statistical analysis. The cleaned/recoded data were uploaded into SPSS, a program used for conducting statistical analyses on social science data, and descriptive analyses were run to describe specific characteristics of the sample (e.g., race/ethnicity, etc.). A total of 362 participants responded to the survey questions. Eight participants were eliminated from the analysis due to incomplete responses and/or non-veteran status. To determine relationships among different variables (e.g., race/ethnicity and identification with a vulnerable group), Pearson Chi-square tests of independence were run. Significant findings were reported at the p < .01 and p < .05 levels. In addition, responses to qualitative questions were reviewed and analyzed for common patterns and themes.
• SARA ABELOSON, MPH is the Senior Director of Programs for Active Minds.

• Glenn Albright, Ph.D. is the Co-Founder and Director of Applied Research at Kognito.

• Akua Asare, M.D. is a Specialist in Best Practices Quality Improvement Solutions at the American College of Cardiology, formerly a Resident at the Miami VA Healthcare System.

• Howard Bakalar is the Senior Vice President and Chief Program Officer for United Way and oversees Mission United of Broward County, FL.

• Joyce Barrow is a Project Director at Justice For Vets.

• Eddie Bocanegra is the Co-Executive Director for the Youth Safety and Violence Prevention and oversees Urban Warriors of the YMCA Metro Chicago, IL.

• Donald Brooks is a U.S. veteran and Veterans Outreach Specialist at Pathways to Housing DC (Washington, DC)

• T.J. Breeden is the Founder and Executive Director of eMerging Entrepreneurs.

• Michael Byer is the President and Co-Founder of M3 Information, LLC.

• Kevin Casey is a Network Homeless Coordinator (VISN 1) at VA New England Healthcare, Boston, MA

• Katie Civiletto is a recent MHA graduate student of the Sloan Program of Health Administration at Cornell University; formerly an Administrative Intern at Veterans One-stop Center of WNY, Inc. in Buffalo, NY.

• Mary Considine is the Chief of Staff at the Fisher House Foundation.

• Jessica Davis is a Senior Associate at Mission:Readiness.

• King Davis, Ph.D. is formerly the Inaugural Director of The Institute for Urban Policy Research & Analysis at the University of Texas at Austin.

• Christopher Deutsch is the Director of Communication at Justice For Vets, a division of the National Association of Drug Court Professionals.

• Jane Eckstein, MA is the Director of Planning and Awareness at Physicians Postgraduate Press, Inc. and a Publisher of The Journal of Clinical Psychiatry and the Primary Care Companion for CNS Disorders.

• Hannah Fairman, MA is a Health Policy Analyst with Wounded Warrior Project in Washington, DC.
• **Pamela Stokes Eggleston, MBA, RYT** is Director of External Affairs at Blue Star Families and the Founder of Yoga2Sleep.

• **Wayne Farmer** is formerly a Vice President for Strategic Development at Give an Hour.

• **Ann Feder, LCSW** is a Mental Health Line Programs Manager at VA Medical Center (VISN 3): VA NY/NJ Veterans Healthcare Network (Bronx, NY).

• **Marcus Finley** is a Senior Mobile Solution Provider with Clearly Innovative.

• **Melissa Fitzgerald** is a Senior Director for Justice For Vets.

• **Jessica Fuchs, MA** is a Program Director at Serving Together, a project of Mental Health Association of Montgomery County, Maryland.

• **Denyse Gordon, MHR** is the Senior Manager of Veteran Support & Development & Diversity and Inclusion at CACI International, Inc.

• **Jason Hansman, JD** is a Senior Program Manager of Health at Iraq and Afghanistan Veterans of America.

• **Meg Helder** is the Director of Program Operations at the YMCA of Chicago, IL.

• **Ralph Ibson** is the National Policy Director of the Wounded Warrior Project in Washington, DC.

• **Kristina Kaufmann** is the Executive Director of Code of Support Foundation.

• **Andrea LaFazia-Geraghty, MSW, MPH** is a Project Manager at the King County Mental Health, Chemical Abuse and Dependency Services Division in Seattle, WA.

• **Pat Lemus** is an Assistant Division Director at the King County Services Division in Seattle, WA.

• **Brittany Marshall, MS** is formerly a Senior Program Officer at The Community Partnership for the Prevention of Homelessness.

