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TECHNICAL
R E P O R T



A Needs Assessment of New York State Veterans

Final Report to the New York State
Health Foundation

Terry L. Schell and Terri Tanielian, editors

Sponsored by the New York State Health Foundation

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Preface

Since October 2001, approximately 2 million U.S. troops have deployed as part of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Many of these previously deployed individuals have since left the military or retired, and most previously deployed National Guard and reservists have returned to their home communities. This report is intended to provide valuable data for state-level planning for veterans' services and consists of several discrete components. These include (1) a qualitative assessment of the thoughts and suggestions of New York veterans and their family members about the challenges they face and the services available to help them meet those challenges; (2) a quantitative needs assessment of a representative sample of veterans and their spouses residing in New York; and (3) a guide to the resources that are currently available in New York state for veterans, their family members, and caregivers.

This report is designed specifically for the sponsor, the New York State Health Foundation. It is intended to provide useful information as the foundation manages its portfolio of research, designs informational materials that are useful for this population, and interacts with various veterans' stakeholder groups throughout the state. Consistent with the funder's interests, the research focused primarily on the health-related challenges faced by veterans, although it also assesses some needs associated with occupational, educational, and financial problems. The research adopted a definition of *OEF/OIF veteran* that includes all individuals who were deployed overseas in support of OEF/OIF and subsequently left active-duty military service. This definition closely corresponds to the eligibility criteria for Veterans Health Administration benefits. It excludes most current active-duty service members but does include members of the National Guard or reserves, as well as a small number of individuals who left, but later returned, to active-duty military service.

This study was funded through a grant from the New York State Health Foundation and was conducted by the RAND Center for Military Health Policy Research, a strategic initiative within RAND Health. Terry Schell was the project leader. Comments and questions can be directed to him at Terry_Schell@rand.org. Terri Tanielian and Susan Hosek serve as the co-directors for the Center for Military Health Policy Research. More information about RAND can be found at www.rand.org.

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Summary

Since October 2001, approximately 2 million U.S. troops have deployed as part of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Although not always counted as official casualties by the U.S. Department of Defense (DoD), mental health disorders and other types of impairments resulting from deployment experiences are beginning to emerge.

DoD, the U.S. Department of Veterans Affairs (VA), and Congress have moved to study the issues, quantify the problems, and formulate policy solutions. They are beginning to implement the hundreds of recommendations that have emerged from various task forces, commissions, and research reports. However, despite widespread policy interest and a firm commitment from the military services to address these injuries, fundamental gaps remain in our knowledge about the needs of veterans returning from Iraq and Afghanistan, the adequacy of the care system available to meet those needs, and the experiences of veterans and service members who use these systems. Since many veterans will seek care in the civilian health care sector, state-based programs that integrate services and provide comprehensive lists of available resources might help service members and their families. But a lack of information about veterans' state-level needs hampers states in their planning efforts.

We recently examined the problems facing the broad population of OEF/OIF service members and veterans (referred to as the “Invisible Wounds” study; see Burnam et al., 2009; Tanielian and Jaycox, 2008; Tanielian et al., 2008; *Post-Deployment Stress: What You Should Know*, 2008; *Post-Deployment Stress: What Families Should Know*, 2008; Meredith et al., 2008; Karney et al., 2008; Tanielian, 2009, 2008; Eibner, 2008; Jaycox, 2008). That project took a broad, societal view of problems facing returning service members and applied a health services perspective to develop policy recommendations. As in the current study of New York veterans, we examined prevalence of problems among returned service members and veterans and the systems of care in place to help them, using both qualitative and quantitative methods. We found that about one in five service members and veterans screened positive for a probable diagnosis of post-traumatic stress disorder (PTSD) or depression and that only about half of those had received any mental health care in the prior year. We identified important gaps both in access to mental health care and in quality of that care at the national level and made recommendations to help close those gaps that were widely disseminated to policymakers, to the media, and to key stakeholders.

Other research teams within the military and the VA health care system have also worked on these issues. We have published two recent reviews of this literature (Ramchand, Schell, Jaycox, and Tanielian, forthcoming; Ramchand, Schell, Karney, et al., 2010). These studies have typically found PTSD rates among previously deployed individuals that vary between 5 and 20 percent, depending on the specific population being sampled. Rates of major depres-

sion are typically similar to the rates of PTSD. In addition, studies of veterans actively seeking services in the VA have found somewhat higher rates of PTSD, depression, and physical health problems than have been found in other populations of returned service members.

Although there are now many studies assessing the challenges that individuals face who previously deployed for OEF/OIF, this existing literature is extremely limited for planning at the state and local levels. There are three reasons that these existing studies do not provide useful guidance to policymakers or service providers in these communities. First, the existing studies have systematically excluded a large proportion of community-dwelling veterans. Across all of the studies on OEF/OIF veterans, there are no studies that can estimate the need among veterans who have left the military service but have not sought treatment in the VA health care system. Neither DoD nor VA researchers have studied these individuals. Secondly, studies at the national level are not necessarily representative of the particular types of veterans who reside in particular states or communities, and they might not provide accurate estimates of the problems and needs of local veterans. Finally, research on veterans' needs has focused almost exclusively on mental health problems. There is considerably less information about their needs across the broader range of services that states and communities might provide, such as other health, occupational, or educational benefits.

The current study is designed to address these shortcomings in the existing literature. It focuses directly on the veterans living in New York state; it includes veterans who currently use VA services as well as those who do not; and it looks at needs across a broad range of domains.

The study took a three-pronged approach to assessing and addressing the needs of veterans in New York state. First, we collected information and advice from a series of qualitative interviews with veterans of OIF/OEF residing in New York, as well as their family members. Second, we conducted a quantitative assessment of the needs of veterans and their spouses from a sample that is broadly representative of OEF/OIF veterans in New York state. Finally, we conducted a review of the services available in New York state for veterans. This information has been compiled in a format that is designed to serve as a guide for veterans.

Qualitative Interviews of Veterans and Their Family Members

We conducted six focus groups across the state of New York. Five of these were with veterans and one with family members. To increase the inclusion of women and family members, we also conducted eight individual phone interviews with female veterans and family members of veterans. Participants were recruited primarily through Iraq and Afghanistan Veterans of America (IAVA), which was funded separately by the New York State Health Foundation to assist with recruiting interviewees. IAVA sent email to its membership within approximately 50 miles of selected focus group locations, and potential participants registered online to attend. Participants received \$50 for their participation.

The interviews were designed to (1) document how veterans and their family members think about the challenges they face; (2) gather opinions about the availability, quality, and comprehensiveness of the available programs and services; and (3) elicit innovative ideas for improvement. Across these interviews, several common themes emerged. In particular, veterans and family members reported a range of mental health concerns following veterans' return from Iraq or Afghanistan, difficulties reconnecting with friends and family, and problems finding jobs commensurate with their skills. There was also a shared perception that it is extremely

difficult to navigate the existing system of benefits and services across both VA and non-VA providers, including difficulties determining (1) what services are available, (2) whether the services would be helpful for one's specific problems, (3) where services are available, (4) who is eligible to receive them, and (5) how to apply. Finally, there was general agreement on several suggestions for improvement, including improving military out-processing and subsequent outreach and educational efforts to increase utilization of existing services; expanding VA services to reduce travel time, waiting times, and delays in scheduling appointments; and expanding programs to help families of veterans.

It should be noted that, while qualitative interviews are extremely useful for gaining insight into how individuals think about specific issues, these research methods have substantial limitations. It is extremely important that the reader keep these limitations in mind while reviewing our results. First, the reader should be careful to avoid treating these opinions and perceptions as if they reflect objective facts in the world. We have abstracted these opinions from the interviews and focus groups but have deliberately not attempted to fact-check their statements. Secondly, participants in our interviews and focus groups were not a representative or random sample of veterans in New York state. In fact, they differed in systematic ways from the large group of veterans who were not interviewed. Finally, it is important to realize that these interviews represent a snapshot of these veterans' opinions at a given point in time. It is possible that the veterans reintegrating in the future will be facing a different set of challenges from those discussed in these interviews.

Although the opinions expressed in qualitative interviews should not be taken as representative or accurate descriptions of the challenges that veterans face, these interviews do provide important insight into veterans' beliefs and perceptions. It is important to document that veterans think that the system of care that serves them is difficult to understand, that it is time-consuming to navigate these systems, and that the quality of care is suspect and highly variable. These perceptions are important because they likely inhibit the use of services that would help veterans meet the challenges they face, even if, by objective or comparative measures, the services are promptly delivered and of high quality.

Quantitative Needs Assessment of Veterans and Their Spouses

We conducted a mixed-mode, telephone and web-based survey with 913 veterans and 293 spouses of these veterans. The data used for sampling veterans were obtained from a release of names and addresses (RONA) request to the VA. The RONA mechanism is designed to allow governmental and nonprofit organizations to provide outreach for veterans' services, and this study provided a targeted needs assessment and service referrals to the participating veterans. The RONA provided names and mailing addresses of all VA-eligible veterans with addresses in New York who became eligible in the prior five years. Because these addresses did not have matched phone numbers and were, in many cases, several years old, we used two commercial databases, LexisNexis and Telematch, to get a land-line telephone number associated with a particular name and address and to identify more-recent addresses if they were available.

Letters were sent to a random sample of veterans explaining the study and providing information to allow them to complete the survey on the web. Individuals who did not complete the survey on the web were called on the phone and given an opportunity to complete the telephone version of the interview. After completing the veteran interview, we asked to inter-

view the spouse of each married veteran participant. Participants and their spouses were each paid \$30 for their participation. Interviews were conducted in August–October 2010.

The assessment of veterans identified several areas of diminished health and well-being. A relatively high percentage of veterans (22 percent) were found to have a probable mental health diagnosis based on symptoms over the prior 30 days, with approximately equal numbers screening positive for major depression and for PTSD (16 percent for each). Ten percent of the sample met criteria for both PTSD and depression. This suggests that veterans are at substantially increased risk for mental health problems, particularly PTSD, relative to similar individuals in the general population. In addition to those with a current probable mental health diagnosis, many participants felt that they would benefit from mental health services. Approximately half of the sample had a probable need for treatment defined by either a current probable diagnosis or a self-indicated need for treatment. About a third of those with a need for treatment had sought mental health services in the prior 12 months. Slightly more than half of those who sought help received a minimally adequate dose of treatment in the past 12 months. When asked about barriers to seeking treatment, the most–commonly endorsed barriers were concerns about the side effects of medications and concerns about potential institutional discrimination (e.g., by an employer or the government) against those getting treatment.

In addition to mental health problems, there was evidence that veterans face significant physical health and economic problems. Veterans were found to have significantly worse overall physical functioning scores than similar individuals in the general population. They were also unemployed at a significantly higher rate than the overall New York unemployment rate. In contrast, the level of alcohol abuse in the sample was very similar to that found among similar individuals in the general population, and relatively low rates of illicit drug use were reported.

Veterans were asked about specific benefits that they thought would be helpful to them. A majority of veterans viewed the following benefits as personally helpful: VA health care; education benefits; housing assistance, including home loans; and assistance at a VA vet center.

In contrast to the broad range of needs experienced by the veterans in the study, their spouses were remarkably similar to the general population. Their mental health, alcohol use, physical functioning, and rate of unemployment were all approximately equal to general-population norms. When asked about a range of common life hassles, few spouses reported being greatly bothered by them. However, when asked about problems experienced at the time of the veteran's return from deployment, 44 percent reported having problems dealing with their veteran spouse's mood changes, and 42 percent reported being worried about the possibility of future military deployments.

Conclusions

As we look across both the qualitative and quantitative needs assessment, several common themes emerge. First, it is clear from our study that veterans' health and well-being are the responsibility of more than just the VA. We found both in our focus groups and in our survey that other clinical and social-service delivery systems are critically important for addressing veterans' needs. The majority of veterans have other sources of health insurance, and much of the care delivered to veterans in New York is through either the civilian health care system or other public-sector providers. When thinking about how to improve the access to high-quality services for veterans, we need to think beyond making changes in the VA and look at factors in

the private health care system, such as severe restrictions on the amount of mental health care provided by some insurance; the availability of both counseling and drug therapy; the mental health screening and referral procedures of primary-care physicians; and the level of training in evidence-based treatments for PTSD and depression among civilian providers.

A second theme that emerges across the qualitative and quantitative needs assessments, as well as our review of the available services (in the appendix), is that the health care systems that serve veterans are extremely complicated. Enabling veterans to access the benefits and services that are available to them will require, in many instances, personalized assistance. Focus group participants widely praised the work of the new regional OEF/OIF care coordinators within the VA. However, (1) most veterans do not know about this resource, and (2) these coordinators are focused primarily on helping coordinate VA care and might not know about other resources or benefits available to veterans. Better outreach is needed to connect veterans with care coordinators who can provide personalized assistance across a range of service sectors. Such outreach is extremely difficult in the current system, which is likely to miss the veterans who are most in need of assistance—i.e., those who have not yet enrolled in the VA system. Improving this outreach would be facilitated by more-up-to-date data on the full population of veterans. For instance, this could be accomplished by having the VA get regularly updated addresses from the databases maintained by the Social Security Administration or Internal Revenue Service.

A third theme that emerges across both the focus groups and the survey is that addressing veterans' mental health needs will require a multipronged approach. It will require reducing barriers to seeking treatment; improving the sustainment of, or adherence to, treatment; and improving the quality of the care being delivered. Given the veterans' concerns about drug side effects, making sure psychotherapy is widely available might be important. Addressing veterans' concerns about occupational discrimination against those who get treatment might be more difficult. However, it might be helpful to educate veterans about the laws ensuring confidentiality of medical services (within both the VA and the civilian sectors), as well as recent changes to the security clearance process that reduce the likelihood of such negative outcomes from treatment. In addition to addressing these barriers, it might be critical to improve the overall quality of mental health care being delivered across all service sectors. This might require programs that increase screening in the civilian sector for the specific mental health problems that affect veterans, reduce wait times for counseling, increase the number of providers trained in the provision of evidence-based treatments for PTSD and depression, and provide mental health services at more-convenient locations and times.

Finally, many of the findings presented in this report have focused on mental health issues, which is consistent with the prominent role they played in both the qualitative and quantitative assessments. However, it is important to note that veterans have other serious needs. The current economic environment is extremely difficult for individuals who are making major career transitions. High unemployment is certainly a substantial threat to veterans' overall psychological and physical well-being. This suggests that job placement, education, and vocational programs might be a welcome and effective means to improve veterans' well-being. Similarly, there is a small, but important, subset of veterans who are facing substantial physical health limitations. Although there are disability benefits available to these individuals for limitations that can be shown to be service connected, there are a broader range of services that would likely benefit these individuals.

Acknowledgments

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Abbreviations

AAPOR	American Association for Public Opinion Research
AUDIT	Alcohol Use Disorders Identification Test
BLS	Bureau of Labor Statistics
BTBIS	Brief Traumatic Brain Injury Screen
CATI	computer-assisted telephone interviewing
CBOC	community-based outpatient clinic
CI	confidence interval
CUNY	City University of New York
DAST	Drug Abuse Screening Test
DMDC	Defense Manpower Data Center
DoD	U.S. Department of Defense
DSM-IV	<i>Diagnostic and Statistical Manual</i> , 4th ed.
EAP	employee assistance program
HHS	U.S. Department of Health and Human Services
HMO	health maintenance organization
IAVA	Iraq and Afghanistan Veterans of America
IED	improvised explosive device
LL	lower limit
MDD	major depressive disorder
MOVA	New York City Mayor's Office of Veterans' Affairs
NAMI	National Alliance on Mental Illness
NCA	National Cemetery Administration
NCS-R	National Comorbidity Survey Replication

NSDUH	National Survey on Drug Use and Health
NYSHealth	New York State Health Foundation
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PCL-M	PTSD Checklist—Military Version
PHQ-8	Patient Health Questionnaire 8
PIN	personal identification number
PPO	preferred provider option
PTSD	post-traumatic stress disorder
RONA	release of names and addresses
RPG	rocket-propelled grenade
SAMHSA	Substance Abuse and Mental Health Services Administration
SD	standard deviation
SF-36	Medical Outcomes Study Short Form 36 General Health Survey
SFAC	Soldier and Family Assistance Center
SWAN	Service Women’s Action Network
TBI	traumatic brain injury
TPA	Transition Patient Advocate
UL	upper limit
USERRA	Uniformed Services Employment and Reemployment Rights Act
VA	U.S. Department of Veterans Affairs
VAMC	U.S. Department of Veterans Affairs Medical Center
VBA	Veterans Benefits Administration
VFW	Veterans of Foreign Wars
VHA	Veterans Health Administration
VOC	Veterans Outreach Center
VSA	veterans’ service agency
VSO	veterans’ service organization
WTU	warrior transition unit
WWII	World War II

Introduction

Since October 2001, approximately 2 million U.S. troops have deployed as part of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). While advances in technology and battlefield care have yielded low rates of physical casualties, concerns have emerged about the incidence and prevalence of mental health disorders and other types of impairments resulting from deployment experiences.

