Invisible Injuries: Mental Health Needs of Tennessee Veterans

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The University of Tennessee, Knoxville
College of Social Work
Office of Research and Public Service

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Project # 13084
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Key Findings

There are 501,665 Veterans of the Armed Forces living in Tennessee. Some of these Veterans face significant mental health challenges, including Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder, Traumatic Brain Injury, and Substance Abuse.

In 2012, the National Council on Behavioral Health estimated that 15,936 of the 52,943 Veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) living in Tennessee have been diagnosed with a mental health disorder.

To better understand the mental health needs of Tennessee’s Veterans, the UT College of Social Work Office of Research and Public Service (UT SWORPS) conducted a Needs Assessment in February and March 2013, on behalf of the UT College of Social Work. This Needs Assessment relied on a comprehensive review of available literature as well as telephone interviews with stakeholders familiar with Veterans’ mental health concerns in Tennessee.

Mental Health Needs

Most frequently, Veterans’ mental health needs include reintegration stressors, depression, post-traumatic stress disorder (PTSD), and traumatic brain injury (TBI). If these challenges are not addressed, they can lead to substance abuse or suicide.¹

Reintegration Stressors

- A 2012 Iraq and Afghanistan Veterans of America (IAVA) survey found that a majority of Iraq and Afghanistan Veterans reported relationship and family difficulties stemming from their deployment and subsequent return home.
- Stakeholders interviewed in Tennessee reported that the Veterans they work with often face reintegration stressors. One provider who works in an outpatient mental health setting said that

¹ Outcomes of unaddressed mental health challenges may also include homelessness, ruptured family relationships, high unemployment, etc. This report focuses solely on concerns raised by interviewed stakeholders for Tennessee Veterans and literature related to those concerns.
the majority of his clients are Veterans and their significant others who are in need of “couples therapy” to cope with post-deployment reintegration issues.

- Reservists and members of the Tennessee National Guard face challenges returning to the workforce, and these challenges are made worse by a lack of decompression time. As one stakeholder explained, Guardsmen “…left a plumbing job, and then they are in a war zone, and then they are expected to come back to their old life…”

**PTSD, Major Depressive Disorder, and TBI**

- Although they are separate disorders, PTSD and Major Depressive Disorder have a high rate of comorbidity.
- The National Council for Behavioral Health (2012) found that 30% of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans in Tennessee have been diagnosed with a mental health disorder. PTSD and Major Depression are the most common diagnoses.
- Nationwide, almost 20% of OEF/OIF combat Veterans reported experiencing TBI symptoms (Tanielian & Jaycox, 2008).
- According to IAVA (2009), across the country, “Tens of thousands are suffering from either two or all three of these conditions [TBI, PTSD, and Major Depressive Disorder].”

**Substance Abuse**

- Roughly 7% of all Veterans in the US met the criteria for a substance abuse disorder (SAMSHA, 2007).
- 20% of OEF/OIF Veterans who received care from the Department of Veterans Affairs between 2001 and 2005 were diagnosed with a substance abuse disorder (SAMSHA, 2007).
- In Tennessee, the Veterans Administration plays a slightly larger role in treating substance abuse when compared to VA facilities nationwide.
  - Nationally in 2011, 1.6% of the substance abuse treatment facilities were run by the VA. In Tennessee, 2.4% of these facilities were run by the VA (SAMSHA, 2011a; SAMSHA, 2011b).
  - A greater proportion (4.3%) of Veterans in Tennessee rely on the VA for substance abuse treatment, when compared to Veterans relying on the VA for substance abuse treatment nationwide (3.0%) (SAMSHA, 2011a; SAMSHA, 2011b).
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Suicide

- In 2008, the VA estimated that 6,500 Veterans of all generations commit suicide annually.
- Vermont Senator Bernard Sanders, chairman of the Senate Veterans’ Affairs Committee, recently stated in a Senate hearing that according to VA reporting, “Up to 22 Veterans commit suicide each day” (VA Mental Health Care: Ensuring Timely, 2013d).
- 37% of respondents in the 2012 IAVA survey reported personally knowing an OIF/OEF Veteran who committed suicide.
- In 2004 and 2005, Veteran suicide rates were roughly twice as high as non-Veteran suicide rates (Malbran, 2009).
  - The 2004 Veteran suicide rate was 17.5 to 21.8 per 100,000, compared to 9.4 per 100,000 in the non-Veteran population.
  - The 2005 Veteran suicide rate was 18.5 to 20.8 per 100,000, compared to 8.9 per 100,000 in the non-Veteran population.
- In Tennessee, the 2011 age-adjusted suicide rate was 14.6 per 100,000 people. This rate is above the national average of 12.4 per 100,000 (TSPN Publishes, 2013).
- According to the Tennessee Suicide Prevention Network, between 2005 and 2011 there were 85 suicides at Fort Campbell.
- According to one stakeholder, from 2010 through June of 2012, suicide-related events (threats, attempts, and completions) have increased among those in the Tennessee National Guard:
  - 14 suicide-related events in 2010
  - 70 suicide-related events in 2011
  - 70 suicide-related events between January and June 2012

Barriers to Meeting Mental Health Needs

Through interviews with stakeholders, researchers obtained estimates of the percentage of Tennessee Veterans who were not accessing mental health services. The estimates provided by stakeholders varied from 30% to 80%, and those who could not provide an estimate offered statements like, “The number is absolutely huge,” suggesting that they believe many are not accessing services. The most frequently cited reasons for not accessing services are:

Stigma

- Stigma was the most often cited reason why Tennessee Veterans choose not to seek treatment.
- A stakeholder who provides mental health counseling to Veterans stated, “They don’t want to be seen as weak or unfit.”
- This suggests that the stigmatizing attitudes about mental health are being perpetuated by military leaders. This may prevent combat Veterans from seeking treatment. As another stakeholder explained, some combat Veterans in Tennessee “fear that they will be demoted if they seek help for mental health problems.”
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- Combat Veterans across the country choose not to seek treatment for fear it will hurt their careers. A 2012 IAVA nationwide survey of OEF/OIF Veterans found that 21% reported not seeking help for mental health problems because they were concerned it would affect their careers.

Denial and Lack of Awareness

- Many Veterans in Tennessee do not access services because they are in denial about needing mental health services. For example, one stakeholder said the Veterans he works with say things like “There’s nothing wrong with me. It’s everyone else...”
- Others felt that Veterans weren’t in denial, but were unaware of having a problem. One stakeholder explained “… [Veterans] don’t know they have PTSD. They have bursts of anger and nightmares, and they just think they need to get control of it.”

Lack of Knowledge about Accessing Available Services

- Stakeholders stated that Tennessee Veterans may not access services because they are not aware of existing services or they are not sure how to navigate the complex, time-consuming VA eligibility process.
- The VA has made strides in providing outreach to Veterans. One stakeholder said that the VA cannot afford to hire professional staff to work solely on outreach but pointed out, “Suicide Prevention Coordinators are the primary personnel for community outreach, as well as teaching military culture competencies and... Local Recovery Coordinators are also involved in this community training.”