• **Michael Meit, MA, MPH** is the Program Area Director of Public Health Research at the National Opinion Research Center (NORC).

• **Kathleen Moakler** is the Director of Government Relations at National Military Family Association.

• **Angie Morgan** is an Owner of LeadStar, LLC, Founder of Homefront Leaders, and a Director of Marine Corps Heritage Foundation.
• **Jamie Stacy** is the Warrior Veteran and Family Support (WVFSN) Program Manager at Code of Support Foundation.

• **Eric Morrison, Ph.D.** is the Director of the National Center for Research and Practice of Military and Veteran Psychology and Dissertation Affiliate for International Psychology with The Chicago School of Professional Psychology

• **John Mundt, Ph.D.** is a Staff Psychologist at the Jesse Brown VA Medical Center in Chicago, IL.

• **Deborah Norman** is an Outreach Coordinator of the Homeownership Preservation Program at United South Broadway Corporation.

• **Jill Roberts** is a Business Development Manager at Clearly Innovative.

• **Karen Ruedisueli** is the Government Relations Deputy Director at the National Military Family Association.

• **John Shelton, Ph.D.** is the CEO of Physicians Postgraduate Press, Inc.

• **Terri Tanielian, MA** is a Senior Social Research Analyst at the RAND Corporation.

• **Patricia Toles-Lucas DHA, MS, BSN, RN** is a Suicide Prevention Coordinator at the DC Veterans Affairs Medical Center.

• **Barbara Van Dahlen, Ph.D.** is the Founder and President of Give an Hour.

• **Laura Vazquez, MA** is a Legislative Analyst for the Immigration Policy Project at the National Council of La Raza

• **Marete Wester** is the Senior Director of Arts Policy at Americans for the Arts.

• **Ludmilla Wikkeling-Scott, DrPH** is the Director of Operations of The Bryant Group LLC.

• **Sarah Krill Williston, M.Ed.** is a Mental Health Counselor and Doctoral candidate of Clinical Psychology at the University of Massachusetts in Boston.

• **Roger Woodworth** is a U.S. Army Veteran and President & CEO of Veterans One-stop Center of WNY, Inc. in Buffalo, NY.

• **Trina Zahller, MSW** is a Program Coordinator for the Veterans Resource Center at the University of New Mexico and volunteers with Regaining Balance.
**APPENDIX C**

**VETERANS EVENTS ATTENDED**

- **June 18, 2013:** Facing the Invisible Wounds of War | Volunteers of America, National Press Club, Washington, DC
- **October 1, 2013:** Keeping the Promise: Maintaining the Health of Military and Veteran Families and Children | Brookings Institution, Washington, DC
- **October 29, 2013:** A Community Conversation: Supporting Our Veterans, Service Members & Their Families | Hampton Roads Town Hall Meeting, Webinar
- **November 2 – 6, 2013:** American Public Health Association Annual Meeting and Exposition | Boston, MA
- **November 10, 2013:** Veterans Day 10K and Tidal Basin Walk | Washington, DC
- **November 11, 2013:** Maryland Vietnam Memorial Service | Baltimore, MD
- **December 6, 2013:** “Warrior Family Symposium Recap - Takeaways and Future Applications” - Warrior Family Roundtable | co-sponsored by the Military Officers Association of America and Zeiders Enterprises, Inc., Washington, DC
- **December 12, 2013:** U.S. Vets Open House Reception | Washington, DC
- **December 17, 2013:** Interagency Council on Homelessness Meeting | Washington, DC
- **December 18, 2013:** Serve DC Engaging Veterans and Military Families in National and Community Service Forum | Washington, DC
- **January 31, 2014:** Champion Speakers Series and Leadership Conference | eMerging Entrepreneurs, Inc., Washington, DC
- **March 27, 2014:** Shining the Light: Female Veterans Making a Difference Event | Women in Military Service for America Memorial, Arlington, VA
- **April 6, 2014:** Give an Hour Celebration of Service: Community Service Project | Veterans On the Rise, Washington, DC
- **April 7, 2014:** Give an Hour Celebration of Service: National Day of Training on Educating the Next Generation of Mental Health Professionals about Military Mental Health | Washington, DC
- **May 7, 2014:** Coming Back with Wes Moore Screening | Walters Art Museum, Baltimore, MD
- **May 8, 2014:** Still Serving America Women Veteran Conference | Hampton, VA
- **May 13, 2014:** After the Uniform 2014: Responding to America’s Women Warriors Panel | National Press Club, Washington, DC
- **June 16-17, 2014:** Health on the Homefront Conference: Addressing the Health Needs of Members of the U.S. Armed Forces, Veterans and Their Families | Virginia Public Health Association, Hampton, VA
- **June, 21, 2014:** “Tuesday Tucks Me In” author reading by Luis Carlos Montalván | Washington, DC
- **June 24, 2014:** Engaging Veterans, Military Service Members and their Families in Community Service Working Group | Washington, DC
- **August 7-9, 2014:** American Psychological Association Annual Convention: Society for Military Psychology (Division 19) | Washington, DC. *CommonHealth ACTION presented at the event.*
- **August 10, 2014:** Code of Support’s Spirit of 45 Event at the World War II Memorial | Washington, DC
- **September 11, 2014:** Foundation Center: Keeping our Veterans Strong: Exploring Opportunities for Veterans Services Organizations | Washington, DC
• November 15-19, 2014: American Public Health Association Annual Meeting and Exposition in New Orleans, LA. Selected for poster presentation titled “Challenges and Innovations in Veterans’ Mental Health: An Environmental Scan”