There is a high level of public concern over these issues. The U.S. Department of Defense (DoD), the U.S. Department of Veterans Affairs (VA), and Congress have moved to study the issues, quantify the problems, and formulate policy solutions. They are beginning to implement the hundreds of recommendations that have emerged from various task forces, commissions, and research studies. However, despite widespread policy interest and a firm commitment from the federal government to address these injuries, fundamental gaps remain in our knowledge about the needs of veterans returning from Iraq and Afghanistan, the adequacy of the care system available to meet those needs, and the experiences of veterans and service members who use these systems. Since many veterans will seek care in the civilian health care sector, state-based programs that integrate services and provide comprehensive lists of available resources might help service members and their families. But a lack of information about veterans' state-level needs hampers states in their planning efforts.

We recently examined this problem in depth, conducting a comprehensive, independent study of these issues at the national level in 2008 (referred to as the "Invisible Wounds" study; see Burnam et al., 2009; Tanielian and Jaycox, 2008; Tanielian et al., 2008; *Post-Deployment Stress: What You Should Know*, 2008; *Post-Deployment Stress: What Families Should Know*, 2008; Meredith et al., 2008; Karney et al., 2008; Tanielian, 2009, 2008; Eibner, 2008; Jaycox, 2008). That project took a broad, societal view of problems that returning service members face, and it applied a health services perspective to develop policy recommendations. As in this study of New York veterans, we examined the prevalence of problems among returned service members and veterans and the systems of care in place to help them, including both qualitative and quantitative methods. We found that about one in five service members and veterans screened positive for a probable diagnosis of post-traumatic stress disorder (PTSD) or depression and that only about half of those had received any mental health care in the prior year. We identified important gaps both in access to care and in quality of care at the national level and made recommendations to help close those gaps that were widely disseminated to policymakers, to the media, and to key stakeholders.

Other research teams within the military and the VA health care system have also worked on these issues. We have published two recent reviews of this literature (Ramchand, Schell, Jaycox, and Tanielian, forthcoming; Ramchand, Schell, Karney, et al., 2010). These studies

have typically found PTSD rates among previously deployed individuals that vary between 5 and 20 percent, depending on the specific population being sampled. Rates of major depression are typically quite similar to the rates of PTSD. In addition, studies of veterans actively seeking services in the VA have found somewhat higher rates of PTSD, depression, and physical health problems than have been found in other populations of returned service members.

Although there are now many studies assessing the challenges that individuals face who were previously deployed for OEF/OIF, this existing literature is extremely limited for planning at the state and local levels. There are three reasons that these existing studies do not provide guidance to policymakers or service providers in the communities.

First, the existing studies have systematically excluded a large proportion—possibly the majority—of community-dwelling veterans.¹ Studies conducted by the military have looked exclusively at active-duty and reserve personnel, typically within the first six months of return from deployment. This excludes everyone who has left the military, as well as most National Guard and reserve personnel who have returned to their home communities. Even the one study that did include active-duty, reserve, and separated personnel (Schell and Marshall, 2008) did not include a sufficient number of separated personnel to allow separate estimates for just this population. In contrast, studies to date conducted by the VA have focused exclusively on OEF/OIF veterans who have enrolled in, and are using, VA health care services. Yet, it appears that the majority of OEF/OIF veterans who are eligible for VA health services have not enrolled. Thus, the VA studies exclude a large group of community-dwelling veterans, specifically those veterans who are not currently being served by the VA and might need services delivered by other civilian or public-sector providers.

Secondly, most of the studies to date have focused on the national population. The veterans residing in any given state or community might be markedly different from the national average. Many service members who leave the military stay in, or return to, states in which they have been stationed. This results in some communities having a large number of Army retirees while others might contain predominantly Navy retirees. Given the two substantial Army installations in New York (Fort Drum and the U.S. Military Academy at West Point), it is reasonable to expect that New York would have more Army veterans than the national average. Because the Army tends to have slightly higher rates of combat exposure and related health problems than other service members (Schell and Marshall, 2008), this might result in higher-than-average rates of these problems in the New York veterans' population.

Finally, most of the studies of OEF/OIF veterans have focused on a relatively narrow range of needs, primarily PTSD and related mental health problems. There is considerably less information about their needs across the broader range of services that states and communities might provide, such as other health, occupational, or educational benefits.

The current study is designed to address these shortcomings in the existing literature. It focuses directly on the veterans living in New York state, includes veterans who currently use VA services and those who do not, and looks at needs across a broad range of domains.

¹ Throughout the report, we use a definition of *OEF/OIF veteran* that includes all individuals who were deployed overseas in support of OEF/OIF and subsequently left active-duty military service. This definition closely corresponds to the eligibility criteria for Veterans Health Administration (VHA) benefits. It excludes most current active-duty service members but does include members of the National Guard or reserves, as well as a small number of individuals who left, but later returned, to active-duty military service.

The study took a three-pronged approach to the needs of veterans in New York state. First, we collected information and advice from a series of qualitative interviews with veterans of OIF/OEF residing in New York, as well as their family members. Second, we conducted a quantitative assessment of the needs of veterans and their spouses from a sample that is broadly representative of OEF/OIF veterans in New York state. Finally, we conducted a review of the services available in New York state for veterans.

The report is organized into four chapters and an appendix. Chapter One serves as a brief introduction to the overall report and frames the unique aspects of this research project. Chapter Two summarizes the methods and results of the qualitative interviews conducted with veterans and their family members throughout New York state. Chapter Three presents the methods and results from a survey assessing the health and well-being of veterans and their spouses in New York state. Chapter Four addresses the broader conclusions and recommendations that can be drawn from this research. In addition, the overall report is briefly summarized in an executive summary. An appendix presents a draft resource guide that is designed to help veterans and their family members better understand the care system that serves them and to describe many of the resources or agencies that serve veterans and their family members.²

² Readers unfamiliar with the systems of mental health care serving veterans might prefer to read the appendix before the other chapters.

Qualitative Needs Assessment of New York State Veterans

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To gain qualitative feedback from veterans and their families, we conducted focus groups and individual interviews across New York state. There were three goals for the focus group discussions: (1) to document how veterans and their family members think about the challenges they face; (2) to elicit opinions about the availability, quality, and comprehensiveness of available programs and services; and (3) to elicit innovative ideas for improvement.

Methods

Design

Our general design and analysis of the qualitative interviews were informed by our past qualitative research. Most of the interviews took place in focus groups, to allow for a discussion and synthesis of ideas among the veterans themselves. In addition, several individual telephone interviews were conducted with individuals whose unique characteristics were not adequately captured among the focus group participants. The focus groups were distributed geographically to reflect the different issues and availability of resources in different parts of the state. Each group was designed to include a diverse pool of participants. Specifically, we attempted to include important veteran “minorities” in each focus group, including women, officers, reservists, and those with 50-percent (or higher) disability ratings (as determined by either the military or VA process). We also included spouses, siblings, and parents of veterans to provide input on the issues of veterans’ families. In order to maximize participation, groups were scheduled for times that were convenient for prospective participants (typically, weekday evenings) and included a light meal. As a token of appreciation, participants were paid a cash stipend of \$50, and each group ran for approximately two hours. All groups were audio recorded and transcribed, and the transcripts were coded and analyzed by RAND research team members. The focus group protocol was approved by the RAND Institutional Review Board.

Recruitment

We identified potential participants through Iraq and Afghanistan Veterans of America (IAVA), which had been funded by the New York State Health Foundation (NYSHHealth) to assist with recruiting interviewees. IAVA sent an email to its members who lived within 50 miles of each of the cities where we planned focus groups. The email informed IAVA members about the study and directed them to a page on the IAVA website where they could register to participate in a focus group. We supplemented IAVA’s recruitment efforts by reaching out to members of the project’s Stakeholder Advisory Panel and other stakeholders (e.g., NYS Division of Veter-

ans' Affairs, office of the Adjutant General's of New York State) in the cities in which focus groups were to be held. In addition, a one-page flyer with information about the focus groups was placed in areas where veterans might gather (e.g., VA hospitals, vet centers). To ensure participation from a diverse cross-section of veterans, we attempted to include, in each of the focus groups, disabled veterans, veterans enrolled or planning to enroll in college, and female veterans. These groups were targeted by IAVA using emailed invitations for the focus groups.

Procedures

Each focus group was attended by two RAND project team members: one to moderate the discussion and one to take notes. We developed a focus group guide to structure each focus group discussion. The moderator began each focus group with an overview of the project and then obtained oral informed consent from all group members. After consenting, focus group members introduced themselves by first name and talked about when their last deployment was and what they have been doing since they returned. Focus group members were then asked to discuss challenges that veterans and their families might have faced in reintegrating since coming home from Iraq or Afghanistan. They were prompted to discuss challenges related to thoughts, feelings, and behaviors, as well as challenges related to everyday life (e.g., housing, employment, family life). Next, focus group members were asked about the available services for returning veterans and family members, as well as their opinions about the quality of these services. Finally, focus group members were asked to discuss what facilitated or served as barriers to veterans and family members seeking help (e.g., finding information about where to seek help) and to identify novel ideas, strategies, or programs that could help to make reintegration easier for veterans and their families.

Participation

Between August and October 2009, we conducted six focus groups in Buffalo, Watertown, Albany (where there were two), New York City (Manhattan), and Long Island (Old Westbury), including four focus groups of veterans only, one group of female veterans only, and one group of family members only. In total, 49 individuals participated in the six focus groups, including ten female veterans and four family members of veterans. Participating veterans varied in age, education, service, rank (officer versus enlisted), service-connected-disability status, and length and date of deployment.

To ensure that we adequately captured the perspectives of female veterans and family members of veterans, we augmented our sample with individual telephone interviews, following the same discussion guide as used for the focus groups. We completed an additional three one-on-one interviews with female veterans and five one-on-one interviews with family members of veterans.

Analysis

Qualitative interviews are useful for gaining insight into how individuals think about specific issues, documenting the diversity of opinions, and generating creative solutions to problems. However, the opinions expressed should not be seen as accurate representatives of aggregate public opinion, and the beliefs expressed might not be factually accurate.

Our analysis of these qualitative data is designed to summarize the content and tone of these conversations—the analysis was not designed to assess the validity of specific pre-existing theories. Information about the number of individuals who expressed various opinions

is sometimes provided in this report to convey the tone of the conversation; however, the reader should not assume that the number of individuals who expressed a viewpoint in our interviews indicates how widespread or accurate that viewpoint is.

Focus groups were attended by two RAND researchers, one of whom took detailed notes designed to summarize the primary points of the discussion while the other moderated the discussion. These discussions were also audio recorded and transcribed. After the interviews, these notes were edited and expanded by the moderating researcher. Notes from all groups were collated into the various discussion topics contained in the protocol. Themes that emerged across or within groups were extracted from these compiled notes and written up in narrative form. The lead author of this chapter then compared this narrative summary to the actual transcripts, to identify omitted points of view as well as to verify that included quotations were accurate.

Results

Information from participants in the qualitative interviews is organized into three sections corresponding to the focus group protocols: perceptions of the challenges that veterans face, perceptions of available services, and suggestions for improving services.

Perceptions of the Challenges That Veterans Face

New York state veterans returning from Iraq and Afghanistan reported facing a variety of challenges once they got home, which are outlined in this section. These included stress and mental health problems, social isolation, confusion about their benefits and how to access services, difficulty finding employment, and funding education. They also reported difficulties in VA disability evaluations and a lack of support for families; female veterans were mixed in their opinions about the availability of VA services specific to their needs.

Stress and Mental Health Problems. Focus group members reported challenges managing life stressors upon returning from deployment, as well as significant post-deployment mental health problems, such as PTSD. Many discussed the challenges they had in talking with their families about their deployment as well as about their symptoms. Many expressed the belief that their mental health problems were different from problems experienced by non-military individuals and that no one really understood what it was like to be in combat.

The stress of reintegrating into civilian life and responsibilities after deployment can be great. Many veterans reported that they did not have enough decompression time between returning from Iraq or Afghanistan and returning to work and family responsibilities, expressing that there is an expectation that one should “get back into the swing of things”: “You have to make that transition right back into being a normal guy, normal person, normal individual, and just shift completely back again.” For those struggling with mental health issues, the stress of reintegration could be especially oppressive:

They give you two weeks of leave and then you have to start paying bills again. I thought my head was going to explode. It was almost like I had tunnel vision and the only thing I could see was everything bad at the end of this tunnel: I’m going to lose my job, I’m going to lose the house, going to lose my wife, my kids are going to have to go on welfare. That’s all I could see.

Veterans reported symptoms of mental health problems, such as “feeling really depressed and even thoughts of offing [myself].” One person related an incident in which he dressed in the morning to go look for a job and his wife returned at 5:00 p.m. to find him still sitting there, since “I forgot where I was. It was bad.” A family member reported finding her sister “naked on top of the refrigerator curled into a ball . . . not letting anyone go near her.” Mental health problems affected individuals across rank and profession. A family member whose spouse was a social worker in the military related an incident at a Memorial Day parade in which her husband became anxious to have his wife and children standing right beside him because, “at any moment, an IED [improvised explosive device] could come down and we’d all be dead . . . and it wasn’t until [then that] we realized he was affected [with symptoms of PTSD].”

Many veterans reported that they had a difficult time seeking help for mental health problems because “then you’re weak and untrustworthy. . . . You know you’re supposed to be tough.” Others waited to seek help because they worried that it would affect their employability: “I didn’t want people to know. If I’m going to go for promotion or something: ‘Oh, he’s not right in the head. We can’t promote him.’” However, others were able to overcome these perceptions and barriers by focusing on their service:

I just don’t care what other people think, honestly, anymore. I’m proud of what I did, you know. I know a lot of people who wouldn’t have done what I did, and I served them and I served this nation.

Several veterans reported using writing as a coping or processing tool; veterans who were enrolled in college mentioned writing essays and papers for college classes about their experiences. Others used public speaking opportunities for the same purpose, finding them “extremely therapeutic.”

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. One veteran described his frustration at civilian co-workers who complained about how hard things have been for them or commented that “things have changed since you were gone,” implying that he was no longer competent at work. As one person related, “I came back to a completely different place where my friends were seriously concerned about what to wear. . . . I was angry because I felt like I really couldn’t relate to anyone.” Many veterans expressed frustration over the perception that their deployment was comparable to an extended vacation. One veteran described how difficult it was to adjust to life’s challenges:

Things happened when I came back that I was unprepared for. My sister had cancer, but people were told not to tell me. We discovered that our roof was leaking and would cost \$18,000. And my daughter, who used to be my best friend, suddenly announced she was getting married. These things were overwhelming.

Social Isolation. Veterans participating in the discussions consistently cited trouble relating to civilian peers, as well as feelings of loss surrounding military discharge—particularly in terms of lost camaraderie. Veterans also reported that the social isolation was difficult to address. The civilian-military cultural divide was a shared challenge for many group members upon reintegration.

As one person commented,

I think it's always going to be impossible to really show or represent what we've been through to somebody [who's] never been in a situation that we've been in and deployed. I think that rift is always going to be between veterans and civilians, and . . . it's going to be impossible to get past it.

Another person felt similarly misunderstood:

If someone finds out you're a veteran, or you tell someone you're a veteran, you're a monster or you're a victim. . . . They're not really listening to you because they've seen the movies or they've watched the news so they know what it's like. . . . I only see true understanding when I meet another veteran.

Another commented on the frustration of trying to relate to civilians: "When I'm faced with civilians who don't understand what I've been through, it's really difficult to try [to] get on the same level with them without making [myself] feel pathetic."

Veterans attending college reported feeling isolated on campus. One person commented that, when she started school, she "only felt comfortable with people that [she] saw in uniforms." Similarly, one person commented, "I was in school with people [who] were, like, ten years younger than me. And I was frustrated with their attitudes and disregard [for] what was going on."

Several veterans reported difficulties meeting new people and forming new relationships, commenting that they often do not say anything about their service when they meet new people, especially trying to avoid certain situations: "Sometimes I'd be eating and people would meet me for the first time and ask how many people I've killed." One female veteran complained, "Why does every guy I date want to know how many people I've killed?"

In addition to affecting veterans' ability to form new relationships with civilians, some also found reconnecting to previous relationships difficult:

It's hard to describe [to family and friends] what happened, how it affected me, and why my ability to trust people has changed. [Before deployment], I was connected to my church, my family, my neighbors; when I left, they were only missing one person, but I was missing everyone. I kept saying to myself, "They're not the way I remembered them." I had gone to bed looking at a picture of my family on the locker, but, when I came back, they didn't seem that excited to see me . . . but, then again, I wasn't the mom they said good-bye to either.

Confusion About Benefits and Eligibility. Although most veterans reported that they had received some information about their veterans' benefits during out-processing or demobilization procedures, the quality and amount of information appear to have varied greatly by unit, service, and deployment date. In particular, those returning from more-recent deployments reported being more informed about available resources and benefits than those who redeployed years earlier.