Geographic Barriers to Services

- Many stakeholders reported that geographic barriers prevent some Tennessee Veterans from accessing mental health services. One stakeholder explained: “Veterans in our state’s more rural and remote counties are frequently underserved because of the distance to available resources, a lack of transportation, or other logistical issues.”
- Some private mental health care outpatient facilities in Tennessee are attempting to address geographic barriers by providing peer support through “…online support groups and phone services to address the fact that people have difficulty coming in person.” If professional intervention is needed to deal with a crisis situation, clinicians must provide those services in person.
- In Tennessee, the VA has not been able to utilize equipment to provide services to the fullest extent possible. VA outpatient clinics and hospital clinics have begun implementing mental health services through telehealth. However, stakeholders familiar with the Vet Centers reported that the Vet Centers have telehealth equipment, but clients cannot access the Vet Center services directly from their homes.
Shortages of Adequately Trained Providers

- Most stakeholders made statements that suggest “double or triple” the number of existing mental health providers were needed to meet the provider shortage.
- Leaders in the VA system in Tennessee have stated the need for more trained personnel has grown in recent years. As the Chief of Social Work Service at the VA Medical Center in Memphis wrote, “The demand for trained clinical personnel to work with our returning soldiers has grown in recent years.”
- Along with the basic level of competence required for working in mental health, those who want to work with Veterans need specialized training or experience in order to work effectively with the Veteran population.
- According to stakeholders, in Tennessee there are “very few” clinicians who have received specialized training in Veterans’ issues. However, there are promising signs that the number of specifically trained clinicians working within the VA may be on the rise as “The VA is preparing to launch a multidisciplinary team staffing model...This model will propose a 6-7 person team that is comprised of prescribers, therapists and admin[istrative] support...”
- Mental health professional organizations are also taking note of the Veterans’ mental health care staffing shortage. For example, the governing body of social work, the National Association of Social Workers (NASW) released practice standards for social work practice with service members, Veterans, and their families.
- One of these practice standards states that to work with Veterans, social workers must be qualified to practice by holding a social work degree, and by acquiring “specialized knowledge and understanding of military cultures” through their social work program or through continuing education (NASW, 2012).
Introduction

Currently, Tennessee is home to 501,665 Veterans of the Armed Forces (U.S. Census Bureau, 2011). There is a saying in the military that “no one returns unchanged” after a deployment. In some cases these changes take shape in physical injuries. For those with mental health impairments, their injuries are seemingly insurmountable. As Senator Bernard Sanders stated, “We owe it to our Veterans to treat not just the physical wounds of war, but the invisible ones as well. Veterans return from the battlefield with conditions ranging from mild depression to severe Post-traumatic Stress Disorder” (VA Mental Health Care: Ensuring Timely, 2013d).

In order to heal from these injuries, Veterans need assistance from mental health professionals. Secretary of Veterans Affairs Eric Shinseki has stated, “As Veterans depart the military, we must ensure that they have access to quality mental health care” (VA Mental Health Care Staffing: Ensuring Quality, 2012). Yet, it has been well documented that many Veterans do not have this access. Studies documenting the need for more attention to Veterans’ mental health care are becoming available at the national level, but not much data is available regarding these trends at the state level.

In Tennessee, “There is a critical need for more social workers in [the state], and Veterans are experiencing long wait times at VA facilities across the state, resulting in serious and sometimes deadly results” (K. Allred, personal communication, June 1, 2012). It is the goal of this report to provide information about the mental health challenges faced by Tennessee’s Veterans and also to explore the barriers to Veterans receiving adequate mental health care.
Methodology

In order to better understand the mental health needs of Tennessee’s Veterans, the UT College of Social Work Office of Research and Public Service (UT SWORPS) conducted a Needs Assessment in February and March 2013 on behalf of the UT College of Social Work. This Needs Assessment relied on a comprehensive review of available literature as well as telephone interviews with stakeholders familiar with veterans’ mental health concerns in Tennessee.

Literature Review

The presence of mental health problems among veterans has been part of the historical record for millennia. However, the prevalence of mental health problems among military veterans, especially for those in the United States, has been largely under-reported for some time. As more veterans of the wars in Iraq and Afghanistan return home, more is being done to understand veterans’ mental health needs, and the reasons these needs often remain unmet.

In order to have a better understanding of these issues, a review of recent (2001-2013) literature was conducted. The information gathered in this literature review informed the development of the interview instrument used in stakeholder interviews. Additionally, information from this literature is included in the report to provide a basic understanding of the needs at the national level and to provide a context for discussing the issues specific to Tennessee veterans.

Stakeholder Telephone Interviews

Based on information obtained from the literature review and on input from UT College of Social Work administrators, a telephone interview guide was created to ensure consistency across interviews. (See Appendix A).

To determine which stakeholders should be included in the interview pool, UT SWORPS staff collaborated with UT College of Social Work administrators who were familiar with Veterans’ mental health service providers in Tennessee. When those initial stakeholders were contacted, some shared information about other stakeholders who could provide information useful to the study. In all, a list of 42 stakeholders was compiled. These stakeholders were contacted by UT SWORPS staff or UT College of Social Work administrators via email. They were informed of the purpose of the interview and told that
the interviews would take approximately 45 minutes to complete. Additionally, the interview questions were provided to stakeholders in the email so that they would have time to prepare for the interviews, if needed.

Of these 42 stakeholders, 12 participated in the interviews. Nine participated in telephone interviews and 3 stakeholders self-administered the interview and submitted their responses via email. Table 1 provides a brief description of the agencies and organizations represented by those who participated in the stakeholder interviews.
### Table 1: Agencies/Organizations Represented by Stakeholder Interviews

<table>
<thead>
<tr>
<th>Agency/Organization Name</th>
<th>Number of Respondents</th>
<th>Description of Agency/Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ben Atchley State Veteran’s Home</td>
<td>1</td>
<td>Ben Atchley State Veterans’ Home is one of three Tennessee State Veterans’ Homes providing skilled nursing care for Veterans. The facilities are governed by the Tennessee State Veterans’ Homes Board.</td>
</tr>
<tr>
<td>Helen Ross McNabb Center, Inc.</td>
<td>1</td>
<td>Helen Ross McNabb Center is a multi-service regional agency, currently operating at 29 locations in 17 East Tennessee counties. It provides mental health care, addiction and co-occurring treatment, recovery, and social services for children, adults, and families.</td>
</tr>
<tr>
<td>Knoxville Vet Center</td>
<td>1</td>
<td>Vet Centers are community based and are part of the U.S. Department of Veterans Affairs. The Vet Centers provide readjustment counseling to eligible Veterans and their families through a wide range of psychosocial services.</td>
</tr>
<tr>
<td>James H. Quillen VA Medical Center—William C. Tallent Outpatient Clinic</td>
<td>1</td>
<td>William C. Tallent Outpatient Clinic provides health care to Veterans and entry into the VA health care system.</td>
</tr>
<tr>
<td>National Alliance on Mental Illness Tennessee Veterans Council</td>
<td>1</td>
<td>NAMI Tennessee is a grassroots, nonprofit, self-help organization made up of people with mental illness, their families, and community members. The Veteran’s Council advocates for Veterans and active military personnel with mental illness and their families.</td>
</tr>
<tr>
<td>Not Alone</td>
<td>2</td>
<td>Not Alone is a national nonprofit organization that provides confidential, no-cost programs and services to warriors, Veterans, and military families facing Post Traumatic Stress Disorder (PTSD), combat stress, and other invisible wounds of war. Not Alone is a 501c3 nonprofit company of Centerstone, which provides a full range of mental health services, substance abuse treatment, and educational services in Indiana and Tennessee.</td>
</tr>
<tr>
<td>Operation Stand Down, Inc.</td>
<td>1</td>
<td>Operation Stand Down Nashville, Inc. (OSDN) is a nonprofit resource for Veterans in Middle Tennessee. OSDN is the only Veteran Service Center in Tennessee, and services are provided at no cost to Veterans. Services provided include employment readiness training, transitional housing, mail service, clothing assistance, and service coordination with other social service agencies.</td>
</tr>
<tr>
<td>United Healthcare Community Plan</td>
<td>1</td>
<td>United Healthcare Community Plan is the largest Medicaid insurer in the United States.</td>
</tr>
<tr>
<td>13th Judicial District Drug Task Force</td>
<td>1</td>
<td>The 13th Judicial District Drug Task Force provides local drug enforcement in Clay, Cumberland, Dekalb, Overton, Pickett, Putnam, and White Counties in Tennessee. They work with other state, federal, and local law enforcement agencies to identify, apprehend, and prosecute drug traffickers, suppliers, distributors, and manufacturers.</td>
</tr>
<tr>
<td>Department of Veterans Affairs (VA) MidSouth Healthcare Network (VISN 9)</td>
<td>1</td>
<td>The Department of Veterans Affairs (VA) MidSouth Healthcare Network (VISN 9) is an integrated healthcare delivery system comprised of six Joint Commission accredited medical centers in Tennessee and portions of Arkansas, Indiana, Kentucky, Mississippi, Ohio, West Virginia, and Virginia.</td>
</tr>
</tbody>
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2 A modified interview guide was utilized for this interview to gather information related to law enforcement perceptions of mental health needs of Veterans.
Mental Health Needs of Tennessee’s Veterans