• U.S. Department of Veterans Affairs Events:
  • September 11, 2013: Serving Those Who Served Us | Washington, DC
  • November 20, 2013: Veterans Outreach Events & Veteran Military Families Breakout Session | Washington, DC
  • November 21, 2013: Veterans Community (Clergy) Outreach Initiative Training (VA Clergy Training) | Woodbridge, VA
  • December 3, 2013: Suicide Among Veterans: Fact, Prevention, and How You Can Help | Quarterly Conference Call
  • April 23, 2014: Caring for Our Veterans: Training for Clergy, Laypersons, Faith-based and Community Partners | Washington, DC
CommonHealth ACTION’s Veterans’ Health Survey was completed by 354 participants: 352 (veterans) and 2 (non-veterans completed on behalf of the veteran’s spouse).

Survey participants’ average age was 52.9 years and the age range was 25 to 91 years. The majority of survey participants were male (66%), White (64%), and had served in the Army (40%). Women, veterans of color, and Army veterans were overrepresented in the survey; the current veteran population is 95% male, 80.3% White, and 19.2% veterans of the Army.
The average number of years that survey participants served in the military was 11.6 with a range of 1 – 38 years. The year of entry range was 1943 – 2010 and year of exit range was 1945 – 2014. Sixteen survey respondents are currently serving in the National Guard or Reserve.
The five U.S. states where the most survey respondents are currently living are Virginia, Texas, Maryland, Michigan, and North Carolina. States with more than 1 million veterans include California (2 million), Texas (1.6 million), and Florida (1.6 million).

SURVEY PARTICIPANTS FROM VETERAN SUBPOPULATIONS
The three categories participants most identified with were disabled (38%), unemployed (26%) and student (25%); while 21% of survey participants did not identify with any of CommonHealth ACTION’s vulnerability characteristics of those that responded to this question.

Of survey participants that identified with at least one characteristic, 34% identified with only one and 42% identified with one or more categories.
SUMMARY STATISTICS EXPERIENCED OR ARE EXPERIENCING ONE OR MORE OF THE FOLLOWING

Nearly half of the survey participants who responded to the question had experienced or are experiencing depression (47%) and PTS or PTSD (45%); 31% experienced none of the selected choices.

**EXPERIENCED OR ARE EXPERIENCING ONE OR MORE OF THE FOLLOWING (MORE THAN ONE CATEGORY)**

Of those who responded to the question, 25% experienced one and 44% experienced more than one of the response choices.

Respondents who identified with at least one subpopulation* that is susceptible to vulnerability experienced depression, PTS or PTSD, and suicide ideation at a greater proportion than those who did not identify with one of the subpopulations. In the summary below, (a) represents survey respondents who identified with at least one subpopulation experiencing vulnerability and (b) represents survey respondents who did not identify with a subpopulation experiencing vulnerability.