Many expressed that, while they did receive some information during out-processing about benefits and services, they were so focused on going home and seeing their families that they did not pay attention to the briefing and could not remember the information weeks,

months, or years later when it was needed. One person remembered being told to file for disability but was unsure where or how to do that. Another pointed out that “you’re not really thinking about what’s going to happen six months down the road when the real problems usually end up starting.” One person described out-processing as “500 people in a room, packed in a room in folding chairs, and there’s death by overheads. . . . For most people, [this] was a waste of our time and a waste of resources.”

There is confusion about eligibility for benefits, especially among veterans who did not receive a disability rating upon separation. Several people reported that they noticed service-connected health problems after separation and thought they were not eligible for benefits because they had not claimed these problems prior to separation. One person was on medication he received during active duty but wondered, “when those prescriptions run out, is that it for me? Even though I would consider them service-related issues, things like respiratory problems, some stomach issues?”

Others felt that there was too much information to digest without an understanding of where to start. One veteran said, “You could Google services for veterans, and you [would] get 16 million pages. Where do you go first?” Similarly, another said, “There are so many different programs out there. A lot of the problem is the coordination, the facilitation of the programs, knowing how to connect to them and network through.”

However, lack of information and knowing where to start was not a universal experience. For instance, individuals near Watertown expressed that they knew where to receive help and that they had “so many magnets and pamphlets.” However, this appears to be due to a unique feature of being so near a major military base that helps coordinate services for both active-duty service members and veterans.

Unemployment and Under-Employment. The majority of focus group members also reported that they struggled with employment issues. They cited the inadequacy of existing placement services and mixed information about veteran-preference programs. Veterans claim that, while employers might ask about service connection (or, more often, this is asked on a form they fill out) and those with service-connected disabilities are supposed to get priority, they do not get hired and suggest that it is due to discrimination. Veterans also reported frustration with unfulfilled promises about jobs with local and state government, that politicians and town supervisors did not “put their money where their mouth was” in regard to jobs for veterans. Obviously, this problem is exacerbated by a historically high unemployment rate during the period in which we conducted these interviews.

In many of the focus groups, veterans perceived that employers had a bias against hiring veterans, both because they might be activated (reserve/guard) and because they might have mental health problems. To help with this, one person suggested that a company’s ability to receive government contracts should be tied to the number of veterans it hires.

Several veterans also expressed frustration with the disparity between their expectations about their employability and their reality of struggling to find employment:

One of the big misconceptions . . . coming off active duty [is that] you walk on water. Companies are going to be coming to find you. They’re going to be recruiting you. [You] never really had that reality check, that . . . you’ve been out of the mix for years. And what you’re doing is not relevant to what’s going on in the civilian world. And they are more impressed with your Microsoft certifications than they are with your leadership time.

Another commented,

I think [that] within the military, you're really built up to say all this stuff you're doing is going to help you in the future. But . . . you're really not a whole lot different from when you left high school, as far as what your skill set is for a lot of jobs. I think I had over 80 positions I applied for, actually interviewed for, skills tests, whatever else, [in] multiple states before I could finally find work.

One challenge that emerged consistently is the issue of translating military experience into employment following discharge. The military does not require certification for many jobs, but the civilian sector does not always recognize military on-the-job experience, making it difficult for some to get a job. As one person said, "I was a mechanic in the military, but I don't have any certification. . . . It makes me feel like my service was a waste."

Veterans also discussed the insufficiency of job-protection regulations (e.g., the Uniformed Services Employment and Reemployment Rights Act [USERRA] [Pub. L. 103-353, 1994]). One person did not have a job after deployment because the company for which that person had worked before deployment had gone bankrupt. According to one veteran, USERRA "doesn't guarantee your job back; it guarantees a job that may not be the same job [or] it may not be in the same location." One person returned from deployment and had to interview for a new job in the company because someone else had been hired to fill his previous position. The stress of starting a new job on top of reintegrating was intense: "I thought my head was going to explode."

For reservists, reintegrating to a civilian job was also challenging. For one person, processes at his job changed during his deployment. His co-workers told him, "We don't do that anymore. You've been away. We've had it rough here. And I'm like, 'Ah. Yeah, I was on vacation for 11 months. Thank you very much.'" Another person had a similar experience of co-workers acting as if he had been on vacation rather than fighting a war:

They don't understand why certain things to you just aren't important anymore because, to them, you were on vacation. You weren't here. Their world kept going. Your world kept going, but the two had nothing to do to correlate together. So they just don't quite understand why you can't just step right back in to what you were doing beforehand.

Difficulties Funding Education. A couple of participants expressed challenges related to funding higher education. While none expressed lack of access to higher education, per se, some expressed frustration with administrative processes and errors that delayed GI Bill benefit payments to their educational institutions.¹ One wife of a veteran expressed: "He's been taking classes, and that's been a nightmare. . . . The school expects payment on his semester bill. . . . I mean, we haven't gotten anything and the semester's close to being over."

Difficulties with Disability Evaluations. Some veterans referenced the military culture as a factor that promoted minimizing difficulties while on active duty. Veterans reported that they did not document their injuries and mental health problems during active duty because

¹ *GI Bill* is an umbrella term often used to refer to a bundle of veterans' rights conferred or affirmed in one or more of the following laws: Servicemen's Readjustment Act (Pub. L. 346, 1944), Adjusted Compensation Act (43 Stat. 121), 1984 revisions to the U.S. Code (known as the Montgomery GI Bill), and the Post-9/11 GI Bill (part of the Supplemental Appropriations Act, Pub. L. 110-252, 2008).

they did not want to be perceived as weak; this has caused problems upon return with acquiring appropriate disability ratings. The inability to prove that conditions were service related resulted in practical barriers to getting help at the VA when discharged. One veteran described the pressure to avoid reporting health problems in the military:

You could just suck it up, and drive on, . . . not reporting injuries, fearing that you could possibly be reclassified into another job category, and you could [fail to get promoted to the job you want]. You got to go and do something else. So you never really report any of your injuries, which is a bad idea when you come out of the military. You don't have any documentation.

Lack of documentation of problems might be compounded for reserve and guard members, who are “dual citizens” in the military and civilian worlds. These individuals worry about having to maintain a physical profile in order to keep their military jobs. “A lot of people have [health] issues but don't bring them forth,” instead seeking care from private physicians or trying to “take care of it themselves.” For individuals who cannot afford private care, health problems might get worse, especially if they have avoided tests or surgeries so the military would not find out about the problems. Instead, they “stuff it and pray [that they] can stay healthy enough to make it” to retirement.

For those seeking disability benefits, veterans expressed frustration that those who are conducting the disability evaluations do not understand their combat experience. Although the rating of service connectedness is the basis of VA treatment priorities and, thus, benefit eligibility, the participants reported that the person doing the ratings might not have any idea what their service experience was. One person commented that his evaluator did not know what an RPG (rocket-propelled grenade) was. Another said that “the people assessing the damage [do not] even know what combat triggers and stressors are.”

Lack of Support for Families. There was a perception that there were few available services for family members, especially at the VA, even though many veterans cited high divorce rates and broken or strained marriages after deployment as evidence of an ongoing need for support for families. One person recognized that there were some family support groups but said that they were not relevant to the needs of his family: “Your wives can go sit down with the [spouses of] Vietnam vets, but it's a bad mix. It's not the same thing. It really isn't. It doesn't make the right, proper fit for what they're going through.” Some family-member participants mentioned groups, such as Blue Star Mothers, a support organization for mothers and families of service members and veterans, and Strong Bonds, a support resource for married service members and veterans. However, although these groups and programs were mentioned as helpful, participants commented that these and similar types of programs (e.g., summer camps for military children) were under-resourced and generally do not directly provide services.

Family members who were able to utilize a local Family Readiness Group—command-sponsored organizations designed to provide information, resources, and support for families of deploying service personnel—emphasized those groups' importance. One mother of a veteran stated that the Family Readiness Group made it “absolutely wonderful . . . to be able to pick up the phone and talk to somebody. . . . I think every National Guard unit in the state of New York, if they don't have one, should have one.” However, families of reservists and those whose service member deployed as an individual augmentee or with an out-of-area unit faced additional challenges during deployment, as there were no local Family Readiness Groups to

check in with them or to serve as a support during deployment. Now, post-deployment, these families reported that they continue to feel isolated and experience a lack of resources.

Family members indicated that there was little to no information available to them about what to expect when their family member returned. One mother worried about how to talk with her son about what he had been through. For some family members, knowing “what to watch for” was a challenge: “If I knew what to expect . . . drug and alcohol abuse was all I looked for. . . . I didn’t expect the withdrawal.” Knowing what to expect was particularly challenging for family members who assumed caretaking roles for disabled veterans. Finding out about available health care opportunities and helping the veteran navigate the system was a daunting task. As one person commented, “there’s really no one contacting families to say, ‘Look, this is a list of things you can do. These are a list of outreach programs.’ Nothing.” However, online and print media, such as a newspaper disseminated by the National Guard, proved helpful for informing some family members.

Issues for parent caretakers also included frustration over getting high-quality health care for their children. Families struggled with not being able to be involved in the veteran’s treatment, unless specifically invited to do so by the veteran. They commented that, “in order for them to get better, we need to be able to be involved in their treatment because they’re either not going to get it or it’s going to be hard for them.”

There was also a perception that support for families in financial distress was inadequate:

I was going to college when I was activated, I had to drop out of that program. [In the military,] I was an E-6,² and it was the best money I ever made in my life. When I came back, I was on unemployment. We ran up a huge amount of credit card debt, and there was nothing else we could do. The Sailors’ and Soldiers’ [Civil] Relief Act³ only keeps [creditors] from charging you more interest.

Women’s Services. Some female veterans had little confidence that the VA could meet their medical needs and preferred to seek care within the civilian sector: “[The VA] probably needs better women’s services. I went there once, and it seemed like the place was filled with WWII [World War II] vets [who] have prostate problems.” A female veteran who had received care from a women’s clinic at the VA was very satisfied with her care and was “thrilled” to have a woman-specific facility, since, while “no one wants to be treated different[ly],” the problems that female veterans face are “different and personal.” However, one woman expressed her dislike of woman-specific programs at the VA because, whenever she sought help, program staff assumed that the help she was seeking was related to military sexual trauma.

Perceptions of Services Available to Veterans and Their Families

Interviewed veterans were asked to list the various providers of veterans’ services that they knew about, as well as to share their opinions about these various providers. Across the diverse set of interviewees, a wide range of service providers was discussed. These included federal, state, and local agencies that directly provide services to veterans, as well organizations that help connect veterans with service providers.

² Sixth rank of an enlisted service member.

³ Now the Servicemembers Civil Relief Act (Pub. L. 108-189, December 19, 2003).

There was a general appreciation for those individuals or organizations that helped coordinate or advocate for veterans' benefits. There was a broad awareness of VA "vet centers," and these centers were generally highly regarded. There was also an appreciation of VA employees who served as OEF/OIF coordinators (those who serve as a general point of contact to help new veterans navigate the VA systems). However, although these coordinators are available in every VA medical center, only interviewed veterans in certain regions (e.g., Long Island) were aware of them. There were also specific individuals or regional nonprofit agencies that were mentioned as being very helpful in attempts to coordinate services. The Veterans Outreach Center (VOC) in Rochester and the Soldier and Family Assistance Center (SFAC) in Watertown were mentioned as providing relatively comprehensive coordination of services for both veterans and family members. Similarly, interviewees mentioned regular emails sent by a regional VA director that included job listings, as well as information about VA activities and programs. However, these informational resources were described as not always well publicized or only locally available, making it appear somewhat haphazard whether a new veteran gets connected with a coordinator or gets put on an email list.

For wounded veterans, the Wounded Warrior Project, a nonprofit organization that supports wounded veterans, was mentioned as doing a comprehensive job of providing information about available services and benefits and helping to coordinate access to those services.

Several interviewees also mentioned less formal resources for assistance in the coordination of services, such as websites and discussion groups at military.com (Monster, undated) and iava.org (IAVA, undated). Also mentioned were veterans' groups at colleges and universities. For family members, interviewees mentioned Blue Star Mothers as a source of information about available services.

While there were a large number of resources mentioned that could help educate veterans about the available services or connect veterans with needed services, there were fewer agencies mentioned that directly provide services. Interviewees mentioned that the New York State Department of Labor and Division of Veterans' Affairs provide assistance in getting employment (particularly civil-service jobs) and applying for state programs or financial benefits. The federal VA itself was mentioned as the primary source for medical and mental health treatments, including both less-formal treatment at vet centers and VA medical centers (VAMCs) and clinics. For the most part, participants were not able to identify many other sources of mental health care (although one interviewee mentioned North Shore University Hospital as a source of free mental health treatment for military members and their families). For these reasons, the veterans' discussion of both the quality of health care and the barriers to health care applied almost exclusively to VA-provided services.

Perceptions of the Quality of VA Medical Services. The perceived quality of the services available at VAMCs varied widely by facility and location. In fact, veterans who had received care at more than one VAMC in the state commented on the lack of standardization of care and the fact that quality differed greatly. This was reinforced by the differences in how veterans talked about the VA from focus group to focus group held in different locations.

Some had very good things to say about the VA and experienced good coordination of care. For example, one person commented, "I haven't had any bad experiences. . . . They do terrific work." Another even went so far as to say, "I love the VA. If I could send a big, giant gift basket to whoever decided to make it happen, I would. Because the VA has been a lifesaver for me." Another experienced good outreach from the VA when he missed an appointment and received a phone call. Similarly, one person expressed, "They always contact me and make

sure I make my appointment and get my drugs and everything. And they've gotten me good counselors [who] are combat vets, because that's what I asked for."

However, others had negative experiences, especially with the look and feel of VA medical facilities, where, in some cases the lobbies were filled with disabled or mentally ill, older veterans:

One of the biggest turn-offs I had in my entire process was actually going to the VA for the first time. . . . You walk in there, see what you see in the lobby, see what you see in the elevator and go, "This probably isn't the place for me." [There are] people [who] need this resource a lot more than I do.

Several people complained that they only received medication for PTSD rather than more-comprehensive treatment, claiming that, when they go in for a visit, "they change my medication and up the dose. That's all they do." Another veteran said,

We have TRICARE (my husband is a military retiree)⁴ so we really don't go to the VA. The VA clinic here was very small, understaffed; you have to wait too long. Since I've been back, they built a new clinic, but our health care is covered, so I can see a civilian doctor. The nearest VA hospital is three hours away.

Another veteran who had been an inpatient for combat PTSD expressed that the inpatient unit was staffed only from Monday at noon to Friday at noon, the food was inedible, and the facility was unclean.

Some participants also expressed the opinion that VA health care providers were disrespectful and not compassionate, treating the veteran as just a number and wanting to rush through service provision to get the person seeking treatment out the door. One participant remarked that her family found the providers lacking basic knowledge of appropriate therapeutic approaches for treating psychological problems.

In contrast to the mixed reports on the quality of care at the VA medical centers and clinics, veterans had overwhelmingly positive things to say about their experiences at vet centers (locations at which services are provided veteran to veteran): "They helped me more in one week at the vet center than I got in six months at the VA." For at least one person, the vet center provided continuity of care "just having the same person to talk to who remembers."

Barriers to Getting Services at the VA. The participants identified several perceived barriers that make it difficult to access the medical and mental health services available in the VA. These are discussed in this section and include difficulty getting information about the services, the excessive time it takes to travel to VA facilities, the narrow hours of available services, difficulty getting appointments, the "red tape" required for getting benefits, and the perception that the VA is geared exclusively for older-generation veterans or veterans who are more-severely disabled or injured.

⁴ TRICARE, the military health care benefit, is available to eligible retirees. Under TRICARE, eligible military retirees can seek care through DoD medical treatment facilities or through civilian providers that accept TRICARE as an insurance carrier. The VA operates the largest integrated health care system in the United States. Care is provided to eligible veterans through a priority enrollment system in VA-owned facilities and clinics located across the country. There are no DoD-owned military treatment facilities in New York state, and there are 12 VAMCs and 38 community-based outpatient clinics (CBOCs).

Perhaps the most-common barrier to getting services was a lack of information about what services were available, how to access them, and how helpful the services were. Across all focus groups, there was the great variation in veterans' knowledge and awareness about the services and benefits for which they might be eligible. The preferred method for sharing information about resources was vet to vet; participants endorsed the idea of relying on peers for learning about programs and for tips in navigating systems. This was evident both during the interviews and focus groups and in numerous anecdotes from veterans about how they actually accessed information. There was also significant variation in the availability of information and the nature of experiences upon redeployment and reintegration based on time of redeployment and military rank. That is, the availability of information seems to have improved for veterans who have returned from deployment more recently, as compared to those who were deployed earlier in OEF/OIF. However, veterans who had been lower-rank service members continue to face challenges in knowing what to expect and where to find information. Participants thought that having higher education or being currently enrolled in school offered major advantages with respect to access to information and ability to successfully meet challenges. In general, the overriding sentiment was that most of the formal methods of providing information about services were not very effective. Instead, several people reported that they found the most-useful information about available services and benefits informally, through conversations with civilians or other veterans. One person found out information from his landlord, who was a Desert Storm veteran.