While the individual mental health needs of each Veteran are different, their challenges most often fall into one or more of the following categories: reintegration stressors, depression, post-traumatic stress disorder (PTSD), and traumatic brain injury (TBI). These challenges can, especially if left untreated, lead to substance abuse or suicide.

Reintegration Stressors

Returning home from a deployment can be a difficult experience for both combat and non-combat troops. For reasons that are both internal and external to the individual, the transitions back into family life and relationships are often stressful. As a needs assessment of New York State Veterans conducted by the Rand Corporation pointed out:

Many Veterans expressed difficulty coping with changes within themselves and changes in their environment that occurred during the period of their deployment. The loss of familiar relationships formed during deployment, coupled with a sense of disconnection from the "normal world" left many feeling confused, angry, and distressed (Schell & Tanielian, 2011).

In 2012, the non-profit Iraq and Afghanistan Veterans of America (IAVA) conducted a survey of 4,278 Iraq and Afghanistan Veterans. The results showed that a significant number reported relationship and family concerns resulting from their deployments. Respondents were asked “Overall, how have your deployments and your return home impacted your spouse or significant other and/or your relationship?” Most often, respondents reported that their relationships were impacted in the following ways:

- Caused strains in relationship (65%)
- Difficulty readjusting (59%)
- Communication challenges (54%)
- Increased fighting (41%)
- Financial challenges (38%)
- Broke-up /divorced (31%)
- Partner was impacted by Veteran’s mental health challenges (29%)
The same IAVA (2012) study found that Veterans with children experienced difficulties with those relationships as a result of their deployment and return home. More specifically, their relationships with their children were impacted because:

- Readjustment was difficult (43%)
- Child was concerned parent would leave again (37%)
- Veteran’s anger issues affected relationships (30%)
- Child has/had emotional problems (25%)
- Veteran had difficulty reasserting parental role (24%)

Veterans in Tennessee face these same challenges with family and relationships, and in many cases it is those stressors that drive a Veteran to seek treatment. One interviewed stakeholder reported that his agency provides outpatient mental health services to roughly 300 Veterans and their families each year. Most of the assistance provided is “couples therapy” for Veterans and their significant others because of post-deployment reintegration issues, like those listed above.

For National Guard, Reservists, or active duty military personnel who have separated from the military, the transition back into the civilian workforce can add another layer of stress. In 2009, it was estimated that approximately 180,000 service members transitioned from military jobs to civilian life (Community Results Center, 2009). According to a needs assessment of Connecticut Veterans, “For some the transition from combat to a previously held job can be challenging...” (Community Results Center, 2009).

These concerns have been raised by Veterans in other parts of the country as well. For example, a needs assessment of Veterans in New York provided a useful anecdote to illustrate the frustration felt by many Veterans. As the study stated, “One Veteran described his frustration at his civilian co-workers who complained about how hard things had been for them or commented that ‘things have changed since you have been gone’ ” (Schell & Tanielian, 2011). Additionally, the same needs assessment found that many Veterans felt like their time in the service was misunderstood by co-workers and that they were frustrated “over the perception that their deployment was comparable to an extended vacation” (Schell & Tanielian, 2011).

Upon separation from the military, Veterans can feel a sense of lost purpose, lost community and lost identity. Jacob Wood, President and Co-Founder of Team Rubicon, provided a telling anecdote to illustrate this point as part of his testimony before the Senate Committee on Veterans Affairs:

Imagine for a moment an 18 year old boy in Omaha, Nebraska. That 18 year old boy graduates high school and joins the Army. The Army sends him to boot camp and gives him a rifle. Later he deploys to Iraq and is promoted to Sergeant. This young man spends twelve months in Iraq, and every day he leads his men outside the wire on a mission to pacify the countryside and protect his country. He has purpose. Every night, back inside the wire, he checks on his men, ensuring they have what they need. They laugh together, they cry together. He has a community. Twelve months later his unit returns home. The young boy, now a man, walks through the airport in his
uniform and is slapped on the back and thanked from all around. He has an identity. Only months later the man leaves the Army and returns home to Omaha, Nebraska. He gets a job and reconnects with old high school friends. Soon, however, he discovers a void—things just aren’t the same. No job can replace the purpose he once felt. Distant high school friends simply cannot understand or replace the community he has left behind. And no mechanic’s overalls or pinstripe suit will ever give him the identity he felt while serving. He is not whole. And now, left to his own devices, he questions his war because all around him question it. He now finds himself trying to justify the lives lost, the lives taken, and the moral code he inevitably compromised. For some this is the most difficult part because the mission may no longer feel noble, the threat no longer imminent. (VA Mental Health Care: Ensuring Timely, 2013e).

These transitions after deployment are often intensified by the fact that members of the Armed Forces are not given adequate decompression time. Veterans need time to decompress and readjust after a deployment and they are not ready to immediately return to their previous jobs (Community Results Center, 2009). New York Veterans who participated in focus groups reported that they felt like they were expected to “get back into the swing of things” after a deployment. Many Veterans said that they needed more decompression time after returning from Iraq or Afghanistan and going back to work and resuming their normal family responsibilities (Schell & Tanielian, 2011).

In Tennessee, Reservists and members of the National Guard also face these challenges returning to the workforce and these challenges are made worse by a lack of decompression time. One stakeholder explained:

The Guard and Reservists are often forgotten, but they have been deployed as well and they come back and have to go right back into their jobs....For Guardsmen, they left a plumbing job and then they are in a war zone and then they are expected to come back to their old life. There is no decompression time for them.

Post-Traumatic Stress Disorder (PTSD) and Major Depressive Disorder

During times of war, the risk of mental health conditions increases and there is greater need for mental health services for those in the military and also for those who have separated from the military. While PTSD was not formally defined and adopted until the 1970’s, it is not a new phenomenon. Veterans of previous wars were known to suffer the same symptoms, but with different names: soldier’s heart, shell shock, and battle fatigue. However, the advances in medical care and in military technology have allowed Veterans of more recent wars to survive injuries that would have been fatal in previous wars (Franklin, 2009). As a result, Veterans of more recent wars have to cope with the psychological ramifications of that trauma (Franklin, 2009).
While PTSD and Major Depressive Disorder are separate disorders which can be experienced individually, they are presented together in this report because of the high comorbidity of the two disorders. For example, as a survey of New York Veterans showed, of the 22% of Veterans who met the criteria for probable PTSD or major depression, most had both of these conditions rather than one or the other in isolation (Schell & Tanielian, 2011).