**Question:** Have you experienced or are you experiencing one or more of the following?

- Experienced Depression (total n=353)
  - a) 157 (47.4%) – of veterans who identified with at least one vulnerability
  - b) 8 (36.3%) – of those who did not experience any vulnerabilities

- Experienced PTS or PTSD (total n=353)
  - a) 128 (38.6%) – of those who identified with at least one vulnerability
  - b) 5 (22.7%) – of those who did not experience any vulnerabilities
• Experienced substance use disorder (total n=353)  
a) 31 (9.4%) – of those who identified with at least one vulnerability  
b) 4 (18%) – of those who did not experience any vulnerabilities  
• Experienced suicide ideation (total n=353)  
a) 51 (15.4%) – of those who experienced at least one vulnerability  
b) 1 (4.5%) – of those who did not experience any vulnerabilities  
• Experienced traumatic brain injury (TBI) (total n=353)  
a) 33 (10%) – of those who experienced at least one vulnerability  
b) 1 (4.5%) – of those who did not experience any vulnerabilities  

*NOTE: 22 survey respondents did not identify with any subpopulations.

While veterans who identified with at least one subpopulation experiencing vulnerability were more likely than their peers to report depression, PTS/PTSD, and suicidal ideation, they were also more likely to report experiencing TBI, which could be a contributing factor to these conditions. Also, a greater proportion of respondents who did not identify with a subpopulation experiencing vulnerability reported more substance use disorder. Both of these findings indicate the need for further research.

The majority of survey participants did not receive support during military service (76%) while about half (49%) received support during transition.
Out of transition supports used, almost a third of survey participants used health services either physical or mental health (31%). Only 3% reported using housing and legal services.

### TYPES OF TRANSITION SUPPORT USED

<table>
<thead>
<tr>
<th>Support Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Support</td>
<td>11</td>
</tr>
<tr>
<td>Housing Support</td>
<td>11</td>
</tr>
<tr>
<td>Other (Open-Ended)</td>
<td>14</td>
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<tr>
<td>Financial Support</td>
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<tr>
<td>Employment Support</td>
<td>37</td>
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<tr>
<td>Veteran Peer Support</td>
<td>61</td>
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<tr>
<td>Family and/or Friend Support</td>
<td>64</td>
</tr>
<tr>
<td>Educational Support</td>
<td>83</td>
</tr>
<tr>
<td>Health Services</td>
<td>108</td>
</tr>
</tbody>
</table>

### QUALITATIVE RESPONSES

- What type(s) of mental health or related support did you receive while serving in the military? These could be programs, services, or other support (open-ended response).
  - Majority of respondents report receiving general counseling. Others reported receiving counseling for PTSD, alcohol and substance abuse, mild depression, psychological and psychiatric care, suicide prevention, exposure therapy, TBI screening/MRI, anxiety support after surgery, stress, and post deployment.
  - Closed ward and mild medication after losing wife on wedding night.

- Which of these supports were helpful and why?
  - The counseling helped respondents get through a rough period of intense training, address panic attacks, cope with hard times/depression, deal with the possibility of deployment, transition to civilian life, relax/relieve stress.

- Which of these supports were not helpful and why?
  - Counseling was not helpful in general (made matters worse, counselor was intrusive, wanted to prescribe drugs).
  - NOTE: although there is a Transition Assistance Program available to those separating from military service, a number of respondents reported not knowing what services were available.

- How did the support you received meet your personal and family needs?
  - Family and friends offered emotional support.
  - Allowed veterans to advance education/get college degree.
  - Provided job skills assistance.
• How did the support you received not meet your personal and family needs?
  • Ban on same-sex benefits
  • Length of time to provide support is too long
  • More counselors needed, particularly those who are “helpful and compassionate” rather than “rude and very unhelpful”
  • Length of time allowed to receive benefits is too short, benefits ran out
  • Lack of (consolidated) information
  • Mental health therapy not readily available

• If you did not find any types of mental health or related supports helpful, what could be changed about that support experience to make it helpful?
  • Military should be prepared to care for mental health needs
  • Ensure privacy and safeguarding of files/keep better records
  • Open service by transgender individuals
  • Tailor services for women
  • Trained counselors, resources on and off base, make services available 24 hours, don’t punish people by taking away security clearance and ending career for seeking help
  • Provide counseling right away, not years later
  • Having someone to advocate on behalf of veterans
  • Remove the stigma