Another significant barrier was the difficulty in traveling to appointments at VA facilities. Several people noted that proximity to a VA facility mattered greatly; those living far from a VA facility had to devote most of a day to attend appointments, which interfered with employment. This was especially problematic for individuals being evaluated for service-connected disabilities. Veterans reported that the process to obtain a disability rating requires multiple medical visits, which could each be a "whole-day event" for someone who lives far away from the medical facility. Similarly, those undergoing counseling for PTSD might have to travel to weekly appointments. Even for those who live within an hour of a VAMC, which would be relatively close, a weekly appointment could require four hours off work per week.

Many interviewees reported that this problem is made more acute because many VA facilities are open only during normal business hours. Although some VA facilities have evening or weekend hours, many operate Monday through Friday, 8:00 a.m. to 4:00 p.m.

Others reported that there were few available mental health appointments, with long wait times for an appointment. Although one person noted that a veteran could get an emergency visit if he or she "were willing to sit around the VA all day" but that then the person would have to wait six weeks for a follow-up appointment. Veterans commented that, if they wanted more-frequent appointments, they would have to use different providers, which means telling their story over and over again and a lack of continuity of care. Similarly, getting into some of the intensive programs was seen as difficult, due to highly restrictive eligibility requirements. The veterans felt that more flexibility was needed in order to serve the veterans who wanted and needed mental health care.

Another barrier mentioned by several interviewees was a high level of frustration with the bureaucratic steps required to get benefits. Veterans felt as though the federal government was "making [them] work" for their benefits, with anecdotes about missing one appointment and getting "kicked out of the system," having to start all over again or the VA "losing" paperwork. These experiences led veterans (and family members) to perceive that the VA does not

want them to use their benefits. The fact that these benefits had been presented as an entitlement during recruitment into the military was especially frustrating to many veterans: “This is what you said you’d give me when I signed up, remember? . . . Well, damn it, I served you. . . . I want what’s mine.” In particular, the time commitment required to apply for benefits was seen as excessive for those who are employed and as representing a significant “hassle.” One person described it as a “full-time job” and that it was “a nightmare. I mean it was a total nightmare—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 give up.” However, one person commented that trying to do everything online helped.

The final class of barriers that focus group participants discussed was related to a general perception that the VA is not designed for people like them. This shows up in several ways, including the belief that available services were designed primarily for people who have severe health problems, were designed for older-generation veterans, or are staffed with counselors without an understanding of the OEF/OIF combat veteran experience. Specifically, several veterans reported that the VA makes them feel as though they do not deserve to get help, that they are not wounded enough, that they should feel they are lucky to be alive with “ten fingers and ten toes.” Some felt that, by accepting help, they would be taking away the resource from other veterans who need it more: “These guys really need it, and I’m taking it from them. . . . For every time I go to seek counseling, I’m taking it away from some homeless vet [who] really needs counseling.” “It is extremely hard to admit, ‘Hey, I need help.’” As another person said, “I didn’t want people to know that I had something wrong with my head.” One parent caretaker indicated that her child veteran was upset at being perceived by others as needing help.

Similarly, one veteran was frustrated that none of the available resources is designed for people who “look like you.” This makes it uncomfortable to seek help and, “if you don’t feel comfortable getting help, you’re not going to get help.” This problem was not unique to the VA but was also mentioned with regard to veterans’ service organizations, such as the American Legion. While these resources were frequently cited as potential resources for veterans, the common perception in the focus groups was that these organizations were full of old men “smoking and drinking.” On the other hand, some participants reported that they had become members of these groups and that these groups want “young blood” and are eager to help.

Finally, several participants expressed the sentiment that the VA is not always staffed by people who understand the OEF/OIF combat experience. Participants expressed the desire that the VA be staffed with veterans and especially that therapists and those conducting disability evaluations be combat veterans, who would understand what they had been through. “I think the people in these positions need to have experience with it themselves. They need to either come from the combat arms or even have been in combat situations themselves I think before they should qualify for those positions.” For people seeking counseling, having a therapist with combat experience was especially important. One person had an experience in which “I was getting counselors right out of the [local university], 23 years old, and it was just outrageous. They couldn’t understand. I had them crying. That was very unprofessional and I couldn’t deal with it.” Another person, whose therapist at the vet center was in the Army reserves, agreed: “She obviously wasn’t in the infantry and can’t relate, but she can relate more than just some random [woman] who came out of [local university].”

Veterans' Suggestions for Improving Services

Participants were asked to provide their own ideas for the types of programs, strategies, or services that might have made their reintegration go more smoothly, that could have addressed some of the barriers they mentioned, or that might address some of the problems and challenges they identified. In general, veterans and their family members mentioned a range of ideas and suggestions that would address the types of issues they encountered. These suggestions could be grouped into five broad categories.

Create a Centralized Source of Information or a Sponsor. Veterans suggested two methods for connecting veterans to information about services and helping them navigate through the system. First, many veterans expressed a desire for a central source of information about their benefits and services, a “clearinghouse” or a phone number to call “and [say] I’m having trouble with this or do they offer this? Where can I go for that? And having somebody who basically has that [information] at their disposal.” The idea was that an expert who knew about all of the various benefits and systems of care would guide a veteran through their options and help with filling out applications and getting appointments. Some would prefer this information on a website: “here’s-what’s-available-for-veterans.com.” One person suggested that it would be helpful to have a state-specific resource, such as a state website with information and links about services, benefits, and other relevant resources. It is important to note that some veterans commented that these resources are already available to those who are still in the guard and reserves, citing as an example Military OneSource (DoD, undated), an online and telephone-based support program that provides information and counseling to eligible military personnel. Although many noted that they did receive benefit information during out-processing, they were not able to remember the information and wished that the information had been given to them “on a CD,” including 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.” 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. On the other hand, not all participants held the view that it was difficult to find good information about benefits and services. One veteran commented that there was “no excuse not to get the information you need” and that there are excellent websites for veterans’ services that might require a little research.

For VA-specific information, veterans were aware that the VA develops “benefit books” every year. One veteran suggested that those books be mailed to all veterans who have not used VA services. However, some people in western New York reported that they had received these books in the mail, a “glossy magazine-type thing that talks about health issues and things like that.”

Second, there was a consistent desire for some type of “sponsor,” perhaps similar to a “Sea Daddy” as used in the Navy, who would be available as a resource for new veterans to help them navigate the process. There was some concern about how to certify this role. Veterans did not want paper or email contact; people wanted a phone call—a personal connection. The sponsor role was described as someone “responsible for tracking you down,” who “tracks down and talks with the soldier . . . so we don’t get any of these guys lost” in the system, “someone there who is a buddy, or a big brother.” There was a wish for special outreach for people who are specifically dealing with mental health or traumatic brain injury (TBI), “things that basically personally degrade your ability to advocate for yourself.”

Building Community for Veterans. Veterans commented that the most-important thing is “to be able to vent. I think that there are a lot of services out there, but I think the most important thing is for veterans, Iraq [and] Afghanistan veterans, to talk to other veterans.” Across the groups, there was a strong desire for getting together in person with other veterans, similar to Veterans of Foreign Wars (VFWs) or other veterans’ service organizations (VSOs) that were established for older generations of veterans. One person suggested that service members should be connected pre-deployment with VSOs to ensure the connection throughout deployment and afterwards. For those enrolled in college, campus veterans’ groups were helpful (where available) and desired (where not available). Some even felt that the focus group itself was therapeutic: “It’s almost like healing for me just to be in the same room with other vets. It’s kind of like group therapy without admitting it.” Finding community to connect to was also relevant to female veterans:

I would like the opportunity to sit and talk with other female veterans, to compare notes. Because there are so few of us, and we are really different from each other, . . . it’s hard to connect on our own. Being a soldier is a masculine identity, so, when we come back, we almost have to pick what role we want to be. It would be nice to be able to talk about that.

(It is worth noting, however, that these interviewees are somewhat unusual in that they volunteered to attend a focus group discussing veterans’ issues. It is likely that any veterans who did not want this type of “community building” would not have participated in this type of data collection.)

Improve the Out-Processing/Demobilization Processes. As mentioned earlier, veterans commented that information on reintegration and benefits was not well presented at out-processing. At that point, service members were thinking only about going home and seeing their families and could not take in any of the information, which turned out to be a problem later on when they needed to find services and apply for benefits. In one group, there was an innovative suggestion that the last week of active duty, when service members are out-processing, be spent at a base close to home:

Instead of a two-week-long demobilization process, maybe chop that in half, then complete the rest at your home-station armory, because you get to go home, see your family, cool down, and maybe you can even take your family with you when you’re getting all of this information. . . . Far . . . preferable [to] sitting in Fort Dix for two weeks and going crazy.

A related suggestion would be to institute a program of active outreach to veterans after they have returned to their homes.

Improve Access to and Quality of VA Care. Interviewees made numerous suggestions about how the VA could be improved so that they would be more likely to access VA care and that the care would be more helpful. Others suggested that there was a need for more VA outposts and vet centers that are “closer and more convenient” to home. Alternatively, the VA could find a convenient way to compensate non-VA clinicians to provide care. Such a program would make it less time-consuming to travel for treatment, provide more treatment options, and reduce waiting times for appointments. As one person said, “I want to go to my own head shrinker that I can see every day.” Another related suggestion for improving accessibility was to extend VA hours to include evenings and weekends.

There were also suggestions for how the VA might be more welcoming to OEF/OIF veterans. A number of veterans suggested that VA health care facilities should be staffed with veterans, complaining that there is currently a “civilian mentality.” Another suggestion was to have special treatment programs for these veterans. Specifically, several veterans wished for an inpatient PTSD program at all VAMCs, noting that people with “ordinary” combat PTSD should not be treated in the same unit as veterans with schizophrenia or other serious mental illnesses.

Create Services and Resources for Family Members. Veterans shared their ideas about services and resources that they felt were needed and would benefit family members. Many veterans and family members described the difficulty maintaining support for family members during the phases of deployment. Some felt that actively getting family members connected to resources throughout the deployment process, especially during pre-deployment, was a critical need. There was a general consensus that helping families anticipate common difficulties during deployment, preparing them with resources for when their service member initially returns, as well as providing resources to address some longer-term post-deployment challenges, would be helpful.

Other individuals recommended support services for families that included opportunities for informal social connection, as well as more-formal support groups or counseling services: “They should form a VFW kind of thing but just for spouses and wives and stuff and girlfriends, so they can all just get together and do stuff together.” One issue that concerned some individuals was geographic access and support for nondeployed husbands:

There’s a family support center at my guard base, but we don’t live near there. So having services that were easier to access would be good. Family support groups are usually for women who were left behind. There should be something for the husbands.

Summary of Qualitative Findings

This study examined the thoughts and opinions of veterans and their family members regarding the process of reintegration following deployment to Iraq and Afghanistan. A wide range of participants was interviewed, including veterans, their parents, siblings, and spouses. The resulting mix of interviewees reflected our recruitment outreach into less populated areas of the state, and it included a diverse range of military experiences, deployment locations, genders, ranks, military branches, and components.

In spite of this diversity, several common themes emerged across almost all interviews. In particular, the veterans and family members reported a range of mental health concerns following their return, difficulties reconnecting with friends and family, and problems finding jobs commensurate with their skills. There was also a shared perception that it is extremely difficult to navigate the existing system of benefits and services across both VA and non-VA providers, including difficulties determining what services are available, whether the services would be helpful for one’s specific problems, where the services are available, who is eligible to receive them, and how to apply. Finally, there was general agreement on several suggestions for improvement, including improving military out-processing and subsequent outreach and educational efforts to increase utilization of existing services; improving VA services to reduce

travel time, waiting times, and delays in scheduling appointments; and expanding programs to help families of veterans.

We made an attempt to examine the unique needs of both female veterans and veterans' family members. In most instances, these individuals' concerns generally mirrored concerns raised among the male veterans interviewed. If anything, female veterans perceived the VA as less welcoming than male veterans; most female veterans who sought care chose to do so within the civilian sector. This might reflect the fact that VA clients are almost exclusively male (even more gender segregated than today's military services). Some female veterans believed that there should be specialized women's services within the VA; however, other female veterans expressed reservations about being singled out in specialty clinics. The general lack of services to support families represented a significant concern among family members. Strategies to increase opportunities for informal support for families during deployment and to facilitate reunion are perceived to be inadequate. However, there was not an expressed consensus on a specific set of services that are needed for this group.

Limitations. While qualitative interviews of the sort conducted here are extremely useful for gaining insight into how individuals think about specific issues and for generating creative solutions to problems, these research methods have substantial limitations. It is extremely important that readers keep these limitations in mind as they try to understand our results. First, the reader should be careful to avoid treating these opinions and perceptions as if they reflect objective facts in the world. We have abstracted these opinions from the interviews and focus groups but have deliberately not attempted to fact-check their statements. Even when there is a strong consensus among participants, it is possible that their perceptions are inaccurate. In particular, the concerns that focus group participants expressed about quality of VA care should not necessarily be taken as evidence of actual quality of care throughout the VA. Formal evaluations of the quality of care provided to patients are needed to make such conclusions.

Similarly, some suggestions for improvement might not be practical or even feasible, while others might already have been implemented. It is possible that implementing the participant recommendations would result in unforeseen adverse consequences. For example, having out-processing conducted after service members had demobilized and returned to their families might result in more veterans missing out-processing altogether. The VA might view other suggestions (e.g., personalized telephone outreach, or expanding treatment benefits to family members or caregivers) as going beyond the activities that it is currently empowered to perform under existing legislation. Finally, many participants wanted a single point of contact to help coordinate needed services. However, the VA has already implemented a program to provide such coordination for VA-provided services; every region in New York state has a designated OEF/OIF services coordinator. Thus, these participant recommendations for new programs might be reinterpreted as a need for better education about existing programs.

Another limitation readers should keep in mind is that the participants in our interviews and focus groups were not a representative or random sample of veterans in New York state. In fact, they differed in systematic ways from the large group of veterans who were not interviewed. We included more women and more veterans living outside New York City than would be included in a representative sample. Perhaps more importantly, we recruited the majority of our interviewees through IAVA, an existing community of veterans, and those who participated in our study all volunteered to speak out on veterans' issues. Thus, it is likely that those

interviewed were more inclined toward participating in a “community of veterans” and generally more engaged in advocacy for veterans’ issues than is the broader population of interest.

Finally, it is important to realize that these interviews represent a snapshot of these veterans’ opinions at a given point in time. It is possible that the veterans reintegrating in 2010 will actually be facing a different set of challenges from those discussed in these interviews. Indeed, all of the agencies serving these veterans are currently making changes in their programs and outreach efforts. These changes might address some of the challenges, barriers, and suggestions that our interviewees have outlined, and they might also generate new concerns. Moreover, our interviews took place during one of the most-severe economic downturns in several generations. It seems likely that this might have resulted in an increased emphasis on financial and employment issues that might not generalize to veterans who are returning several years from now, presumably, into a better job market.

Quantitative Needs Assessment of New York State Veterans and Their Spouses

Christine Anne Vaughan, Terry L. Schell, Lisa H. Jaycox, Grant N. Marshall, and Terri Tanielian

The goal of the current survey is to assess the health and well-being of the OEF and OIF veterans residing in the state of New York. This assessment was designed to inform policymakers and service providers about the needs of this population while also providing referral information to survey participants.

This study builds on a large body of literature documenting the challenges experienced by service members who have been deployed for OEF/OIF. However, these studies have focused almost exclusively on active-duty personnel and on mental health outcomes, such as PTSD and depression (for recent reviews, see Ramchand, Schell, Jaycox, and Tanielian, forthcoming, and Ramchand, Schell, Karney, et al., 2010). These studies have found rates of PTSD that vary between 5 and 20 percent, depending on the specific population being sampled. However, it is not clear how existing findings can be applied to the specific population of combat veterans who reside in New York state. In addition, these studies of mental health do not address the broader range of needs for which veterans might want or seek services. There is comparatively little research on substance use, general physical functioning, or the employment and financial problems that this veteran population is facing. Without this information, it is difficult for the service providers and policymakers serving the state of New York to effectively meet the needs of the veterans residing in their state. This study was designed to fill those gaps.

Veteran Survey

Sampling and Procedures

The data used for sampling veterans were obtained from a release of names and addresses (RONA) request to the VA. RONA information is available to members of Congress, as well as other governmental and nonprofit organizations (e.g., educational institutions) that provide outreach for veterans' services (see VA, 2010). The RONA request was made by a member of the U.S. Congress from New York and in conjunction with the New York State Division of Veterans' Affairs and NYStateHealth. RAND performed a comprehensive needs assessment of a subset of veterans from this list and provided information to each participant about how to access a range of psychological and medical services in New York state.