**Exposure to Trauma**

One explanation for the higher rates of PTSD and major depression is Veterans’ increased exposure to combat trauma. A RAND Corporation survey of 1,965 service members and Veterans found that for Veterans, exposure to combat trauma was the “single-best predictor for both PTSD and major depression” (Tanielian & Jaycox, 2008). In terms of the types of trauma experienced, Veterans of the wars in Iraq and Afghanistan were more likely to experience trauma vicariously (seeing a friend wounded or killed) than they were to be traumatized directly by their own injuries. According to the same 2008 RAND Corporation survey, Veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) reported the following trauma exposures:

- Having a friend who was seriously wounded or killed
- Seeing dead or seriously injured noncombatants
- Witnessing an accident resulting in serious injury or death
- Smelling decomposing bodies
- Being physically moved or knocked over by an explosion
- Being injured, but not requiring hospitalization
- Sustaining a blow to the head from any accident or injury
- Being injured and requiring hospitalization
- Engaging in hand-to-hand combat
- Witnessing brutality towards detainees/prisoners
- Being responsible for the death of a civilian

Other sources supported these claims and stated that many combat Veterans were exposed to both vicarious and direct trauma. A report by the National Council for Behavioral Health (2012) stated that during 2003, 87% of Marines serving in Iraq were exposed to trauma, as they “saw dead bodies, were shot at, were attacked/ambushed, received rocket or mortar fire, and/or knew someone who was killed or seriously injured.”

PTSD symptoms usually appear soon after the traumatic event, but in some cases may not appear until years or months after the trauma occurred. Also, symptoms may be intermittent over a number of years. However, once symptoms “last longer than 4 weeks, cause great distress, or interfere with work or home life, a diagnosis of PTSD may be appropriate” (National Council on Behavioral Health, 2012). Major Depressive Disorder often accompanies PTSD and is characterized by the presence of one or more depressive episodes lasting two weeks or more. During these depressive episodes, those with depression exhibit depressed affect and/or a loss of interest or pleasure in their usual activities.
Additionally, in order to meet the criteria for Major Depressive Disorder they must also exhibit at least 4 of the other common depressive symptoms (e.g. changes in appetite, changes in sleep patterns, difficulty concentrating, and recurrent thoughts of death or suicide) (National Council on Behavioral Health, 2012).

There are some factors that put a service member at greater risk for PTSD and depression after exposure to a traumatic event. According to an IAVA report, those troops who are younger, combat-injured, and in the National Guard or Reserve are more likely to suffer psychological injuries (Williamson & Mulhall, 2009). Those who are dealing with financial and relationship problems during deployment and Reservists who lack the social safety net of active duty military life have higher rates of PTSD (Williamson & Mulhall, 2009). As these individuals transition from active duty, they will need mental health services as Veterans. As one interviewed stakeholder who works with Tennessee Veterans explained, “I think with ramping down of OEF and the drawdown, the longer these guys are out, the more their problems with PTSD and Depression are going to come out.”

**Prevalence**

Although most Veterans are able to return from combat and are able to readjust successfully, it is estimated that 5% to 15% of Iraq and Afghanistan Veterans have PTSD and between 2% and 14% have major depression (Tanielian & Jaycox, 2008). Among Vietnam Veterans, estimates of PTSD are higher, with approximately 31% of male Vietnam Veterans having PTSD at some point after their military service (Williamson & Mulhall, 2009).

When comparing rates of PTSD and depression among Veterans to rates in the general population, the results are telling. While the 12-month prevalence of PTSD in the general population is 2%, in the Veteran population that rate increases to 16% (Schell & Tanielian, 2011). Similar prevalence estimates for major depression suggest that depression among individuals in the general population affects 4% to 7% of the population, while among Veterans the rate is approximately 16%.

While information about the prevalence of mental health disorders among Veterans of other conflicts is not available for Tennessee’s Veterans, these data are available for Tennessee Veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). Of the 52,943 Tennessee OEF/OIF Veterans, 15,936 have been diagnosed with a mental health disorder (National Council for Behavioral Health, 2012). PTSD and Major Depression are the most common diagnoses, accounting for 9,794 (61%) of the diagnosed mental health disorders among Tennessee’s OEF/OIF Veterans.

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3 In this study, researchers matched age and gender distribution of the individuals in the general population to mirror that of the Veteran population before determining prevalence estimates for PTSD and Major Depressive Disorder.

4 This number only includes those who have been diagnosed with PTSD and/or Major Depressive Disorder. It does not account for the number of Veterans who have probable PTSD or Major Depressive disorder based on symptoms, but have not been diagnosed.
In addition to PTSD and depression, the other “signature wound” of OEF/OIF is Traumatic Brain Injury (TBI) (Tanielian & Jaycox, 2008). In combat theatres TBI is most often the result of Improvised Explosive Device (IED) blast waves, penetrating head wounds, and other head and neck injuries. TBI appears to be a salient issue for OEF/OIF combat Veterans, as 19% reported experiencing probable TBI (Tanielian & Jaycox, 2008). It is important to note that this number was derived from a survey that also included active service members, not just those who had completely separated from military service. However, given the prevalence of TBI, it is expected while some will completely recover from the injury, there will be those who continue to have some degree of functional impairment for many years after their service ends. As a result, TBI will be a factor in meeting the mental health needs of Veterans in the years to come.

A review of the literature shows that much of the available information about TBI is superficial and that more in-depth understanding of the symptoms, causes, and treatments of TBI are needed. It is known that there is a relationship between TBI and PTSD, but the exact nature of that relationship has yet to be determined. One reason for the lack of understanding about the relationship between the two is that PTSD has traditionally been a disorder treated by mental health clinicians, whereas TBI has been under the jurisdiction of vocational rehabilitation, neurologists and other members of the medical community (Stein & McCallister, 2009).

Additionally, one of the major challenges in treating those with TBI is that it is difficult to distinguish some PTSD symptoms from mild TBI symptoms. As shown in Figure 1, there is significant overlap in the symptoms of the two disorders. Additionally, major depressive disorder is often associated with TBI, and can complicate treatment of TBI. According to IAVA (2009), “Tens of thousands are suffering from either two or all three of these conditions [TBI, PTSD, and Major Depressive Disorder].”

Substance Abuse

An estimated 7.1% of all Veterans in the US met the criteria for a substance abuse disorder (SAMSHA, 2007). Additionally, 20% of OEF/OIF Veterans who received care from the Department of Veterans Affairs between 2001 and 2005 were diagnosed with a substance abuse disorder (SAMSHA, 2007). Given these rates, it is understandable that military and VA officials “are concerned that among personnel deployed to these fronts, the difficulties of deployment and combat may be contributing to a rise in problems related to substance abuse” (“The Threat,” 2010).

There are certain factors that put some Veterans at greater risk for substance abuse. Younger Veterans with lower household incomes are at greater risk for substance abuse. As a 2007 SAMSHA report found, Veterans aged 18-25 are more likely to have substance abuse disorders than older Veterans. Additionally, Veterans with incomes of less than $20,000 per year were more likely to struggle with substance abuse disorders than Veterans with higher incomes (SAMSHA, 2007).

Veterans, like those in the general population, were more likely to use alcohol than illicit drugs. For instance, a survey of 913 Veterans in New York State found that 88% drank alcohol, 38% had at least one binge drinking episode, and 16% reported frequent binge drinking in the month prior to the survey.\(^5\)\(^6\) In terms of illicit drug use, 9% of those in the same sample reported illicit use in the past year. More specifically, 7% of Veterans reported using marijuana, 4% reported recreational use of prescription medication, and 2% reported using cocaine, opium, amphetamines, or ecstasy (Schell & Tanielian, 2011). Substance abuse is a threat to returning Veterans for a number of reasons. The first of these is that, just as in the civilian population, “substance abuse doesn’t just wreak havoc on individuals’ health; it also contributes to violence, abuse, and other crises in family relationships including family disintegration” (“The Threat,” 2010).