HAVE EXPERIENCED STIGMA RELATED TO MENTAL HEALTH CARE

- Yes 68%
- No 32%
• How has stigma affected the ability to access veterans’ mental health services or support?
  • “Stigma reduces willingness to reach out and trust the system. Reputation reduces willingness to trust effective treatment.”
  • Deters veterans from seeking help for fear that they will lose their jobs, families, respect, status, etc, or that they will be considered “unstable, unfit, unable, or unqualified”
  • Humiliating to ask for help, especially when there’s lack of confidentiality, regulation, and guidance
  • “Stigma isn’t the issue, ACCESS is the issue”

• What do you think can be done to reduce or eliminate stigma?
  • Make it okay/more acceptable to seek help
  • Education and awareness of health care provides, staff, civilians, and veterans that some mental health challenges (e.g., PTSD) are treatable and manageable, especially if diagnosed early
  • More thorough screening and training about mental health/PTSD – “this is indeed an illness, not a disability”
  • “It has to start with the military and then work its way to traditional services.”
  • Evaluate all veterans prior to separation
  • Ensure confidentiality/allow access to anonymous/private services
  • Validate experiences

• If you were designing a support program for veterans and their families to ensure they are healthy and happy in the transition, what would it look like?
  • Continuum of care/support for families, not just the veteran (family support groups)
  • Comprehensive care/case management with thorough evaluation that includes 90, 180, and 365 day follow ups
  • A separate program/support system for females (that include female case workers/mentors “where they can openly discuss sexual harassment and rape that occurred while on AD [active duty]...without fear of reprisal”
  • Offer an orientation (to the VA and services,
  • Ensure mental, physical, and financial stability BEFORE they separate from service
  • Better training for staff so they are compassionate and non-judgmental rather than rude and disrespectful
  • Easier access to services and support for families
  • Treat veterans with respect, dignity, and appreciation
  • Peer-to-peer support for veterans and their families/mentor or sponsor for every veteran
  • Provide “life skills” and job training
  • More rapid response and availability of appointments/reduce wait time for veterans to see physician
  • Offer a period of transition, with pay, to help veterans adjust to civilian life (could receive counseling and training during the transition)
  • Would use technology (Skype, face time)/telemedicine/mobile services so veterans wouldn’t have to travel to appointments
• “A formal program needs to be instituted, staffed, and maintained. Right now, there’s nothing… soldiers, especially reserves go basically from the battlefield to the boulevard”

• Is there anything else you would like to share about what is needed to support veterans?
  • Although there is a lot more available (i.e., services, resources) than there were years ago, many don’t know it’s available
  • There should be jobs held specifically for veterans, especially for those with specialized skills – “the military trains us to do these jobs and we get out and have to start school all over again…it doesn’t make sense.”
  • “Think tanks should include veterans. Too many decisions are being made for veterans without veteran input.”
  • I would not treat veterans from different eras in different ways. All should have the same benefits
ORGANIZATION NAME: ACTIVE MINDS

Program Description: Active Minds is the leading national organization empowering students to speak openly about mental health in order to educate others and encourage help-seeking. We are changing the culture on campuses and in the community by providing information, leadership opportunities and advocacy training to the next generation.

By developing and supporting student-run chapters and peer-to-peer education and outreach on more than 400 campuses nationwide, Active Minds increases awareness of mental health, provides resources regarding mental illness, encourages students to seek help as soon as it is needed, and serves as liaison between students and the mental health community. We work with our students to best serve the unique needs of their diverse student peers including student veterans, LGBTQ individuals, first-generation college students, and more.

Through campus-wide events and national programs, Active Minds aims to remove the stigma that surrounds mental health issues and transform campuses to better support student mental health.

- Contact Information: Alison Malmon, Executive Director, 202-332-9595, info@activeminds.org
- URL: www.activeminds.org

ORGANIZATION NAME: CACI’S VETERAN SUPPORT & INCLUSION

Program Description: CACI’s Veteran Support & Inclusion office collaborates with various organizations, transition assistance programs, and military rehabilitation centers to provide veterans with training and resources to successfully transition into the civilian workforce. The team specifically champions disabled veterans, and created a Veteran Mentoring program initially designed to pair disabled veterans with veteran employees within CACI.