The RONA request was for the names and address of individuals who had become eligible for VA services in the prior five years. We believe that the records received from the VA and provided to RAND included individuals who became eligible for VA services between the

summer of 2004 and the summer of 2009 and had a New York address at the time of VA eligibility. This list included individuals regardless of whether they had enrolled in the VA health care system or had ever received VA benefits or services. However, it also included many individuals who were ineligible for the current needs-assessment study. For example, individuals who had moved out of the state of New York or who had never been deployed in support of OEF/OIF were included in the RONA list.

Contact information did not include telephone numbers and was, in most cases, several years old. We used two commercial databases, LexisNexis and Telematch, to obtain a land-line telephone number associated with each name and address and to identify more-recent addresses if they were available.

To maximize the range of individuals who were included in the study, we conducted a mixed-mode survey using both web-based and computer-assisted telephone interviewing (CATI) modes. Initially, all sampled individuals were sent a letter inviting them to participate in the study, as well as a letter of support from the New York State Department of Veterans' Affairs describing the importance of the needs assessment. These letters contained an explanation of the study and its eligibility requirements, as well as notification that participants would be paid \$30 for taking part. The mailing also included a web address and personal identification number (PIN) to allow the recipient to participate in the web-based version of the study. In addition, a telephone number was included to enable addressees to opt out of future contacts. Data were collected between August and October of 2010. Abt SRBI performed web and CATI programming of the instrument, and calls were placed through its call center.

For those sampled individuals for whom we were able to identify a telephone number, we followed up the initial letter with telephone calls to recruit them to participate in a CATI survey. Each individual was called up to 12 times over approximately three weeks. A second letter was sent out in the middle of this call period, reminding potential participants of the study and providing the web address and PIN information again.

This combined recruitment strategy resulted in a relatively unusual sample design that contains two separate sampling frames. First, there is a relatively conventional, dual-mode survey of a list-based sample. This sample includes individuals for whom we had a valid telephone number and who could complete the study either on the web or on the telephone. Second, this sample is supplemented by a web-only survey of individuals for whom we had incomplete or incorrect contact information. These participants responded to a mailing sent to an address that could be several years old.

The overall sampling frame for the study was based on a random sample ($N = 7,400$) from more than 45,000 names and addresses in the RONA data. We successfully mailed out letters to 6,263 individuals (individuals were excluded when their LexisNexis-updated addresses indicated that they had moved out of state or if their mail was returned as undeliverable). Within this group, we were able to find a valid telephone number for 2,536 individuals. These 2,536 individuals constituted the sampling frame for the dual-mode survey. Among those screened on the phone, 47 percent were eligible for the study, while about 36 percent were ineligible due to lack of deployment and about 16 percent because they no longer lived in New York. There were 728 respondents from this sampling frame (436 on the phone and 292 on the web) yielding an estimated response rate of 53 percent (American Association for Public Opinion Research [AAPOR], definition RR3) (AAPOR, 2009). The majority of non-response was due to telephone numbers that were never answered or that went to voicemail on

all 12 attempts, while only 8 percent of contacts resulted in a refusal (either a refusal to screen or withholding consent to participate).

This estimate of the response rate is likely to under-estimate the true response rate among all individuals in this sample frame. This is because the eligibility among those successfully screened almost certainly overestimates the eligibility among those we failed to screen, for two reasons. First, one of the primary causes of ineligibility was relocation outside New York, and such relocation is likely associated with nonresponse due to having an incorrect address. Second, we sent participants a notification letter containing a description of the eligibility requirements. Thus, some of the nonresponse is likely to be from individuals who realize they are ineligible based on this letter and then “self-screen” by not answering the voice mail, not accessing the website, or hanging up the call before we had an opportunity to ask the screening questions. Thus, while the most-common response-rate calculations (e.g., AAPOR RR3) assume that the eligibility is the same for those who were screened and those who were unscreened, in the current study, the eligibility is likely lower among people whom we failed to screen.

As expected, relatively few respondents came from the web-only sampling frame—that is, individuals with incomplete contact information. It is unusual for researchers to include these individuals due to the low probability that they can be successfully contacted. However, we believed that attempting to recruit these individuals allowed the study to have a more-representative sample by including individuals without regular telephone service. In total, 185 respondent surveys were completed from this sample frame. It is not possible to compute the most-common response rates (e.g., AAPOR RR3) for this sampling frame because we have no way to directly assess the rate of eligibility. Individuals who did not meet the eligibility requirements outlined in the letter would not have logged into the survey, and individuals who had moved out of state were unlikely to have even received the letter. In addition, we have no way of estimating the number of individuals who actually received the mailing. Thus, other standard metrics (e.g., refusal rates) cannot be computed for this sampling frame.

All protocols and instruments used in this needs assessment were reviewed and approved by the RAND Human Subjects Protection Committee prior to data collection. All respondents gave oral informed consent to participate. They were informed that their responses would be kept confidential and would not be shared with the military or VA. They were also informed that the study has a National Institutes of Health (NIH) certificate of confidentiality to protect against any possible court-ordered release of data.

Veterans’ Survey Measures

Sociodemographics. Veteran participants reported their age, gender, marital status, presence of children under the age of 18 in the home, race/ethnicity, and highest level of education. Veteran respondents also provided information about their history of military service, including branch of service, current duty status, military rank, and the number and recency of deployments and indicated whether they had been rated as partially disabled or disabled by the military or VA. To determine current duty status, veteran respondents were asked whether they were in the “National Guard or Reserve,” “retired from the military,” “discharged or separated from the military,” or in the “Active Component.”

Combat Trauma Exposure. Combat trauma exposure was measured by asking veteran respondents whether they had experienced any of 11 traumatic combat experiences. The list of traumatic combat experiences was adapted from Hoge et al. (2004) and includes both direct (e.g., getting injured requiring hospitalization) and vicarious trauma exposure (e.g., witness-

ing a traumatic event that occurred to others). The full instrument contains 24 traumatic exposures. However, past research has indicated that many of these items were empirically redundant with one another (Schell and Marshall, 2008). Specifically, the subset of exposures used in the scale was chosen because the remaining items were not predictive of PTSD when controlling for these 11.

Probable TBI. The Brief Traumatic Brain Injury Screen (BTBIS), which the military has used to assess personnel returning from OEF/OIF, was used to screen for the presence of probable TBI in veterans (Schwab et al., 2007). The BTBIS has demonstrated a positive value for predicting TBI in the OEF/OIF population (Schwab et al., 2007). Probable TBI is indicated by any injury during deployment that resulted in an alteration of consciousness immediately following the injury—e.g., being confused, experiencing memory loss, being unconscious for any length of time. Meeting screening criteria for having experienced a probable TBI does not require current TBI-related morbidity. Thus, the instrument does not assess ongoing functional or cognitive impairment caused by a TBI. Most individuals who screen positive for having experienced a probable TBI are likely to have full cognitive functioning.

Probable PTSD. Veterans' post-traumatic stress symptoms were assessed with the PTSD Checklist—Military Version (PCL-M; Weathers, Huska, and Keane, 1991), an instrument that contains 17 symptom items keyed directly to the *Diagnostic and Statistical Manual*, fourth edition (DSM-IV; American Psychiatric Association, 1994). Responses to the PCL-M are provided with respect to combat stress experiences on a five-point scale reflecting extent of symptom severity. Answers were provided for the period “in the last 30 days.” The PCL-M has been used to study post-traumatic distress in various military samples (e.g., Grieger et al., 2006).

Probable diagnoses were derived following guidelines offered by Weathers, Litz, et al. (1993). In particular, symptoms were counted as present if the respondent indicated that he or she had been “moderately (3)” bothered by the symptom. Symptoms were then scored according to the DSM-IV definition. This scoring has been shown to have high specificity and sensitivity, 0.92 and 0.99, respectively (see Brewin, 2005, for a review of different scoring methods).

Probable Major Depression. The Patient Health Questionnaire 8 (PHQ-8) was used to assess symptoms of major depression in veteran respondents (Kroenke, Spitzer, and Williams, 2001; Löwe, Kroenke, et al., 2004). The PHQ-8, a variant of the PHQ-9, consists of items assessing the actual criteria on which a DSM-IV diagnosis of major depression is based, with the exception of thoughts of suicide. Responses to the PHQ-8 are provided with respect to the frequency with which symptoms were experienced in the past two weeks, using a four-point (0–3) scale. In the current study, the duration for symptom reporting was altered from two weeks to a month to coincide with the duration used for assessment of PTSD symptoms. The PHQ-8 is well validated and widely used as a brief screening measure (e.g., Löwe, Spitzer, et al., 2004). Probable moderate or severe depression was indicated by a total score of 10 or above, following the recommended cutpoint (Kroenke, Spitzer, and Williams, 2001). This cutpoint yields a sensitivity of 0.99 and a specificity of 0.92, which is slightly more specific than the PHQ-9 (Kroenke, Spitzer, and Williams, 2001). Given the expanded duration used for symptom reporting in the current study, probable major depression is determined using a more-conservative threshold—i.e., to earn a score of 3 for any given item, a participant had to have experienced the symptom for “nearly every day” over the past month instead of just the past two weeks. We believe that estimates obtained with the past-month symptom duration would depart only minimally, if at all, from estimates that would have resulted from an assessment of symptoms over the usual two-week interval. Any differences stemming from the use

of the past-month time frame would be manifested in an under-estimation of the true rate of major depression per DSM-IV criteria in this sample.

Alcohol Use. Veteran respondents' problematic alcohol use during the past month was assessed by asking about the number of days on which respondents consumed alcohol and the number of days on which respondents engaged in binge drinking during the past 30 days. We calculated the percentage of veterans who reported consuming no alcoholic beverages over the past month (i.e., abstinence); the percentage of veterans who reported binge drinking, defined as five or more drinks on one occasion for males and four or more drinks on one occasion for females (Wechsler et al., 1994), at least once over the past month; and the percentage of veterans who engaged in frequent binge drinking, defined here as binge drinking on five or more days during the past month.

Drug Use. To assess veterans' use of illicit substances during the past 12 months, we asked the question, "In the past 12 months have you used any <blank>?" with respect to three different categories of illicit substances: (1) marijuana; (2) other illegal drugs, including cocaine, opium, amphetamines, or ecstasy, and (3) any prescription medication that was not prescribed for the respondent by a doctor or was used in a way other than as prescribed. These are very similar to other standard measures of self-reported drug use, which have been found to be relatively reliable (e.g., Harrison et al., 2007).

Barriers to Care. To assess barriers to seeking health care for mental health concerns, veterans were asked a single question: "If you wanted help for an emotional or personal problem, which of the following would make it difficult?" This question was followed by statements posed as potential barriers to treatment. For each statement, respondents indicated whether it was "true" or "false" that the barrier described would make it difficult for them to get treatment. Potential barriers to care were drawn from three separate instruments: the National Comorbidity Survey Replication (NCS-R) (e.g., Kessler et al., 2005); the Hoge et al. (2004) study of barriers to care in the military; and our own instrument, which was developed for use among individuals with a range of traumatic experiences (e.g., Wong et al., 2006). From these instruments, we selected barriers, retaining all barriers found by Hoge et al. (2004) to be highly endorsed in a military sample. For heuristic purposes, we distinguished among three broad classes of barriers to care: logistical barriers (e.g., "it would be difficult to schedule an appointment"), institutional and cultural barriers ("it could harm my career"), and beliefs about and preferences for treatment (e.g., "even good mental health care is not very effective").

Past-Year Unmet Need, Utilization, and Adequacy of Mental Health Services. Unmet need for mental health services during the past year was assessed by asking veteran respondents a single question: "In the past 12 months was there ever a time when you wanted to get professional help for a mental health, stress, family or alcohol problem but did not?" To determine past-year utilization of services for mental health concerns, we posed several questions. A single question inquired as to whether respondents had seen any provider for mental health services in the past 12 months—i.e., "In the past 12 months have you visited any professional like a doctor, a psychologist, or a counselor to get help with issues such as stress, emotional, alcohol, drug, or family problems?" Psychotropic drug use was assessed with two questions—i.e., "Have you been prescribed any medication for a mental health or emotional problem in the past 12 months?" and "Did you take the medication for as long as your doctor wanted you to?" For each type of provider seen, additional questions inquired about the number of sessions and the length of the typical session.

Participants were judged to have had a minimally adequate trial of a psychotropic drug if they (1) had taken a prescribed medication for as long as the doctor wanted and (2) had at least four visits with a doctor or therapist in the past 12 months. Minimally adequate exposure to psychotherapy was defined as having had at least eight visits with a “mental health professional such as a psychiatrist, psychologist or counselor” in the past 12 months, with visits averaging at least 30 minutes. Criteria for minimally adequate courses of treatment were adapted from the NCS-R (Wang et al., 2005). These criteria for minimally adequate treatment of PTSD and major depression were developed by Wang et al. (2005) based on a comprehensive review of available guidelines for therapies that have demonstrated efficacy. The NCS-R requires that pharmacotherapy be supervised by a physician and be taken for at least eight weeks. We allowed that pharmacotherapy in the military might be supervised by medical personnel other than a physician; also, rather than require a specific treatment length, we asked respondents whether they had completed their course of treatment. Whereas the NCS-R also requires that all eight psychotherapy sessions occur with the same provider, our definition did not require use of a single provider for all sessions. It is worth noting that, because this definition looks only at treatment in the past 12 months, it will exclude some individuals who did get a minimally adequate dose of treatment that began more than a year ago, as well as some individuals who started treatment shortly before the interview and who are in the process of receiving a minimally adequate dose.

Physical Health. The Medical Outcomes Study Short Form 36 General Health Survey (SF-36; Ware et al., 1993) subscales of Physical Functioning and Role Limitations Due to Physical Health were used to assess physical health of veteran respondents. To assess Physical Functioning, respondents were asked how much their health currently limits them in ten different physical activities, covering a range of intensity levels (e.g., vigorous activities, walking more than a mile, bathing or dressing oneself). Role Limitations Due to Physical Problems were assessed with four items asking the respondent about the occurrence of four problems with “work or other regular daily activities as a result of your physical health” during the past four weeks. The subscale scores range from 0 to 100, and higher scores indicate better physical health. The reliability and validity of the SF-36 have been extensively documented in past research (Brazier et al., 1992; Buchwald et al., 1996; Stansfeld, Roberts, and Foot, 1997; Ware et al., 1993).

Employment Characteristics and Needs. Current employment status was assessed by asking each veteran to select the category that best describes his or her current work status. Response options included “working full-time,” “working part-time,” “unemployed and looking for work,” “disabled and not working,” “full-time student,” “part-time student,” “homemaker,” “retired,” and “not employed, not looking for work.” The rate of unemployment in the current sample was computed two ways that differ only in the denominator. In both cases, the numerator is the number of individuals who were “unemployed and looking for work.” One method used the entire sample as the denominator, to permit division of the sample into mutually exclusive categories of current employment status for descriptive purposes. The other method used a denominator designed to correspond closely to the commonly reported U-3 measure of unemployment used by the Bureau of Labor Statistics (BLS) (2010). This denominator is restricted to the workforce, defined as individuals who are currently employed (either part or full time) and those who are unemployed and looking for work. Because we have simpler employment questions than the items used by BLS, there might be some slight differences between the official U-3 rate and the corresponding rate reported in this study. For example,

BLS considers someone unemployed and looking for work if he or she has looked for work at any time in the past four weeks even if he or she has since stopped looking, while we required that the respondent be currently looking for work. Similarly, BLS excludes some types of part-time work from counting as part of the workforce (e.g., less than 15 hours per week when working for a family-owned enterprise). In general, these minor differences might result in our measure slightly under-estimating the U-3 unemployment rate achieved with the longer set of questions.

Among veterans who reported full- or part-time employment, several employment characteristics were assessed, including whether they were working fewer hours than they would like, whether their current job makes good use of their skills and training, whether they perceived that additional training or college would help to advance their career, and whether they were currently looking for a new job or additional job. Past-year college attendance was also assessed and reported for the entire sample of veterans.

Financial Strain. Financial strain was assessed by two main indicators. One indicator of financial strain was the categorization of veterans as above or below 100 percent of the federal poverty guidelines set by the U.S. Department of Health and Human Services (HHS) for 2010 (HHS, 2010). This categorization is derived from the respondent's best estimate of his or her household's total annual income from all sources before taxes the prior year and the number of people in his or her household supported by the total household income. The other indicator of financial strain was the veteran's reports of whether he or she had been behind in rent or mortgage payments during the past year.

Utilization, Perceived Helpfulness, and Understanding of Veterans' Benefits and Services. Veterans were asked to indicate which of eight benefits and services available to them they had used since leaving the military; which of nine benefits and services they would consider helpful, regardless of whether they had accessed them; and whether they considered themselves to have a "good" understanding of the benefits available to veterans and knew how to get answers to questions about benefits.

Veterans' Survey Findings

To assess the extent to which the current sample of veterans is representative of the larger population of U.S. service members previously deployed as part of OEF/OIF, the current sample was compared with the larger population on several sociodemographic characteristics. The characteristics of the population of previously deployed service members were derived from the Contingency Tracking System Deployment File and the Work Experience File from the Defense Manpower Data Center (DMDC) for 2008.