Further, the stressors of combat, deployment, and reintegration put Veterans at risk for substance abuse, as they may attempt to use substances to cope with these stressors. In cases where Veterans are coping with PTSD, depression, and TBI, attempts to self-medicate with alcohol or drugs can exacerbate symptoms and lead to greater impairment, difficulty functioning, violence, or suicide. In some instances, these problems can result in criminal charges. One stakeholder who is familiar with drug enforcement in middle Tennessee reported that of those who are charged with drug-related crimes in his jurisdiction, “[in the past] 5% to 6% were Veterans, but that is probably on the increase since Iraq Veterans have come home...probably 15% are Veterans.” Information from other sources suggests that Veteran arrests are often related to substance use disorders. More specifically, in Davidson County, TN, of 389 Veterans arrested in 2012, 30% of those were charged with public intoxication (K. Chaffin, personal communication, March 21, 2013).

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5 Binge drinking is the consumption of 5 or more alcoholic drinks in one sitting for a man and for or more drinks in one sitting for a woman.
6 Frequent binge drinking is defined as binge drinking on 5 or more days in the past month.
Data from the National Survey of Substance Abuse Treatment Services provides information about the number of individuals who are receiving substance abuse treatment. The data are collected based on the number of individuals in treatment on March 31 of each year to provide a snapshot of location, characteristics, and services offered to those being treated for substance abuse. From the 2011 data, it appears that in Tennessee, the Veterans Administration plays a slightly larger role in treating substance when compared to VA facilities nationwide. Nationwide, 1.6% of the substance abuse treatment facilities are Department of Veterans Affairs facilities. However, in Tennessee 2.4% of the substance abuse facilities are VA facilities (SAMSHA, 2011a; SAMSHA, 2011b). Additionally, a slightly greater proportion (4.3%) of Veterans in Tennessee rely on the VA for treatment, compared to the proportion (3.0%) served by the VA nationwide (SAMSHA, 2011a; SAMSHA, 2011b).

Suicide

Much like substance abuse, suicidal behavior stems from environmental stressors in concert with mental health problems like major depressive disorder, PTSD, and TBI. That is, one does not engage in suicidal ideation or behavior without the presence of environmental stressors and mental health concerns. Environmental stressors and mental health concerns do not always lead to suicidal ideation and behavior, but if not properly treated, these issues have “long-term, cascading consequences” (Tanielian & Jaycox, 2008).

A report for the Department of Veterans Affairs Veterans Health Administration Quality Enhancement Research Initiative stated “Recent estimates suggest current or former military represent 20 percent of all known suicides in the US and the rate of suicides among Veterans utilizing Veterans Health Administration (VHA) services is estimated to be higher than the general population” (O’Neil, et al., 2012).

Difficulty in Determining Prevalence

It is not clear from the existing literature exactly how much higher suicide rates are in the Veteran population. As a Congressional Research Service report about the prevalence of suicide among Veterans stated, “The true incidence of suicide among Veterans is not known” (Sundararaman, Panangala, & Lister, 2008). One reason for this is that most of the available information does not distinguish between Veterans and active duty service members (Sundararaman et al, 2008). This lack of distinction is problematic because while active duty service members and Veterans do share the common bond of military service, the reality is that they are two distinct groups with differing support systems, stressors, and varying access to health care.

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7 While substance abuse and suicide are not the only possible outcomes of unaddressed mental health challenges, they were the only concerns raised by stakeholders interviewed for this report. Other unaddressed mental health challenges may include homelessness, ruptured family relationships, unemployment, etc. but are not covered here as they were not raised by stakeholders.
Another reason it is difficult to determine the suicide rate among Veterans is quite simply that there is no federal organization or agency that tracks the number of Veteran suicides at the national level (Malbran, 2009). The information available to calculate the numbers requires cooperation from each state, which has proven difficult for researchers. This was a particularly salient issue for a report released by the VA in 2012. This report attempted to determine the suicide rate among Veterans in all 50 states, regardless of whether or not they had sought services from the VA. However, researchers were only able to include data from 21 states due to “inconsistent availability of requested information in all states” and “conflicting interpretations of Social Security laws” (Kemp & Bossarte, 2012).

The result, as the authors stated, is that the “information provided by the 21 states may not be generalizable to the larger Veteran population” (Kemp & Bossarte, 2012). This is particularly important to note for the present study because Tennessee was one of the states not included in the report. Despite these limitations regarding the utility of suicide statistics, Kemp and Bossarte’s 2012 report is important. The report is expected to be the first in a series and as the report’s authors state:

[The report] is an initial attempt to look at all of this information together in order to provide an overall picture of Veteran suicides to drive suicide prevention development and improve outcomes for Veterans at risk of suicide. It is expected that reporting will be refined as time goes on and more data become available (Kemp & Bossarte, 2012).

**Available Suicide Data**

Because there is no national tracking for Veteran suicide, as Sundaraman et al (2008) noted, “Information is limited to the findings of special epidemiological studies and surveys...” Despite these limitations, in order to understand the scope of the problem, it is important to consider what data are available.

Although the 2012 VA report may not have been able to provide an overall picture of Veteran suicides, it was able to provide information about non-fatal suicide attempts by those receiving care from the VA. Utilizing VA data, it was determined that from FY 2009 through FY2012, 43,273 Veterans receiving care from the VA made non-fatal suicide attempts. The report also calculated the non-fatal suicide event rate of approximately 190 per 100,000 Veterans (Kemp & Bossarte, 2012).\(^8\) While these numbers cannot be compared to similar estimates in the non-Veteran community, these numbers are significant as the VA and other mental health care providers attempt to understand the scope of the problem and develop effective prevention programs.

In terms of completed suicides, in 2008 the VA estimated that 6,500 Veterans of all generations commit suicide annually (Williamson & Mulhall, 2009). More recently, Senator Bernard Sanders stated that

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\(^8\) These numbers do not include those Veterans who were not connected with the VA at the time of their non-fatal suicide event.
according to VA reporting, “up to up to 22 Veterans commit suicide each day” (VA Mental Health Care: Ensuring Timely, 2013d). To put those numbers in the context of the general population, Veterans only make up 13% of the population, but the VA estimates that they account for 20% of the suicides (Williamson & Mulhall, 2009).

Sources outside the federal government have found similarly startling numbers. CBS News reported on the suicide epidemic among Veterans. Using information provided by 45 states, CBS News reported on suicide rates for Veterans versus non-Veterans in 2004-2005 (Malbran, 2009). This reporting provided a comprehensive look at the issue of suicide among Veterans, as it included information about Veterans regardless of whether or not they were service connected with the VA. Additionally, in order to put the numbers in perspective, the rates were adjusted for age and gender. This allowed for a true comparison between the Veteran and non-Veteran groups. The results were startling: Veteran suicide rates were roughly twice as high as non-Veteran suicide rates. More specifically, in 2004 the Veteran suicide rate was 17.5 to 21.8 per 100,000, compared to 9.4 per 100,000 in the non-Veteran population. In 2005 the Veteran suicide rate was 18.5 to 20.8 per 100,000 compared to 8.9 per 100,000 in the non-Veteran population (Malbran, 2009).

Many Iraq and Afghanistan Veterans have been personally affected by the suicide epidemic, as 37% of respondents in the 2012 IAVA survey reported personally knowing an OIF/OEF Veteran who committed suicide. Of those who knew an OIF/OEF combat Veteran who committed suicide, 30% reported that person had separated from the military at the time of the suicide (IAVA, 2012). Other information available lends credence to the notion of a suicide epidemic among OIF/OEF Veterans. For example, one IAVA report regarding suicide rates among service-connected OIF/OEF Veterans found a suicide rate of 38 per 100,000, compared to 11.5 deaths per 100,000 in the general population (Martinez and Bingham, 2011).