- Contact Information: Denyse Gordon, dgordon@caci.com
- URL: www.caci.com

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10. Please note that the resources and programs listed here were identified in the environmental scan. We encourage individuals to reach out to the organizations directly to learn more about their work.
ORGANIZATION NAME: GIVE AN HOUR

**Program Description:** Give an Hour is a nonprofit 501(c)(3), founded in September 2005 by Dr. Barbara Van Dahlen, a psychologist in the Washington, D.C., area. The organization is dedicated to meeting the mental health needs of military personnel, their families, and the communities affected by the ongoing conflicts in Iraq and Afghanistan. Give an Hour has nearly 7,000 providers across the nation—in all 50 states, D.C., Puerto Rico, and Guam—with more volunteer mental health professionals joining its network every day. In addition to counseling, providers also consult to schools, first responders, employers, and community organizations. Give an Hour has already provided approximately 140,000 hours of free service, valued at more than $14 million. To learn more, visit www.giveanhour.org or connected.giveanhour.org.

**Contact Information**
- **URL:** info@giveanhour.org, 240-668-4365

Additional Resources Provided by Interviewed Key Informants

ORGANIZATION NAME: CODE OF SUPPORT FOUNDATION (COSF)

**Program description:** Code of Support Foundation (COSF) a national non-profit organization dedicated to bridging the civilian-military divide. COSF works to engage and leverage the full spectrum of this nation’s resources to ensure that our service members, veterans and their families receive the support they need and have earned through their service and sacrifice.

- COSF was established in 2010 by MG (Ret) Alan B. Salisbury with the goal of bridging the growing divide between our civilian and military communities. Through its efforts, COSF works to catalyze and facilitate collaboration between support organizations, to ensure service members, veterans and their families receive the support and opportunities they need to successfully transition back into civilian life.

- Programs include the Warrior Veteran Family Support Network, Case Coordination for Service Members, Veterans and Families, an Awareness and Engagement program designed to empower all Americans to become committed and involved in supporting our veteran community. COSF serves all generations of service members, veterans and families, regardless of discharge status, or geographic location.

**Contact Information:** Kristina Kaufmann, Executive Director; Kristina.Kaufmann@codeofsupport.org; 571-527-3232

**URL:** www.codeofsupport.org
ORGANIZATION NAME: EMERGING ENTREPRENEURS, INC.

- **Program description:** eMerging Entrepreneurs, Inc. is a 501(c)(3) non-profit organization, that provides Small Business Training, and Entrepreneurial Developmental services to veterans, military spouses, urban youth, and other under-served communities. Our organization employs a grassroots approach to assisting those who seek to advance their small business interests; partnering with state & federal agencies, universities, local chambers of commerce, and military installations in an effort to extend high-tech training & resource solutions to under-served communities. As a result of our efforts, eMerging Entrepreneurs’ Executive Director, T.J. Breeden received the White House’s “Champions of Change” award (in conjunction with President Obama’s “Winning the Future” initiative), and was selected as the US Small Business Administration’s “Veteran Entrepreneurship Advocate of the Year.”

- **Contact Information:** T.J. Breeden, Founder & Executive Director - PO Box 13022 Durham, NC 27709 (919) 886-4711, Tj.breeden@emerginginc.org

- **URL:** www.emerginginc.org

ORGANIZATION NAME: FISHER HOUSE FOUNDATION, INC.

- **Program Description:** Fisher House Foundation, Inc. is an international not-for-profit organization established to improve quality of life for members of the military, retirees, veterans, and their families. The Foundation builds comfort homes at military and VA medical centers and gifts them to the government. It works to educate and inform the military and veterans communities and their families, and the general public about Fisher Houses and provides necessary support to individual Fisher Houses. Other Quality of Life programs include a scholarship program for military children, a grants program for volunteer organizations with innovative plans for quality of life projects, the “Hero Miles” and “Hotels for Heroes” programs, and individual assistance to members of the military and their families during a crisis.

- **Contact Information:** info@fisherhouse.org | (888) 294-8560

- **URL:** www.fisherhouse.org

ORGANIZATION AND/OR PROGRAM NAME: DR. JOHN MUNDT, LICENSED CLINICAL PSYCHOLOGIST, PROFESSIONAL SPEAKER/TRAINER

- **Program description:** I am a psychologist and trainer with more than twenty years’ experience providing mental health care to veterans. In the context of my work as a professional speaker, I provide seminars, lectures and in services to groups, organizations or agencies regarding veterans' mental health problems (PTSD and trauma in particular). Typical audiences include mental health providers, attorneys & judiciary, law enforcement officials, college staff/faculty, and any other groups with an interest in increased understanding regarding the challenges of deployment, homecoming and readjustment.