In general, the current sample of veterans closely resembled the national population of service members previously deployed for OEF/OIF in terms of sociodemographic characteristics (see Table 3.1). Largely consistent with the composition of the U.S. military force that was previously deployed in OEF/OIF, roughly three to four times as many veterans sampled had served in the Army than in the Navy, Air Force, or Marine Corps. This composition is largely consistent with that of the U.S. military force that had previously deployed in OEF/OIF. However, the current sample slightly overrepresented the Army and slightly under-represented the Navy and Air Force. This difference is most likely accounted for by the smaller number of Navy and Air Force bases in New York state than in the rest of the United States. Most veter-

Table 3.1
Sociodemographic Characteristics of Veterans (N = 913)

Characteristic	Percentage	95% CI LL	95% CI UL
Branch of service			
Army	55	52.0	58.5
Navy	14	11.4	15.9
Air Force	17	14.1	19.0
Marine Corps	15	12.2	16.8
Current duty status			
Reserve/guard	41	37.8	44.2
Retired/discharged	56	52.9	59.4
Active	3	1.8	3.9
Rank			
Enlisted	82	79.1	84.1
Officer	17	14.5	19.3
Warrant officer	2	0.7	2.3
Race			
White	73	70.3	76.1
Black	11	8.9	13.0
Hispanic	11	8.8	12.9
Other	5	3.6	6.4
Currently married	53	50.0	56.5
Male	89	87.1	91.2
Has had multiple deployments	40	36.9	43.3
Months since last deployment			
0–24	25	21.7	27.4
25–48	34	30.6	36.8
49–72	32	28.9	35.1
>72	10	7.9	11.8
Months of last deployment			
1–3	8	6.6	10.2
4–6	19	16.2	21.3
7–9	20	17.4	22.6
10–12	34	30.8	36.9
>12	19	16.4	21.5
35 years old or younger	54	50.8	57.3
Rated as disabled by the military or VA	31	28.4	34.4
Mean percentage disabled among those with some disability	38	35.1	41.2
College degree or higher	33	29.8	35.9
Children under 18 living at home	45	41.5	48.0

NOTE: CI = confidence interval. LL = lower limit. UL = upper limit.

ans in the New York state sample had been enlisted personnel, had experienced only a single deployment, were retired or discharged from the military, and reported not having been rated by the military or VA as disabled. Most veterans in the sample were white married men under the age of 35 who had no college degree and no children under 18 living at home.

The sample differs in some ways from the overall national population of service members previously deployed in OEF/OIF, as well as from our prior “Invisible Wounds” study. The most-obvious difference is that this sample is made up primarily by individuals who have retired or otherwise separated from service. It also includes a substantial number of community-dwelling National Guard members and reservists. There are a very small number of active-duty personnel in the sample; these are individuals who have returned to active duty after being separated at some earlier date. Relative to the full population of individuals previously deployed for OEF/OIF, the sample has slightly more individuals who were unmarried, were white, or had been officers, while we had slightly fewer individuals who were black or of enlisted rank in the present sample. We do not know whether these small differences were due to biases in our sampling or because the characteristics of the population of veterans residing in New York is slightly different from the national population of all previously deployed service members.

The goal of our sampling procedure was to represent the target population of veterans currently residing in New York state who had served in OEF/OIF and separated from the military since 2004. As sociodemographic characteristics on this target population were not readily available to permit comparison to the current sample, we compared the current sample with the larger population of previously deployed OEF/OIF service members in the entire United States (as described earlier). This comparison is predicated on the assumption that the population of previously deployed OEF/OIF veterans residing in New York state is broadly comparable to the U.S. population of OEF/OIF veterans as a whole with respect to key sociodemographic characteristics. Thus, one source of sociodemographic discrepancies between the current sample and the larger population of U.S. service members deployed in OEF/OIF might be attributable to differences between the populations of OEF/OIF veterans in New York versus in the United States as a whole. Another possible cause of sociodemographic discrepancies is nonresponse bias, i.e., certain demographic subgroups might have been under-sampled, thereby reducing the representativeness of the current sample with respect to the target population of OEF/OIF veterans residing in New York.

As shown in Table 3.2, rates of exposure to specific types of combat trauma ranged from 3 percent to 46 percent. Vicarious types of trauma (e.g., having a friend who was seriously wounded or killed) were more-commonly experienced than direct types of trauma (e.g., being injured, requiring hospitalization). We compared rates of trauma exposure in the current study with that observed in our earlier work of previously deployed OEF/OIF U.S. service members, the RAND “Invisible Wounds” study (Schell and Marshall, 2008). That study was designed to be representative of the total previously deployed force, including a large subsample that was still on active duty. The ordering of frequencies of different trauma types was very similar across these two studies. For example, in both studies the most-frequently endorsed¹ trauma type was “having a friend who was seriously wounded or killed” (“Invisible Wounds”: 50 percent, current study: 46 percent), and the least commonly endorsed trauma type was “being responsible for the death of a civilian” (“Invisible Wounds”: 5 percent, current study: 3 percent). How-

¹ Chosen or selected.

Table 3.2
Rates of Trauma Exposure Among Veterans (N = 913)

Type of Combat Trauma	Percentage	95% CI LL	95% CI UL
Having a friend who was seriously wounded or killed	46	42.8	49.2
Seeing dead or seriously injured noncombatants	41	37.7	44.1
Witnessing an accident resulting in serious injury or death	37	33.9	40.2
Smelling decomposing bodies	32	29.3	35.4
Being physically moved or knocked over by an explosion	25	21.9	27.5
Being injured, not requiring hospitalization	24	21.3	26.8
Having a blow to the head from any accident or injury	17	14.2	19.1
Experiencing probable TBI	14	11.4	15.8
Being injured, requiring hospitalization	10	8.4	12.3
Engaging in hand-to-hand combat	7	5.0	8.2
Witnessing brutality toward detainees/prisoners	6	4.2	7.2
Being responsible for the death of a civilian	3	2.2	4.5

ever, overall, rates of exposure were slightly lower (1–8 percent) in the current study for almost all traumas. Notably, the rate of having experienced a probable TBI during deployment was also lower in the current study (14 percent) than in the sample in “Invisible Wounds.” It is not possible to estimate the number of veterans in our sample who currently have health problems resulting from those TBIs. The survey was administered approximately four years post-injury, and the vast majority of impairments from these injuries are likely to have resolved in that time period (Iverson, Lange, and Zasler, 2007). These small but consistent differences across studies might be due to the larger proportion of active-duty personnel in the “Invisible Wounds” study or due to some unique characteristics of the New York veteran population.

As shown in Table 3.3, rates of probable PTSD and major depressive disorder (MDD) in the current sample were both 16 percent for the 30 days prior to the interview. To interpret these findings in a broader context, we compared these rates to prevalence estimates obtained in large, nationally representative epidemiological studies of PTSD and major depression. Because the sample of veterans differs from the full national population on gender and age, we adjusted the national norms to match our sample on these characteristics. Based on 12-month prevalence estimates of PTSD obtained in the NCS-R (Kessler et al., 2005), we would expect a 12-month prevalence of PTSD to be 2 percent among individuals of the same age and gender distribution of our sample. This indicates that risk of probable PTSD is at least eight times higher in the current sample of veterans than for similar individuals in the general population.² Several studies have used the same depression instrument in nationally representative samples. These studies suggest that the prevalence in depression among similar individuals in the general population (matched on age and gender) falls between 4 percent and 7 percent (Kroenke,

² The NCS-R assesses the occurrence of PTSD symptoms for *any* one-month interval over the past year, while we assess PTSD symptoms only for the one-month interval before the survey. Therefore, prevalence estimates of PTSD using the NCS-R time interval will yield higher prevalence estimates of PTSD than the time interval used in the current study. Thus, the rate of PTSD in the current sample is likely greater than 7.5 times the rate of PTSD in the general population.

Table 3.3
Rates of Probable Major Depressive Disorder and Post-Traumatic Stress Disorder with Comorbidity Among Veterans (N = 913)

Condition	Percentage	95% CI LL	95% CI UL
Probable PTSD	16	13.4	18.1
Probable MDD	16	13.3	18.0
Co-morbidity			
No PTSD or depression	78	75.4	80.8
PTSD only	6	4.7	7.8
Depression only	6	4.6	7.7
Both PTSD and depression	10	7.6	11.4

Strine, et al., 2009; Pratt and Brody, 2008). Thus, the veterans' sample is at a two- to four-fold greater risk of probable major depression than that of the general population. As displayed in Table 3.3, among the roughly one-fifth (22 percent) of the sample who met criteria for probable PTSD or major depression, co-occurrence of the two conditions was more common than the experience of either condition in isolation from the other one. Thus, a substantial portion of the veterans are suffering from multiple mental health conditions.

The rates of probable PTSD and MDD were highly associated with the number of different types of trauma experienced during OEF/OIF deployments (see Table 3.4). Among respondents who experienced none of the 11 trauma types assessed, the rate of having any probable diagnosis (either PTSD or MDD) was only 7 percent. In this low-trauma group, rates of both PTSD and MDD were similar to rates found among similar individuals in the general population (matched to the current sample on age and gender). In contrast, among veterans with a high level of trauma exposure (at least four out of the 11 trauma types assessed), the rates for these disorders were dramatically higher than found in the general population. Nearly half of the participants at the highest levels of trauma exposure met diagnostic criteria for either PTSD or major depression. This suggests that the vast majority of mental health problems are

Table 3.4
Rates of Probable Psychiatric Disorders by Level of Trauma Exposure (N = 913)

Level of Trauma Exposure	%	PTSD		%	MDD		Either PTSD or MDD		
		95% CI LL	95% CI UL		95% CI LL	95% CI UL	95% CI LL	95% CI UL	
No reported trauma (N = 251)	2	0.5	4.3	6	3.4	9.5	7	4.0	10.4
Medium trauma (N = 396)	12	8.5	14.8	12	9.1	15.6	18	13.9	21.5
High trauma (N = 266)	35	28.8	40.3	29	23.8	34.8	42	36.1	48.1

NOTE: Level of trauma is determined by the number of traumas experienced during deployment out of 11 possible. Medium trauma was defined as 1–3 types of trauma experienced; high trauma was defined as 4 or more types of trauma. See Table 3.2 for a list of traumas.

likely due to combat trauma, rather than more mundane stressors associated with career or life transitions caused by leaving the military. Just over a fifth (22 percent) of veterans in the current sample reported having had no alcoholic drinks over the past 30 days, indicating that the majority of the sample are drinkers (see Table 3.5). The rate of abstinence from alcohol in this sample is slightly lower than that obtained in a civilian sample (31 percent) that was weighted to match a sample of previously deployed OEF/OIF veterans on demographic characteristics (Ramchand, Miles, Schell, et al., forthcoming). However, the frequency of binge drinking (defined as five or more drinks on one occasion for males and four or more for females) over the past month in the current sample of veterans was nearly identical to that observed in a demographically matched, nationally representative civilian sample (Ramchand, Miles, Schell, et al., forthcoming); the mean number of days on which binge drinking occurred per month was 2.3 in the civilian sample and 2.4 in the current veteran sample. Over one-third of the current sample reported binge drinking at least once over the past month, and 16 percent reported binge drinking on at least five days during the past month. Thus, while veterans do not appear to be at substantially increased risk for alcohol abuse relative to similar civilians, a considerable number of individuals misuse alcohol and might benefit from treatment.

Reports of illicit substance use in general over the past year indicated that these substances were used by only a small fraction of the current sample of veterans (see Table 3.6). In a national sample of individuals from the 2009 National Survey on Drug Use and Health (NSDUH) that was matched to our sample of veterans on gender and age, rates of past-year use of any illicit drugs and marijuana specifically were 18 percent and 14 percent, respectively

Table 3.5
Rates and Frequency of Alcohol Abstinence and Binge Drinking During the Past 30 Days Among Veterans (N = 913)

Alcohol Use	Percentage or Mean (SD)	95% CI LL	95% CI UL
Percentage of veterans who abstained from alcohol consumption	22	19.6	25.0
Percentage of veterans who had at least one binge-drinking episode	38	34.8	41.2
Average number of days of binge drinking	2.4 (5.2)	2.0	2.7
Frequent binge drinking (5+ times)	16	13.6	18.4

NOTE: SD = standard deviation. For average number of days of binge drinking, the mean is outside the parentheses and the SD is inside parentheses. Binge drinking is defined as the consumption of five or more alcoholic drinks in the same sitting for a man or four or more alcoholic drinks in the same sitting for a woman. Frequent binge drinking is defined here as binge drinking on five or more days during the past month.

Table 3.6
Rates of Past-Year Illicit Drug Use Among Veterans (N = 913)

Substance	Percentage	95% CI LL	95% CI UL
Use of any illicit drug	9	7.2	11.0
Marijuana	7	5.0	8.2
Cocaine, opium, amphetamines, or ecstasy	2	0.9	2.6
Prescription medication used other than as prescribed	4	2.6	5.1

(SAMHSA, 2010). In contrast, only 9 percent and 7 percent of veteran respondents reported past-year use of any illicit substance and marijuana, respectively. Thus, the rates of drug use among veterans in this sample were half of the rates found among similar individuals in the general U.S. population. As shown already, problematic alcohol use (i.e., binge drinking) was much more common than illicit drug use.

A nontrivial proportion of veterans in the current sample (20 percent) reported that they had desired—but had not received—mental health services some time during the past year. Nearly one-quarter (24 percent) of the current sample had received mental health services during the past year, as indicated by at least one mental health visit to a doctor or mental health specialist (e.g., a psychologist or counselor), during the past year. As shown in Table 3.7, more than twice as many veterans reported mental health visits to mental health specialists (20 percent) as reported mental health visits to medical doctors (9 percent).³ Some form of minimally adequate mental health care was received by just over a tenth of the sample (13 percent) during the past year. This constitutes roughly half of the 24 percent of veterans who had sought any mental health treatment during the past year. Specifically, minimally adequate “talk” treatment had been received by 10 percent of the sample during the past year, which is half of the 20 percent who had seen any mental health specialist over the past year. Similarly, just over a

Table 3.7
Mental Health Services Among All Veterans (N = 913) and Veterans in Need of Mental Health Treatment During the Past Year (N = 514)

Mental Health Service	All Veterans (N = 913)			Veterans Needing Treatment (N = 514)		
	%	95% CI LL	95% CI UL	%	95% CI LL	95% CI UL
Mental health services were desired but not obtained	20	17.8	23.0	n.a.		
Any mental health visit to a doctor or mental health specialist	24	21.1	26.7	34	29.8	37.9
Any mental health visit to a doctor	9	7.3	11.1	12	9.2	14.9
Any mental health visit to a mental health specialist	20	17.6	22.8	30	26.4	34.3
Prescribed medication was taken for the duration of the prescription	11	9.1	13.2	18	14.3	20.8
Any minimally adequate treatment	13	10.7	15.0	20	16.6	23.6
Minimally adequate talk treatment	10	8.2	12.1	16	12.8	19.1
Minimally adequate drug treatment	8	6.5	10.1	14	10.5	16.4

NOTE: A veteran is considered to be in need of mental health services if he or she (1) met criteria for probable MDD or PTSD during the past month, (2) reported that there was a time when he or she wanted mental health treatment but did not get it during the past year, (3) reported that counseling from a civilian therapist would be helpful, or (4) reported that drug or alcohol treatment would be helpful. Data are not reported on the variable “Mental health services were desired but not obtained” for veterans in need of mental health services because this variable was part of the definition of being in need of mental health services.

³ It is not clear from our data whether participants considered psychiatrists to be in the *medical doctor* or *mental health specialist* categories. Thus, some individuals who indicated *medical doctor* might have been seen by a psychiatrist.

tenth of the current sample of veterans (11 percent) reported that they had taken prescribed psychotropic medication for the duration of the prescription, and slightly fewer (8 percent) had received psychotropic drug treatment that met the standard for minimally adequate care. On average, veterans reported that roughly a third of their mental health visits to medical doctors (39 percent; 95-percent CI [28.2 percent, 48.8 percent]) and to mental health specialists (33 percent; 95-percent CI [26.4 percent, 39.5 percent]) during the past year were to providers outside the VA.

In addition to looking at service utilization in the whole sample, we looked at services within the subset of our sample that had a need for treatment. Need for treatment was defined by meeting at least one of the following criteria: (1) probable major depression or PTSD during the past month, (2) had wanted but not received mental health services at some point during the past year, (3) reporting that counseling from a civilian therapist would be helpful to them, or (4) reporting that drug or alcohol treatment would be helpful. Just over half of the overall sample of veterans (56 percent) was determined to be in need of mental health services based on this definition. The rates of past-year utilization and adequacy were slightly higher among veterans in need of mental health services than in the full sample of veterans. For almost all measures, the rates of utilization in the sample with mental health need were approximately 1.5 times the rates found in the broader sample. In general, the pattern of findings among veterans with mental health need was similar to that obtained in the overall sample, e.g., mental health visits to mental health specialists were more-commonly reported than mental health visits to medical doctors.