In Tennessee, there is also a significant concern for the well-being of Veterans. Agencies such as the Tennessee Suicide Prevention network have expressed “…concern about the Veteran suicide rate [in Tennessee], which has reached all-time highs in recent years” (S. Ridgeway, personal communication, June 12, 2012). While a suicide rate for Tennessee Veterans is not available, information about suicide rates statewide and among service members can be used to frame the discussion of Veteran suicide in Tennessee. Statewide, the 2011 age-adjusted suicide rate was 14.6 per 100,000 people. This rate is above the national average of 12.4 per 100,000 (TSPN Publishes, 2013). Among those with military service in Tennessee, between 2005 and 2011, there were 85 suicides at Fort Campbell (Saving Veteran Lives, n.d.). While it is not known how many of those suicides involved combat Veterans, given the high number of deployments from Fort Campbell, it is presumed that at least some of those 85 had one or more deployments.

As a Time magazine article said about the relationship between suicide and deployment at Ft. Campbell, “The installations with the highest suicide rate are those with the highest deployment optempo: Fort Campbell, Fort Carson, Fort Stewart, Fort Hood, and Fort Riley…” (Ritchie, 2011).
The suicide threat has also affected Tennessee National Guardsmen. One stakeholder provided information about the suicide trends within the Tennessee National Guard. In 2010 there were 14 suicide-related events. In 2011, there were 70 suicide-related events, and in 2012 those numbers were expected to be even higher as there were 70 such reports in the first 6 months of the year. As with the information from Fort Campbell, it is not known how many of these events involved combat Veterans. However, given the fact that between 2001 and 2007 a total of 254,894 National Guard have served in Iraq and Afghanistan, it is likely that some of these events in Tennessee involved combat Veterans (Waterhouse & O’Bryant, 2008).

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9 “Suicide-related events” include threats of suicide, suicide attempts, and suicide completions.
Barriers to Meeting Mental Health Needs

In order to determine the amount of unmet needs of Tennessee’s Veterans, stakeholders were asked to provide an estimate of the percentage of Veterans who were not accessing services in Tennessee. The estimates provided by stakeholders varied from 30% to 80%. Some stakeholders who could not provide an estimate made statements like “The number is absolutely huge” which suggests that they believe many are not accessing services. Stakeholders were also asked why they believed Veterans were not accessing services. Most often, stakeholders reported that Veterans do not access services because they:

- are concerned about stigma
- are in denial or unaware that they have a mental health problem
- lack knowledge about accessing available services
- face geographic barriers to services
- face a shortage of adequately trained mental health providers

These reasons were supported by the literature, suggesting that these are issues faced by Tennessee Veterans and Veterans nationwide. The remainder of this report will provide a more detailed description of these factors as they relate to Tennessee Veterans and Veterans across the United States.

Stigma

The vast majority of stakeholders reported that concern about stigma was a reason why Tennessee Veterans choose not to seek treatment. As a stakeholder who provides mental health counseling to Veterans stated, “They don’t want to be seen as weak or unfit.” Stigma is a concern for Veterans nationwide, as evidenced by recent studies. One study found that for Iraq and Afghanistan combat Veterans, “About 50% of soldiers and Marines who test positive for a psychological problem are concerned that they will be seen as weak by their fellow service members” (Williamson & Mulhall, 2009). One proposed way to overcome the stigma of mental health would be to award the Purple Heart for mental health injuries. As a National Alliance on Mental Illness report stated, “Posttraumatic stress and other mental health injuries that are the result of hostile action... should be eligible for award of the

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10 One stakeholder refused to provide feedback on this issue.
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Purple Heart with the same level of appreciation and recognition as those awarded to warriors with visible wounds” (NAMI, 2012). Doing so would also help to reduce stigma and “legitimize the equality of the mental or invisible wound and encourage Veterans to seek treatment” (VA Mental Health Care: Ensuring Timely, 2013a).

Another stakeholder who provided input for this report stated, “The greatest barrier seems to be mental health stigma... members of the Armed Forces may consider help-seeking behavior a sign of weakness, and current personnel may be worried about the effects of a mental health referral on their careers.” This suggests that the stigmatizing attitudes about mental health are being perpetuated by military leaders. This may prevent combat Veterans from seeking treatment. As another stakeholder explained, some combat Veterans in Tennessee “fear that they will be demoted if they seek help for mental health problems.” There is evidence to support this claim from polls of Veterans nationwide. For example, of the half of Iraq and Afghanistan combat Veterans who did not seek care for their invisible injuries despite someone close to them suggesting it, 21% said they did not seek help because, “I was concerned it would affect my career” (IAVA, 2012). There are some signs that commanders’ negative attitudes toward mental health care are changing. One stakeholder explained that the atmosphere seems to be changing at Fort Campbell and at Tennessee National Guard installations. She explained that, “Commanders are more likely to see that soldiers get help... Even though there is progress, the stigma is still there.” To promote continued changes in attitudes and in order to ensure accountability among leaders at all levels, the Chair of the NAMI Veterans and Military Council recently testified before the Senate Committee on Veterans Affairs that, “Performance evaluations should immediately and specifically include measurements of how leaders are or are not ending stigma, bullying, hazing, and suicide” (VA Mental Health Care: Ensuring Timely, 2013a).

Denial and Lack of Awareness

As one stakeholder explained, many Veterans in Tennessee do not access services because they are in denial about needing mental health services. He explained that when counseling Veterans he often hears them say, “There’s nothing wrong with me. It’s everyone else. Everyone else has changed.” Another stakeholder stated that when it comes to PTSD, there is a lack of awareness that they are suffering from issues both on the patient and family members’ parts. They don’t know they have PTSD. They have bursts of anger and nightmares and they just think they need to get control of it.

In a 2012 survey of Iraq and Afghanistan Veterans, 51% of those surveyed stated that someone close to them suggested that they seek care for a mental health injury. While roughly half did seek care, the other half did not. When asked why they did not seek help, 66% said that they “didn’t need it” (IAVA, 2012). It is possible that some of those individuals truly did not need help for an invisible injury; however, given the high rates of exposure to trauma among Veterans and reintegration difficulties, it is more likely that many of these combat Veterans either were in denial of having a problem or were not aware that they had a mental health concern.
Lack of Knowledge about Accessing Available Services

A number of stakeholders stated that Tennessee Veterans may not access services because they are not aware of existing services or they are not sure how to navigate the complex, time-consuming VA eligibility process. As one stakeholder explained, the eligibility process for VA benefits “depends on a lot of things, like length of service and when they were active.” While in the best of circumstances the process can be confusing, if a Veteran is in need of mental health assistance, the process can seem impossible to navigate. As one stakeholder explained, “Combat Veterans and their families are overwhelmed. They know there are programs out there, but they don’t know how to access them or what the programs outside of the VA are....”

There is also evidence in other states of this need. For example, a study of New York state OEF/OIF Veterans found that of those who desired healthcare, 14% “did not know where to get help or whom to see” (Schell & Tanielian, 2011). Additionally, 19% reported that the “high cost of mental health care” was a barrier. However, the report stated that since almost all of the Veterans in the sample were eligible for free mental health care at the VA, “concerns about treatment cost... might reflect a lack of awareness of eligibility to receive free mental health care or other problems receiving mental health services from the VA” (Schell & Tanielian, 2011). A 2012 NAMI report stated that across the country, “Veterans who seek mental health care can find the VA medical system hard to penetrate.” One OEF/OIF Veteran described the application process as “...a total nightmare [that] stressed me out to the hilt. That’s what a lot of guys go through, and they just give up. I talked to so many guys, and they just give up” (Schell & Tanielian, 2011). One possible explanation for this difficulty is that the “…DoD and the VA are passive systems, leaving the burden on the service member to self-diagnose and seek out care” (Williamson and Mulhall, 2009).