- **Contact Information:** Dr. John Mundt, 312-608-0668, drjohnmundt@hotmail.com

- **URL:** www.drjohnmundt.com
PROGRAM NAME: THE JOURNAL OF CLINICAL PSYCHIATRY VETERANS MENTAL HEALTH INITIATIVE

• **Program description:** Strong Veterans is an ongoing multimedia program designed to equip mental health care professionals and primary care providers with essential information to assist in diagnosing and treating US military veterans who suffer from mental health issues. Resources are equally devoted to identifying and meeting the mental health service needs of their families. Posttraumatic stress, depression, anxiety, and addiction disorders figure prominently alongside the mental health challenges of homelessness, disability, unemployment, and sexual abuse. At StrongVeterans.com, offerings in both print and electronic formats include formal articles, commentaries, educational activities, meeting proceedings, and information exchange forums for professionals. This ever-expanding compendium provides professional members of the health care community with evidence-based, peer-reviewed scientific data along with thoughtful reflections. Our overall mission is to help restore personal well-being to our veterans and families and smooth their transition from the battlefield to civilian life.

• **Contact Information:** Dr. John Shelton, jshelton@psychiatrist.com, (901) 273-2701

• **URL:** www.strongveterans.com

PROGRAM NAME: KING COUNTY REGIONAL VETERANS INITIATIVE

• **Program description:** In February 2013 King County Executive Dow Constantine launched the Regional Veterans Initiative (RVI) – The vision of the RVI is to ensure King County Veterans and their families are aware of the full range of available services and supports, and can access them easily. The RVI goals are:
  • Establish a coordinated Regional Veteran Services Network inclusive of local, state and federal partners to maximize the use of regional resources
  • Educate the community and providers about the Veteran services system
  • Improve customer service and access to care for Veterans and their families
  • Create a regional Veterans information, public awareness and communication strategy
  • Establish and conduct continuous improvement evaluation to measure performance, promote service improvements and support long term sustainability.

The RVI is nearing the end of one year and has accomplishments and progress on many of the deliverables in the 2013-2015 RVI Action

• **Contact Information:** Dana Sawyers - Regional Veterans Initiative Coordinator, King County, dana.sawyers@kingcounty.gov
  401 5th Ave, Suite 500
  Seattle, WA 98104
  Office: 206-263-1327
  Cell: 206-434-0587

• **URL:** http://www.kingcounty.gov/socialservices/veterans/RegionalVeteransInitiative.aspx
ORGANIZATION NAME: RAND CORPORATION

- **Program description:** RAND’s mission is to help policymakers make decisions that are based on the best available information. RAND has a tradition of high-quality research and analysis that is rigorous, objective, multidisciplinary and broad in scope. Regardless of the research sponsor, RAND’s work is free of commercial, partisan, and ideological bias. RAND’s research is peer-reviewed by experts inside and outside of RAND. This scrutiny is part of what makes RAND a trusted source of expertise and analysis. Finally, the work is as transparent and open as possible. RAND’s commitment to the public good means that they want our work to reach and be understood by as many people as possible, not just other experts and academics. All of RAND’s unrestricted reports are available for download from their website for free and from anywhere in the world. RAND has an extensive portfolio of work related to improving veterans mental health.

- **Contact Information:** For information about research related to veterans mental health, contact Terri Tanielian by phone at 703 413 1100 X5404 or by email at Terri_Tanielian@rand.org

- **URL:** www.rand.org

ORGANIZATION NAME: SERVING TOGETHER

- **Program description:** Serving Together provides easier access to local information and resources to military, veterans, and their families through outreach and education, an online searchable database (www.ServingTogetherProject.org), and direct one-on-one support through our Veteran and Family Peer Navigator. The Peer Navigator connects military, veterans, and their families with the resources they need—employment, benefits, healthcare, housing, and education. Serving Together also provides continuing education seminars for mental health professionals around issues effecting military and veterans, and offers Mental Health First Aid trainings to prepare community members to better understand mental illness and crisis.