These findings on service utilization and quality of care very closely replicate the findings from the “Invisible Wounds” study (Schell and Marshall, 2008).⁴ In both studies, (1) there is a large proportion of respondents who had a need for mental health care in the past year, (2) about half of those with a need for care sought mental health care in the past year, and (3) only about half of those who sought care received or completed a minimally adequate course of treatment. This suggests that there is considerable room for improvement in both access to treatment and the quality and completeness of that treatment.

To understand why veterans might refrain from obtaining mental health services if they desired them, we examined rates of endorsement of several possible barriers to mental health services (see Table 3.8). The most-frequently cited reason for not getting mental health services if desired was perceived medication side effects, which was endorsed by more than a third of the sample (35 percent). Other barriers endorsed by a sizable proportion of the sample were of an institutional and cultural nature and pertained primarily to one’s career. Specifically, veterans affirmed concerns about the deleterious impact that obtaining mental health services would have on one’s career (33 percent), one’s eligibility for a security clearance (32 percent), the confidence of co-workers (26 percent), and the respect of one’s supervisor (21 percent). In contrast, veterans’ concerns about potentially detrimental effects of obtaining mental health services on their relationships with friends and family members were less-frequently cited, e.g., only 14 percent of the sample endorsed concern over losing the respect of their friends and family for seeking mental health services. Concerns about the negative impact that receiving

⁴ The current study used a slightly different definition of *need for treatment* from that used for the “Invisible Wounds” study. In the current study, we count an individual as having a need for treatment if he or she has a past-30-day probable diagnosis for PTSD or depression or if he or she has a self-assessed need for mental health treatment in the past year. In the “Invisible Wounds” study, we used only probable diagnosis to determine need for treatment.

Table 3.8
Barriers to Mental Health Care Among Veterans Who Desired It (N = 913)

Type of Barrier	Percentage	95% CI LL	95% CI UL
Logistical			
High cost of mental health care	19	16.9	22.0
Difficulty getting child care or time off work	14	11.5	16.0
Difficulty scheduling an appointment	13	10.5	14.8
Not knowing where to get help or whom to see	12	10.3	14.6
Difficulty arranging transportation	4	2.4	4.9
Institutional and cultural			
Professional help could harm veteran's career	33	30.2	36.3
Possibility of being denied a security clearance in the future	32	28.7	34.8
Co-workers would have less confidence if they knew	26	23.1	28.9
Veteran's supervisor might respect him/her less	21	18.6	23.9
Concerns about confidentiality of treatment	20	17.7	23.0
Friends and family would respect veteran less	14	11.9	16.5
Potential loss of contact or custody of children	4	2.4	4.8
Veteran's spouse/partner would not want him/her to get treatment	2	1.0	2.8
Beliefs about and preferences for treatment			
Medications with potential to help have too many side effects	35	31.3	37.8
Perception that even good mental health care is not very effective	15	12.6	17.3
Perceived ineffectiveness of mental health treatments available	11	9.1	13.4

mental health services could have on the procurement of a security clearance are particularly interesting given the U.S. military's efforts in 2008 to reduce this barrier by making changes to the question regarding mental health treatment on the application for a security clearance (i.e., the SF 86). The persistence of this concern among veterans suggests that they might be unaware of these efforts or, if aware of these efforts, are still concerned that a history of mental health services would be revealed in the course of a security-clearance investigation and preclude obtaining a security clearance.

Other barriers to mental health services endorsed by a nontrivial proportion of the sample included concerns about confidentiality of treatment (20 percent) and the high cost of mental health care (19 percent). As almost all veterans in the sample are eligible for free mental health care at the VA by virtue of being discharged in the past five years and having been deployed in OEF/OIF, concerns about treatment cost by nearly a fifth of the sample might reflect a lack of awareness of eligibility to receive free mental health care through the VA or other problems receiving mental health services from the VA.

The findings on barriers to mental health treatment were very similar to the findings in the “Invisible Wounds” study (Schell and Marshall, 2008), even though that earlier study included a large number of active-duty personnel. We believe that this underscores the robustness of concerns in the population of previously deployed OEF/OIF veterans about medication side effects and about damage to one’s career. These concerns remain barriers to obtaining mental health services even after the service member leaves the military.

When asked whether they would prefer to obtain mental health treatment from a provider in the VA or a civilian provider outside the military or VA, veterans with a need for mental health treatment (as defined previously) were fairly evenly split between expressing a preference for a mental health provider in a VA facility (54 percent; 95-percent CI [49.6 percent, 58.5 percent]) versus a civilian provider (46 percent; 95-percent CI [41.5 percent, 50.4 percent]). Similar results were obtained when examining provider preferences in the entire sample of veteran respondents. In addition, a majority of veterans in the current sample have some health insurance outside the VA (64 percent), indicating that a substantial proportion of them have health care options beyond the VA if desired. However, it is not clear whether these other types of health insurance include adequate coverage of mental health conditions. In general, it appears that some veterans prefer care in the VA system and some in the civilian system. Meeting the demand for treatment in the overall veteran population might require addressing barriers in both systems.

To characterize the physical health of veterans in the current sample, we compared their average scores on the Physical Functioning and Role Limitations Due to Physical Health subscales of the SF-36 with norms for the general population adjusted to match the age and gender distribution of the current sample. The adjusted general-population norms for the Physical Functioning and Physical Role Limitations subscales of the SF-36 (Version 1.0) were 91.0 and 88.8, respectively (Ware et al., 1993), with higher scores indicating better functioning. Relative to similar individuals in the general population, the veterans in the current sample had lower average scores on the Physical Functioning (mean [M] = 87.3, SD = 19.4; 95-percent CI [86.1, 88.6]) and Physical Role Limitations (M = 78.2, SD = 34.0; 95-percent CI [76.0, 80.5]) subscales of the SF-36. Veteran respondents’ lower average score on the Physical Functioning subscale suggests that they experience greater difficulty performing physical activities of varying levels of intensity than same-sex, similarly aged members of the general population. Similarly, veteran respondents’ lower average score on the Role Limitations Due to Physical Health subscale indicates that they experience more problems in work or other everyday activities due to their physical health than do same-sex, similarly aged members of the general population. These differences are not descriptively large; the veterans are between 0.2 and 0.3 standard deviations below normal, which is typically considered a small or medium effect size (Cohen, 1988). In general, these lower average scores are accompanied by higher variance than is found in the general population. This means that the differences are attributable to a small subset of veterans who have considerably worse physical functioning than the general population, rather than slightly worse health for all veterans.

As shown in Table 3.9, the majority of veterans reported full- or part-time employment (72 percent). Nearly a fifth (18 percent) were not working, which included individuals who were disabled, students, homemakers, retired, or unemployed and not looking for work. Among the entire sample of veterans, 10 percent were unemployed and currently looking for work. Converting this definition of unemployment similar to the standard, U-3 definition used in official statistics (BLS, 2010), the rate of unemployment among veterans in the current sample was

Table 3.9
Current Employment Status and Past-Year College Attendance Among All Veterans (N = 913) and Job Characteristics Among Employed Veterans (N = 655)

	Percentage	95% CI LL	95% CI UL
Current employment status			
Employed full or part time	72	68.9	74.7
Unemployed and looking for work	10	8.3	12.3
Not working ^a	18	15.4	20.4
Enrolled in university or college during the past year	36	32.7	39.0
Job characteristics of employed veterans			
Working fewer hours than would like	15	12.3	17.9
Current job makes good use of skills and training	73	69.6	76.6
Additional training or college would help to advance career	77	73.8	80.4
Currently looking for a new job or an additional job	38	33.8	41.4

^a Includes students, homemakers, retired veterans, disabled veterans, and veterans who were otherwise not looking for work.

nearly 13 percent, which was notably higher than the 8.3 percent unemployment for New York state in August 2010 (BLS, undated).

Among the veterans who reported full- or part-time employment, a small minority indicated working fewer hours than desired (15 percent), and over a third were currently looking for a new or additional job (38 percent). Approximately three-quarters of employed veterans perceived that their current job makes good use of their skills and training (73 percent), and a similar proportion of veterans felt that additional training or college would help to advance their career (77 percent). Among the entire sample of veterans, over a third had been enrolled in college or university courses during the past year (36 percent), suggesting that a sizable minority of veterans have already taken steps to acquire new knowledge or skills.

Between 7 and 10 percent of veterans in the current sample showed signs of financial strain according to the two main indicators we assessed: Roughly 7 percent (95-percent CI [4.9, 8.2]) of veterans fell below 100 percent of the federal poverty guidelines established by HHS (2010), and roughly 10 percent (95-percent CI [7.8, 11.6]) had been behind in rent or mortgage payments at some point during the past 12 months.

The majority of veterans in the current sample considered themselves to have a “good” understanding of the benefits available to them (58 percent; 95-percent CI [54.8, 61.2]) and to know how to get answers to their questions about veterans’ benefits (74 percent; 95-percent CI [70.6, 76.3]). However, it is worth noting that the proportions of veterans who indicated not having a good understanding of the benefits available to them (42 percent) and not knowing how to get their questions answered (27 percent), although technically minorities, are sizable. These findings indicate that greater outreach efforts might be helpful to veterans to explain their benefits to them and connect them with representatives of benefit and service organizations who can answer their questions about benefits.

In an effort to look at what services are needed, we asked respondents about both the services they have accessed and the ones that would be helpful to them,⁵ regardless of whether they had used the benefit in question. The great majority of veteran respondents (79 percent) reported having used at least one of the eight varied types of benefits assessed in the survey. As shown in Table 3.10, the most–commonly used benefit was health care at a VA facility (59 percent). A slightly larger percentage of veteran respondents perceived that health care at a VA facility would be helpful, regardless of whether they had ever received health care at a VA facility (70 percent) (see Table 3.11). Assistance at a VA vet center had been obtained by nearly a third of veteran respondents (28 percent) and was rated as a benefit that would be helpful by almost twice as many veteran respondents (53 percent). Consistent with data reported previ-

Table 3.10
Veterans’ Benefits Received Since Leaving the Military (N = 913)

Benefit	Percentage	95% CI LL	95% CI UL
Health care at a VA facility	59	55.6	62.0
Financial aid for education	39	35.4	41.7
Disability payments	29	26.1	32.0
Assistance at a VA vet center	28	24.7	30.5
Reduced costs of health insurance for self or family	12	9.5	13.7
Housing assistance or loans	9	7.3	11.1
Military retirement pay	9	7.4	11.2
Job training	6	4.0	7.0

Table 3.11
Services That Veterans Said Would Be Helpful, Regardless of Whether They Have Been Used (N = 913)

Service	Percentage	95% CI LL	95% CI UL
Health care at the VA	70	67.2	73.2
Financial aid for education	61	57.6	64.0
Housing assistance or loans	59	56.2	62.6
Assistance at a VA vet center	53	49.8	56.2
Job training	46	42.3	48.8
Disability payments	45	41.2	47.7
Counseling by a civilian therapist	43	40.2	46.6
Drug or alcohol treatment	18	15.5	20.5
Transitional housing	18	15.2	20.1
None of the above	8	6.1	9.6

⁵ The question about perceived helpfulness of benefits was worded to ask specifically about helpfulness to the individual, as opposed to veterans in general: “Which of the following services would be helpful for you, even if you have not used them?”

ously on respondents' preferences for a civilian mental health provider, 43 percent of veteran respondents indicated that counseling by a civilian therapist would be helpful. Nearly a fifth of the sample reported that drug or alcohol treatment would be helpful (18 percent).

Echoing previously described findings on the perceived advantages of additional training or college for career advancement, financial aid for education had been used by a sizable proportion of veteran respondents (39 percent) and was endorsed by the majority of veteran respondents as a benefit that would be helpful (61 percent). In contrast, job training had been used by a small percentage of veteran respondents (6 percent) but was perceived by nearly half of the sample to be a benefit that would be helpful (46 percent).

Disability payments had been received by almost one-third of veteran respondents (29 percent) and were viewed by almost half of respondents (45 percent) as a benefit that would be helpful. Military retirement pay had been received by a relatively small proportion of respondents (9 percent). Housing assistance or loans appeared to have been under-utilized by veteran respondents (9 percent), compared with the more than half of respondents who indicated that this benefit would be helpful (59 percent) and the 18 percent of respondents who said that transitional housing would be helpful.

These findings suggest that future efforts to mitigate discrepancies between veterans' desired and actually received benefits might be most fruitful if they focus on connecting more veterans to assistance at VA vet centers, financial aid for education, job training, and housing assistance or loans.

Spouse Survey

Sampling and Procedures

The study also aimed to assess the health-related and social support needs of spouses of veterans residing in New York state. During the veterans' interviews, respondents were asked whether they were married. After we completed the interview, we asked each married veteran whether we could also speak to his or her spouse. The respondents were informed (1) that the interview was to "identify services or benefits that he/she would find helpful," (2) that it would take approximately ten minutes, and (3) that we would pay them an additional \$30. For any veteran who did not give us permission to speak to his or her spouse, we terminated the interview. If the veteran agreed and the spouse was immediately available, the spouse was asked to complete the interview at that time using the same survey mode as the veteran (web or phone). If the spouse was not immediately available, we collected contact information and attempted to reach the spouse by phone. Of the 484 married veterans, we successfully completed interviews with 61 percent ($N = 293$) of their spouses.

Spouse Survey Measures

Sociodemographics. Spouse participants reported their age, gender, marital status, presence of children under the age of 18 in the home, race/ethnicity, and highest level of education. Spouses also reported their history of U.S. military service and whether they were married to the veteran at the time of his or her last deployment.

Probable Major Depression. The PHQ-8 was used to assess symptoms of major depression in spouse respondents (Kroenke, Spitzer, and Williams, 2001; Löwe, Kroenke, et al., 2004). The PHQ-8, a variant of the PHQ-9, consists of items assessing the actual criteria on

which a DSM-IV diagnosis of major depression is based, with the exception of thoughts of suicide. Responses to the PHQ-8 are provided with respect to the frequency with which symptoms were experienced. This is the same instrument and scoring that were used for the veterans, as described earlier.

Alcohol Use. Problematic alcohol use during the past month was assessed by asking about past-30-day alcohol use, using the same measures as were used with the veteran sample. We calculated the percentage of spouses who reported consuming no alcoholic beverages over the past month (i.e., abstinence); the percentage of spouses who reported binge drinking, defined as five or more drinks on one occasion for males and four or more drinks on one occasion for females (Wechsler et al., 1994), at least once over the past month; and the percentage of spouses who engaged in frequent binge drinking, defined here as binge drinking on five or more days during the past month.

Barriers to Care. To assess barriers to seeking health care for mental health concerns, spouses were asked a single question: “If you wanted help for an emotional or personal problem, which of the following would make it difficult?” This question was followed by statements posed as potential barriers to treatment. Respondents endorsed each statement, by responding “true,” that they thought would make it difficult to get treatment.

Past-Year Unmet Need for and Utilization of Mental Health Services. Similar to the survey of veterans, spouses’ unmet need for mental health services at any time in the past 12 months was assessed by asking, “In the past 12 months was there ever a time when you wanted to get professional help for a mental health, stress, family or alcohol problem but did not?” Spouses’ past-year utilization of services for mental health concerns was determined by asking whether respondents had seen any provider for mental health services in the past 12 months and, if so, what type of providers the respondent had visited (e.g., regular medical doctor or primary-care physician; mental health specialist, such as a psychiatrist, psychologist, or counselor). An example question from this series of inquiries is, “In the past 12 months have you visited any professional like a doctor, a psychologist, or a counselor to get help with issues such as stress, emotional, alcohol, drug, or family problems?”

Physical Health. The SF-36 (Ware et al., 1993) subscales of Physical Functioning and Role Limitations Due to Physical Health were used to assess the physical health of spouse respondents. This is the same measure used to assess physical functioning among veterans (described earlier); however, given the differences in the gender composition of the veteran respondents as compared with the spouse respondents, somewhat different population norms apply because scores are interpreted differently based on gender.

Employment Characteristics and Needs. Current employment status was assessed by asking spouse respondents to select the category that best describes their current work status. This is the same measure as was used for the veterans’ survey.

Financial Strain. To assess financial strain from the spouse’s perspective, each spouse respondent was asked to indicate how much difficulty he or she had experienced paying bills during the past four months. Response options included “no difficulty,” “a little difficulty,” “some difficulty,” and “a great deal of difficulty.”

Familial Relationships and Adjustment. Spouse respondents were asked several questions about psychosocial functioning. A single question was asked to assess current global marital satisfaction: “Overall, how satisfied are you with your marriage right now? Response options included “very satisfied,” “somewhat satisfied,” “neutral,” “somewhat dissatisfied,” and “very dissatisfied.” This single-item measure of global relationship satisfaction has evidenced validity

based on previously documented associations with other psychometrically sound measures of global relationship satisfaction (Johnson, 1995).