The VA does, however, provide outreach about navigating the system for those who have recently returned from deployment. One stakeholder stated that their local VA outpatient clinic does a “welcome back orientation for any of the military branches returning from OEF/OIF.” However, this type of outreach and education may not be as effective as it could be. As one study of Veterans needs pointed out, “While recent Veterans are given information on the VA before they are discharged, it can be difficult to grasp all of the details at that time” (Community Results Center, 2009). To make these sessions more useful, Veterans in other states have suggested a solution. These Veterans suggested being given benefits information “on a CD” during out-processing. These Veterans suggested that the CD could include information on “… what you need to do when you get out of the process for your service connection, what you’re eligible for, what kind of resources are out there at the federal level” (Schell & Tanielian, 2011). Further, Schell and Tanielian (2011) explained, “Veterans also commented that this information was too general and that they would rather have information about services provided in their place of residence and specific to their needs.”

Additionally, one stakeholder who works for a non-profit mental health provider stated that while their program only serves about 100 East Tennessee Veterans in crisis per year, they are interested in providing better services to those Veterans. Instead of providing counseling or rehabilitative services to
Veterans, they “... are willing to do more in terms of education in how to access the system.” Their agency “… needs someone who can serve as a liaison, helping people access the system.” The need for more liaisons and outreach workers was mentioned by several stakeholders. One stakeholder admitted that at her agency, “Our outreach [expletive deleted]. We grow virally by word of mouth.” However, she said that if they were able to increase outreach efforts, they would be able to take on more clients. Similarly, at one VA facility a stakeholder explained that “… outreach hasn’t been successful at the client level.” He explained that for every 1,000 served in terms of outreach, approximately 10 Veterans will come in for services. He did say, however, that they have had better results from providing education to mental health service providers. That community education functions as a form of indirect outreach because those providers learn about available services, and then, in turn, refer individuals to the VA facility. While these examples show that outreach efforts could be improved in some cases, there are instances where the VA has been successful in providing outreach. More specifically, the VA has overcome budgetary limitations by assigning outreach duties to VA personnel already working with the community. As one stakeholder explained:

We do not have any social workers whose duties are solely to accomplish outreach services. We have many who are in the community providing training and promoting our services but even the VA cannot afford to hire professional staff to only do community outreach. Our Suicide Prevention Coordinators are the primary personnel for community outreach, as well as teaching Military Culture competencies. Our Local Recovery Coordinators are also involved in this community training.

**Geographic Barriers to Services**

A number of stakeholders identified geographic barriers as one of the reasons that some Tennessee Veterans do not have access to services. As one stakeholder explained, “Veterans in our state’s more rural and remote counties are frequently underserved because of the distance to available resources, a lack of transportation, or other logistical issues.” Specific examples of this problem in Tennessee were detailed by a stakeholder who provides mental health services to Veterans. He explained that the East Tennessee agency “… serves people in 17 counties. Some of those counties are near the Kentucky border. That is a long drive. Some served at the Vet Center have to drive an hour and a half one way for an appointment.” Studies of Veterans’ needs elsewhere suggest that this problem for Veterans in rural areas across the country. Not having access to local services is problematic for those Veterans and their family members who are employed because “those living far away from VA facility had to devote most of the day to attend appointments” (Schell & Tanielian, 2011). In cases where Veterans have been diagnosed with PTSD, the recommended treatment includes weekly therapy appointments. As the study pointed out, “Even for those who live within an hour of a VAMC, which is relatively close, a weekly appointment could require four hours off work per week” (Schell & Tanielian, 2011).

Policy recommendations from NAMI (2012) state that “Improved distance delivery through technology should be implemented to remove the travel burden from Veterans and improve the use of professional
care over time.” To reinforce this point, the Chair of the NAMI Veterans and Military Council stated in recent Senate Committee on Veterans Affairs testimony that, “Current technology can be leveraged to consolidate appointments and reduce travel expense and to deliver counseling via distance means such as computers and telephones” (VA Mental Health Care: Ensuring Timely, 2013a). Some private mental health care providers in Tennessee reported that they are “providing online support groups and phone services to address the fact that people have difficulty coming in person.” However, most of these efforts utilize peer support. As one stakeholder explained, “Clinical staff is available to deal with crisis issues if those arise,” but otherwise a “sub-clinical” individual, like a Veteran peer, is responsible for leading those.

The VA has also begun utilizing telehealth and video-to-home technologies so Veterans can receive care from providers at VA outpatient clinics and hospitals without leaving their homes (R. Campbell, personal communication, May 24, 2013). However, the VA still has some challenges in implementing these technologies at all facilities, including Vet Centers. As one respondent explained, “We have the telehealth equipment, but no one else does.” He went on to explain that some clients can’t access the VA system if they are outside of the intranet. The intranet can only be accessed at Vet Centers and VA facilities. He stated that if a Veteran has physical access to one of those facilities, “they would just get services there rather than use teleconferencing equipment to access services in Knoxville.” Additionally, he said that programs like Skype cannot be used to access services because of privacy issues and security concerns with the Vet Center computer system.

**Shortages of Adequately Trained Providers**

Stakeholders were asked if they believed that there was a shortage of mental health professionals trained to work with Tennessee Veterans. All but one of the stakeholders interviewed stated that there was a need. In most cases, they could not give a specific number or percentage. Rather, stakeholders made statements suggesting that “double or triple” the number of existing mental health providers were needed to address the problem. In addition, officials in Tennessee have stated that there will be a growing need for even more clinicians in the future. As the Commissioner of the Tennessee Department of Mental Health wrote:

> Due to the increasing number of young Veterans returning home with trauma and the number of older Veterans moving into Tennessee, we believe that training social work students now to work with these, and other Veteran populations experiencing mental health needs, will help develop a broader base of professional social workers able to effectively serve Veterans in our state (E. Varney, personal communication, June 7, 2012).

Additionally, leaders within the VA system in Tennessee have stated the need for more trained personnel has grown in recent years. As the Chief of Social Work Service at the VA Medical Center in Memphis, TN wrote, “The demand for trained clinical personnel to work with our returning soldiers has grown in recent years...” (L. Stevens, personal communication, June 18, 2012). According to the
Commissioner for the Tennessee Department of Veterans Affairs, this increased demand is partially the result of “aggressive outreach programs in our rural and underserved counties” and it is expected that the demand will only continue to grow in Tennessee (V. Cox-Wingo, personal communication, n.d.).

The need for more adequately trained staff is also well-documented by those at the Federal level. In a recent statement to the U.S. Senate Committee on Veterans Affairs, the Ranking member of committee, Senator Richard Burr stated, “VA is seeing an increase in demand not only from Veterans of Iraq and Afghanistan, but also from Vietnam and other generations as well” (VA Mental Health Care: Ensuring Timely, 2013b). To help address the shortage, President Obama signed an Executive Order in August 2012. This Executive Order “called for the VA to hire 800 peer to peer counselors and 1,600 mental health professionals...” (National Council, 2012).

When considering the need for adequately trained mental health professionals, the unique needs of the Veteran population must be considered. In addition to the basic level of competence required for working in mental health, those who want to work with Veterans need specialized training or experience in order to work effectively. As one stakeholder stated, Veterans are wary of seeking help from civilians because they fear that “civilians aren’t going to understand what they are going through.”

Another stakeholder explained that the combat Veterans he works with ... See the lack of cultural competence from civilian service providers as a lack of respect and respect is a huge issue in the military. The way they see it, the lack of knowledge (about military structure) equals a lack of respect for the military and their service.