- **Contact Information:** Jessica Fuchs, 301-424-0656, ext., 556, jfuchs@mhamc.org

- **URL:** www.ServingTogetherProject.org

ORGANIZATION NAME: UNITED SOUTH BROADWAY CORPORATION (USBC)

- **Program Description:** We are an Albuquerque-based community development agency focusing on neighborhood revitalization and affordable housing in New Mexico. Our HUD-certified housing counselors help any New Mexico homeowners, regardless of income, who are struggling to make their mortgage payments or are currently facing foreclosure due to financial hardships brought about by job loss, divorce, death of a spouse, high medical expenses, and similar emergencies. We help homeowners map out a budget for their current income and evaluate their options, including applying for affordable loan modifications. Our Fair Lending Center also provides legal services to low-income homeowners facing foreclosure proceedings in the New Mexico courts. Our goal is to help homeowners keep their homes, prevent homelessness, and avoid or limit damage to their credit.

- **Contact Information:** Deborah M. Norman, 505-349-3758, outreach@unitedsouthbroadway.org

- **URL:** www.unitedsouthbroadway.org
ORGANIZATION NAME: UNITE US

• **Program description:** Unite US is the digital backbone of the Veteran and Military resource community. We are transforming the way Veterans and military families connect to each other and resources in their local community. Our holistic technology platform addresses social connectivity, operational software, and collaborative case coordination. Since our launch in late 2013, we have secured a public/private partnership with the VA, implemented “Coordinated Networks of Service Providers” across the country at the state and city level, and have over 300 software clients.

• **Contact Information:** Taylor Justice, 239-823-5895, taylor@uniteus.com

• **URL:** www.UniteUS.com

ORGANIZATION AND/OR PROGRAM NAME: URBAN WARRIORS, YOUTH SAFETY AND VIOLENCE PREVENTION, YMCA OF METROPOLITAN CHICAGO

• **Program description:** Urban Warriors is an innovative program built on a peer mentoring concept, bringing American military veterans and youth together to share common life experiences, primarily surviving in hostile environments and striving to cope. The goal of the program is to foster youth resiliency, which in turn will reduce incidences of violence for high risk youth. Through the interaction of storytelling and modeling, youth are able to learn coping skills and methods to overcoming adversity from their veteran mentors. Moreover, the program enables symbiotic connections between youth and veterans, providing both groups an opportunity to share their encounters with violence and trauma (during combat or in their neighborhoods). For participating veterans, sharing stories about trauma can help to unpack their combat experiences, reduce stigma about mental health challenges that have emerged from those experiences, and reduce feelings of isolation amidst those challenges.

• **Contact Information:** Eddie Bocanegra, ebocanegra@ymcachicago.org

• **URL:** www.ymcachicago.org/ysvp

ORGANIZATION NAME: YOGA2SLEEP, LLC

• **Program description:** The mission of Yoga2Sleep, LLC is to assist the tired, restless and sleep deprived, serving communities through a deep passion for yoga. We encourage the wonder and discovery of an exciting, holistic way to channel energy so that rest and slumber come easier. Yoga2Sleep’s services help clients decrease stress levels to get better sleep for the best life. We offer programs to teach veterans and military service members to become still, be present and relax. Yoga2Sleep use breathing exercises to de-stress and release tension. We teach yoga and provide yoga therapy to veterans of all eras and service members, some of whom are dealing with PTSD, TBI and military sexual trauma (MST).

• **Contact Information:** Pamela Stokes Eggleston, MBA, RYT, pamsegg@gmail.com

• **URL:** www.yoga2sleep.com
**REFERENCES**

**GLOSSARY**


**PART I: UNDERSTANDING THE CONTEXT OF VETERANS’ MENTAL HEALTH**


PART II: USING AN EQUITY FRAMEWORK TO UNDERSTAND HOW VETERANS EXPERIENCE VULNERABILITY


PART III: VETERANS FROM SUBPOPULATIONS WHO HAVE BEEN HISTORICALLY OPPRESSED

Profile 1: Female Veterans


Profile 2: Immigrants


Profile 3: LGBTIQ


**Profile 4: Veterans of Color**


Profile 5: Disabled Veterans


Profile 6: Elderly Veterans


Profile 7: Homeless Veterans


**Profile 8: Incarcerated Veterans**


Profile 9: Other-Than-Honorably Discharged Veterans


Profile 10: Rural Veterans


Profile 11: Student Veterans


**Profile 12: Unemployed Veterans**