According to stakeholders, in Tennessee there are “very few” clinicians who have received specialized training in Veterans issues. Stakeholders familiar with VA outpatient clinic services stated that “The VA has 5 specialized evidence-based treatments” that are used for specialized treatment of PTSD/trauma. According to this stakeholder, “most” of the clinicians have received the required training for “one or two” of these treatments. While this is a step in the right direction, it is clear that there is more room for improvement since not all of the clinicians have received training in several of these treatment modalities. Additionally, there are promising signs that the number of specifically trained clinicians working within the VA may be on the rise and that changes are coming to the VA to further increase the quality of care for Veterans. According to one stakeholder, “the VA is preparing to launch a multidisciplinary team staffing model. This model will propose a 6-7 person team that is comprised of prescribers, therapists and admin[istrative] support, reportedly for each 1,000 Veterans served...Our VISN has approximately 1000 mental health staff authorized right now; we have about 92% of those positions filled.”

VISN stands for Veterans Integrated Service Network. There are 23 VISN Regions. VISN 9—the Mid South Healthcare Network—is composed of Tennessee, Kentucky, and West Virginia.
Mental health professional organizations are also taking note of the Veterans’ mental health care staffing shortage. For example, the governing body of social work, the National Association of Social Workers (NASW) released practice standards for social work practice with service members, Veterans, and their families. One of the practice standards states that to work with Veterans, social workers must be qualified to practice not only by holding a social work degree, but also by acquiring “specialized knowledge and understanding of military cultures” through their social work program or through continuing education (NASW, 2012).

Veterans have also stated a desire for mental health professionals to have specialized training. As the 2012 IAVA survey showed, 77% of those surveyed said that in order to provide “excellent services for Veterans’ mental health concerns” it was “very important” that clinicians “understand military life and culture” (IAVA, 2012). Additionally, 70% stated that it was very important for counselors to “receive specialized training in how to work with service members and Veterans” while 59% stated that it was very important for “civilian counselors (to) receive special training in military life and culture” (IAVA, 2012).

In the same IAVA 2012 survey, 70% of those surveyed stated that it was very important for them to have counselors who served in the military and 57% reported it was very important for them to have access to peer support groups (IAVA, 2012). To fill some of the gap in Veterans’ mental health services, peer counseling should also be considered as an effective tool. As previously mentioned, the Executive Order signed by President Obama called for 800 peer to peer counselors to be hired by the VA (National Council, 2012). In testimony before the U.S. Senate Committee on Veterans Affairs, the Director of the Tragedy Assistance Program for Survivors (TAPS) stated that “Peer-based support can help maintain an umbrella of care for our Veterans that is critically needed. We believe that peer-based support can provide a needed safety net for Veterans who are waiting for appointments or waiting on benefits” (VA Mental Health Care: Ensuring Timely, 2013c). One interviewed stakeholder shared that he is a Veteran and a certified peer counselor in Tennessee. He believes that increasing the number of certified peer counselors is necessary to help Veterans in crisis. He explained that he is able to visit a Veteran in an inpatient mental health facility and “sit down across the table from them and say ‘I’ve been there’ and that is very powerful.”
Conclusions

As more OIF/OEF Veterans return home and other Veterans of war retire and begin to utilize Veterans’ benefits, the need for mental health services will increase. Reintegration stressors, PTSD, TBI and Substance Abuse are all very real threats to the Veteran population in Tennessee. If left unaddressed, these issues can lead to legal problems, violence, and suicide.

It is imperative that Veterans receive the support they need to overcome barriers to services such as mental health stigma, lack of knowledge about services and benefits, and geographic service barriers. By increasing the number of trained mental health care professionals and making peer counselors available to Veterans, these threats to Veterans’ health and well-being will be addressed, leading to improved outcomes for Tennessee’s Veterans and their families.
Works Cited


VA Mental Health Care: Ensuring Timely Access to High-Quality Care: Hearing before the Committee on Veterans’ Affairs, United States Senate, 113th Congress (2013a) (testimony of Kenny Allred). Retrieved from http://www.Veterans.senate.gov/hearings.cfm?action=release.display&release_id=3ae7e7c8-646b-4f15-91e4-fc223e94b394

VA Mental Health Care: Ensuring Timely Access to High-Quality Care: Hearing before the Committee on Veterans’ Affairs, United States Senate, 113th Congress (2013b) (testimony of Senator Richard Burr, Ranking member). Retrieved from http://www.Veterans.senate.gov/hearings.cfm?action=release.display&release_id=3ae7e7c8-646b-4f15-91e4-fc223e94b394


VA Mental Health Care: Ensuring Timely Access to High-Quality Care: Hearing before the Committee on Veterans’ Affairs, United States Senate, 113th Congress (2013c) (testimony of Kim Ruocco). Retrieved from http://www.Veterans.senate.gov/hearings.cfm?action=release.display&release_id=3ae7e7c8-646b-4f15-91e4-fc223e94b394
VA Mental Health Care: Ensuring Timely Access to High-Quality Care: Hearing before the Committee on Veterans’ Affairs, United States Senate, 113th Congress (2013d) (testimony of Sen. Bernard Sanders, Chairman). Retrieved from http://www.Veterans.senate.gov/hearings.cfm?action=release.display&release_id=3ae7e7c8-646b-4f15-91e4-fc223e94b394

VA Mental Health Care: Ensuring Timely Access to High-Quality Care: Hearing before the Committee on Veterans’ Affairs, United States Senate, 113th Congress (2013e) (testimony of Jacob Wood). Retrieved from http://www.Veterans.senate.gov/hearings.cfm?action=release.display&release_id=3ae7e7c8-646b-4f15-91e4-fc223e94b394


Appendix A—Interview Guide for Needs Assessment

- Telephone Interview with ______________________________________________________________

- Questions for Needs Assessment

1. Does your office work with Tennessee Veterans across the state or just some counties in the state? If not statewide, what counties does your agency serve?

2. Based on your work with Tennessee Veterans and their families, do you feel there is a large number of Veterans with mental health needs who need services but currently are not accessing services?

   If so,

   - What is your estimate re: the percentage of Veterans/families with mental health needs who aren’t accessing services?

   - What are some of the reasons Veterans/families with needs are not actually accessing services? [Probe, if needed: not enough service providers, lack of awareness re: available services, stigma, lack of military cultural competence among civilian providers?]

3. What is your agency doing to bring in those with unmet needs? Do you collect any data that helps target outreach or data that describe outreach efforts? How many staff members with a degree in social work do you have involved in those outreach efforts [i.e., not case managers, program coordinators –just staff holding BSW/MSW involved in outreach]?

4. Based on your work with Tennessee Veterans and their families and your sense of unmet needs, what is the number of additional mental health clinicians needed to meet demand? [Probe for within the agency AND also statewide]
5. What is the average wait time for first mental health appointments? [For those in service delivery/For those in advocacy or other stakeholders, ask for estimates as they hear from Veterans they work with in other capacities]

6. What percentage of new patients actually have a full assessment and begin treatment within 14 days of the first mental health appointment (official performance measure since FY 2012 for VA facilities) [For those in service delivery/For those in advocacy or other stakeholders, ask for estimates as they hear from Veterans they work with in other capacities. For ALL, ask perceptions of what gets in the way of meeting the 14-day requirement, for cases where requirement is not met.]

7. Do you have an estimate of clinics and behavioral health clinicians who currently deal with issues of Veterans’ families across the state? Or in your region/counties?

8. What percentage of current behavioral health clinicians in the state have received specialized training in PTSD/ trauma/etc.? [Probe for region/county, agency level]

9. On the flip side, what percentage of current behavioral health clinicians work with Veterans and their families at present but lack sufficient specialized training to adequately address needs of Veterans’ trauma/PTSD/brain injury/etc. and needs of their families? [Again, probe for state, region/county, agency level]

10. Is there anything else you would like to say about the work with Veterans and their families?