Spouse respondents were also asked about the extent to which they were bothered by several different psychosocial problems. These specific questions were developed for this study. Psychosocial problems fell into three broad categories: adjustment problems that occurred at the time the spouse returned from deployment, current psychosocial problems not directly related to deployment or military status, and current problems with their children. For post-deployment adjustment problems, each spouse was asked whether he or she had experienced any of six problems since his or her spouse's return from his or her most-recent deployment. Examples of problems assessed include "getting to know him/her again" and "adjusting to having him/her as a part of your daily family routine again." For psychosocial problems not directly related to deployment or military status, spouse respondents were asked how much they had been bothered by each of nine "common problems people have every day" over the past year. Response options for each problem included "not bothered/not applicable," "a little bothered," "somewhat bothered," and "bothered a great deal." Examples of these psychosocial problems are "not having enough time to do the things you want to do" and "changing roles or responsibilities in the family or marriage." Using the same set of response options, spouses who had children under the age of 18 living at home were asked how much they had been bothered by each of four problems with their children over the past year. Examples of child-related problems include "problems with your children's behavior" and "difficulties with your children."

Spouse Survey Findings

All spouses in this sample were married to one of the veterans in the sample at the time of the study. Other than gender, the spouses' demographic characteristics were extremely similar to the demographics of married veterans. The overall demographics of the spouses are given in Table 3.12. A small proportion of spouse respondents had a history of U.S. military service (11 percent), and the majority did not have a college degree (57 percent). The great majority of spouse respondents were married to the veteran respondent at the time of the veteran's most-recent deployment.

As shown in Table 3.13, the rate of probable MDD among spouse respondents was 10 percent for the 30 days prior to the interview. Several studies have used the same depression instrument in nationally representative samples. These studies suggest that the prevalence of depression among similar individuals in the general population (matched to the spouse sample on age and gender) falls between 7 percent and 11 percent (Kroenke, Strine, et al., 2009; Pratt and Brody, 2008). This suggests that the spouse respondents are at no greater risk for major depression than their peers in the general population. This finding stands in stark contrast to the dramatically elevated risk for mental health problems observed in veteran respondents relative to the general population.

Forty percent of spouse respondents abstained from alcohol during the past 30 days. Nearly a fifth of respondents (19 percent) reported at least one binge-drinking episode, and the average number of days of binge drinking was 0.6 during the past 30 days. Frequent binge drinking (i.e., binge-drinking episodes on five or more days during the past 30) was reported by only 3 percent of spouse respondents. Overall, problematic alcohol use appears to be relatively uncommon among spouse respondents.

Table 3.12
Spouses' Sociodemographic Characteristics (N = 293)

Characteristic	Percentage	95% CI LL	95% CI UL
Male	9	5.6	12.1
Race			
White	82	77.7	86.6
Black	6	2.9	8.3
Hispanic	7	3.8	9.5
Other	6	2.9	8.3
35 years old or younger	37	31.5	42.6
Has a history of U.S. military service	11	7.1	14.1
Was married to veteran at time of his or her last deployment	82	77.5	86.3
Has children under the age of 18 living with him or her	64	58.5	69.5
College degree or higher	43	37.5	49.0

Table 3.13
Depression and Alcohol Use Among Spouses During the Past 30 Days (N = 293)

Condition	Mean (SD) or Percentage	95% CI LL	95% CI UL
Percentage of spouses with probable depression	10	6.5	13.4
Percentage of spouses who abstained from alcohol consumption	40	34.2	45.5
Percentage of spouses who reported at least one binge-drinking episode	19	14.4	23.4
Average number of days of binge drinking	0.6 (2.0)	0.3	0.8
Percentage of spouses who reported five or more episodes of binge drinking (i.e., frequent binge drinking)	3	1.1	5.1

NOTE: For average number of days of binge drinking, the mean is outside the parentheses and the SD is inside them. Binge drinking is defined as the consumption of five or more alcoholic drinks in the same sitting for men or four or more alcoholic drinks in the same sitting for women. Frequent binge drinking is defined here as binge drinking on five or more days during the past month.

As shown in Table 3.14, a small proportion of spouse respondents (14 percent) indicated an unmet need for mental health services in the past year. Just over one-fifth of spouse respondents (21 percent) reported any mental health visit to a doctor or mental health specialist during the past year. Relative to the veterans, this is approximately the same level of service seeking, even though the spouses showed dramatically lower rates of unmet need and of probable major depression.

To understand why spouses might refrain from obtaining mental health services if they wanted them, we examined rates of endorsement of several possible barriers to mental health services (see Table 3.15). Similar to veteran respondents, the most-frequently cited reason that spouse respondents who wanted mental health services gave for not getting them was medica-

Table 3.14
Spouses' Mental Health Services in the Past 12 Months (N = 293)

Mental Health Service	Percentage	95% CI LL	95% CI UL
Mental health services were desired but not obtained	14	9.8	17.8
Any mental health visit to a doctor or mental health specialist	21	16.0	25.4
Any mental health visit to a doctor	12	8.0	15.4
Any mental health visit to a mental health specialist	13	9.2	17.0

Table 3.15
Barriers to Mental Health Care Among Spouses Who Wanted It (N = 293)

Barrier	Percentage	95% CI LL	95% CI UL
Logistical			
High cost of mental health care	20	15.6	24.9
Difficulty getting child care or time off work	18	13.6	22.4
Not knowing where to get help or whom to see	13	9.2	17.0
Difficulty scheduling an appointment	10	6.6	13.5
Difficulty arranging transportation	5	2.1	6.9
Institutional and cultural			
Co-workers would have less confidence if they knew	10	6.1	12.9
Concerns about confidentiality of treatment	8	4.9	11.2
Friends and family would respect me less	8	5.1	11.5
My supervisor might respect me less	8	5.2	11.6
It could harm my career	5	2.6	7.8
Potential loss of contact or custody of children	2	0.2	3.3
My spouse/partner would not want me to get treatment	2	0.4	3.7
Beliefs about and preferences for treatment			
Medications with potential to help have too many side effects	38	32.4	44.2
Perception that even good mental health care is not very effective	10	6.2	13.1
Perceived ineffectiveness of mental health treatments available	9	5.3	12.2

tion side effects, which was endorsed by more than a third of the sample (38 percent). Two logistical barriers were the next most-commonly endorsed—the high cost of mental health care (20 percent) and difficulty getting child care or time off work (18 percent). In separate questions about health insurance, we found that the overwhelming majority (94 percent) of spouse respondents reported having health insurance coverage. Thus, concerns about the cost of mental health care might partly reflect inadequacy of coverage for mental health treatment under many health insurance policies. Overall, concern about the side effects of psychotropic medication, financial cost, and difficulty of freeing oneself from child care– or work-related

obligations would likely be the greatest deterrents of treatment seeking among spouse respondents, if they desired mental health treatment.

It is important to note that these barriers are quite different from the barriers endorsed by the veterans themselves. Cultural barriers and fear of discrimination emerged as prominent obstacles to obtaining mental health care for veterans themselves; however, these barriers were rarely endorsed by their spouses. For example, the barrier “It could harm my career” was endorsed by only 5 percent of spouse respondents.

To describe the physical health of spouses, we compared their average scores on the Physical Functioning and Physical Role Limitations subscales of the SF-36 to norms for the general population after adjustment to match the age and gender distribution of spouse respondents in the current sample. Relative to population-based norms for mean scores on the Physical Functioning and Physical Role Limitations subscales of the SF-36, which were 86.7 and 83.5, respectively (Ware et al., 1993), spouse respondents had nearly equal scores on the Physical Functioning ($M = 86.7$, $SD = 20.9$; 95-percent CI [84.3, 89.1]) and Physical Role Limitations ($M = 81.2$, $SD = 34.3$; 95-percent CI [77.2, 85.1]) subscales of the SF-36. Thus, spouse respondents reported almost identical levels of physical functioning to those of their peers in the general population.

As shown in Table 3.16, the majority of spouses reported full- or part-time employment (66 percent). By comparison, 27 percent reported not working. The latter group included individuals who were disabled, as well as those who were students, homemakers, retired, or unemployed and not looking for work. Seven percent of the overall spouse sample was unemployed and looking for work. If we compute an unemployment rate similar to the standard definition of unemployment used by BLS (U-3), the rate of unemployment for spouse respondents was 9 percent. This rate of unemployment was slightly lower than that observed among veteran respondents but very similar to the 8.3-percent unemployment rate for New York state in August 2010 (BLS, undated).

Among the spouses who reported full- or part-time employment, 16 percent were looking for new or additional jobs. This contrasts sharply with the 38 percent of employed veteran respondents who reported currently looking for a new or additional job. Of note, only a small proportion of spouse respondents had been enrolled in college or university courses during the past year (16 percent). This proportion is roughly half the proportion of veteran respondents who had been enrolled in college or university courses during the past year (36 percent). One possible interpretation of this difference is that veteran respondents are especially motivated to pursue higher education now because of the education benefits to which their newly attained veteran status entitles them (Steele, Salcedo, and Coley, 2010). This interpretation is consistent

Table 3.16
Spouses’ Current Employment Status and Past-Year College Attendance (N = 293)

Employment Status	Percentage	95% CI LL	95% CI UL
Employed full or part time	66	61.0	71.9
Unemployed and looking for work	7	3.7	9.4
Not working	27	21.9	32.1
Was enrolled in college or university during the past year	16	11.7	20.2

with the large number of veterans (39 percent) who reported having used financial aid for education since leaving the military.

Spouse respondents' perceptions of financial strain were assessed by asking them how much difficulty they had experienced paying their bills over the past four months. Nearly half (49 percent) reported no difficulty, nearly a third reported a little difficulty (28 percent), and nearly a fifth (16 percent) reported some difficulty. Only a very small percentage of spouse respondents reported having had a great deal of difficulty paying their bills over the past four months (7 percent). Thus, financial problems do not appear to be widespread among spouses.

When spouses were asked how satisfied they were with their marriages overall, only 9 percent expressed dissatisfaction with their marital relationships. However, sizable numbers reported experiencing some relationship problems when their spouses returned from deployment (see Table 3.17). The most-commonly endorsed problem was dealing with the veteran's mood changes (44 percent). Other post-deployment problems cited by at least one-third of spouse respondents included worrying about possible future deployments (42 percent), adjusting to the veteran's reintegration into the daily family routine (35 percent), and rebalancing household responsibilities (35 percent).

The proportion of spouses who had problems related to the veteran's mood changes was twice as high as the proportion of veterans with probable psychiatric diagnoses (21 percent). There are several possible explanations for this finding. It might reflect spouses' problems with veteran's mental health symptoms, such as irritability or depressed mood, that are less severe than is required for probable diagnosis, other mood problems not assessed by our instruments (e.g., anger problems), or the fact that we assessed probable psychiatric diagnoses only over the prior 30 days rather than since return from deployment. This finding does seem to corroborate a key theme that emerged from veterans' survey responses—that mental health problems represent one of the major challenges of post-deployment adjustment for veterans.

A relatively small proportion of spouse respondents reported currently being bothered “a great deal” by each of the psychosocial problems not specific to being married to a veteran (see Table 3.18). The psychosocial problem that most-commonly bothered spouse respondents was “not having enough time to do the things you want to do” (13 percent). Similarly, as shown in Table 3.19, spouses were rarely greatly bothered by problems with their children, i.e., no more than 7 percent of spouses with children indicated being bothered “a great deal” by any

Table 3.17
Percentage of Spouses with Various Relationship Adjustment Problems (N = 293)

	Percentage	95% CI LL	95% CI UL
Currently dissatisfied with marital relationship	9	5.4	11.9
Post-deployment problems			
Dealing with veteran's mood changes	44	38.2	49.7
Worrying about veteran's possible future deployments	42	35.8	47.2
Adjusting to having veteran as a part of the daily family routine again	35	29.8	40.8
Rebalancing household responsibilities with veteran	35	29.5	40.4
Getting to know veteran again	25	19.9	29.9
Rebalancing child responsibilities with veteran	23	18.3	28.0

Table 3.18
Percentage of Spouses Who Were “Bothered a Great Deal” by Various Psychosocial Problems During the Past Year (N = 293)

Psychosocial Problem	Percentage	95% CI LL	95% CI UL
Not having enough time to do the things you want to do	13	8.6	16.3
Experiencing financial difficulties	10	6.9	13.9
Having too many responsibilities	9	6.0	12.7
Problems with growing apart from your spouse	6	3.4	9.0
Taking care of family members	5	2.1	6.9
Problems getting along with your family	5	2.1	6.9
Changing roles in the family or marriage	4	1.4	5.6
Worrying about meeting work obligations	4	1.4	5.6
Problems with housing	2	0.4	3.7

Table 3.19
Percentage of Spouses Who Were “Bothered a Great Deal” by Various Child-Related Problems (N = 185)

Child-Related Problem	Percentage	95% CI LL	95% CI UL
Problems with your child’s behavior	7	3.4	10.8
Concerns about how your child is doing at school	6	2.6	9.4
Difficulties with your child	6	2.6	9.4
Disagreements with veteran over discipline of a child	4	1.4	7.3

of the child-related problems. Thus, it appears that the psychosocial and child-related problems assessed here are not paramount causes of concern to the great majority of veterans’ spouses.

Limitations

There are several limitations to the assessment methods that should be kept in mind when interpreting our findings. Perhaps the most-important limitation is that our sampling methods might not produce a completely representative sample of veterans residing in New York state. On the plus side, the demographic characteristics of the sample closely match known characteristics of the veteran population. Specifically, the proportions of survey respondents who were women, who had been officers, and who had multiple deployments are all extremely similar to the overall characteristics of service members previously deployed for OEF/OIF. In terms of the important characteristics that have been shown to be associated with PTSD in OEF/OIF veterans, this sample appears highly representative of the overall previously deployed force. In addition, the spouse sample appears very similar to a representative population sample in terms of their health and well-being. Thus, it does not appear that the recruitment methods resulted in the sampling of unusually healthy or unhealthy households.

This evidence of sample representativeness notwithstanding, we know that several types of individuals are systematically under-represented in the sample. We started with a list of the names and addresses of VA-eligible individuals with New York addresses. While this is the best available data source for sampling, it does exclude some veterans residing in New York. Specifically, those veterans who had a non–New York address at the time of discharge but who migrated to New York later would not be included on this list. This is because the VA does not regularly update or maintain addresses for all eligible veterans. In addition, individuals who have relocated frequently since leaving the service, even if these moves were within New York, are less likely to be reached either by letter or by phone and are under-represented in the sample. Similarly, our data-collection methods require either a land-line telephone or Internet access. Thus, we know that the study under-represents several types of individuals: those who recently migrated to New York, those with transient addresses, and those without a land-line telephone or Internet service. Finally, while the response rate was quite good for a population-based telephone study, the possibility exists that the individuals who did not respond differ systematically from those who did respond. In short, while the demographic characteristics of the sample look very similar to what we had expected, there are still several types of individuals who are under-represented. If those under-represented individuals have substantially different health and well-being from those in our sample, our findings will over- or under-estimate the true needs of our target population.

Our findings are also limited somewhat by the nature of our measures. First, we used mental health measures that assessed symptoms only over the past 30 days. Some of the respondents who did not meet screening criteria for PTSD and major depression in the past 30 days would have met criteria at some time in the past or will meet it at some point in the future. Essentially, this study is a snapshot of mental health problems at one point in time, whereas the symptoms of those with PTSD or major depression tend to fluctuate over time. When planning for delivery of services it is important to realize that the number of individuals who will have a psychiatric disorder at some point over the next year, or the next decade, is necessarily higher than the number who have the disorder at a specific point in time. The study is also limited because we relied on self-report data collection. The measures of depression and PTSD used in this study have been shown to be closely associated with clinical diagnoses, and they are the standard measures used in epidemiological studies of the U.S. military and veterans. However, to the extent that clinical interviews might have yielded different findings, these results should be viewed with caution, and additional research is warranted. Future research might, for example, document the presence of mental health problems using structured diagnostic interviews or other sources of data to assess the health care provided to OEF/OIF veterans.

Conclusions

This assessment of the health and well-being of veterans in New York state was designed to identify opportunities for improvement in services and benefits offered to these veterans. Similarly, we conducted a separate assessment of several aspects of the health and psychosocial functioning of spouses of the married veterans surveyed.

Given this array of assessment data from both the veterans and their spouses, the most-significant finding is the unusually high rates of mental health problems among veterans. While these findings are only slightly higher than those we found in our early study of a

broader sample of OEF/OIF veterans, they represent a relatively dramatic increase in risk for mental health problems compared with similar individuals in the general U.S. population. Specifically, veterans' risk of major depression was two to four times higher than similar individuals in the general population, and veterans' risk of PTSD was at least eight times higher than similar individuals in the general population. This finding is also consistent with the broader literature suggesting that National Guard/reserve (Milliken, Auchterlonie, and Hoge, 2007), as well as those who leave the military (Schell and Marshall, 2008), might be slightly more susceptible to mental health problems than are active-duty personnel. For example, even though this sample of veterans experienced slightly fewer exposures to trauma than participants in the "Invisible Wounds" study, they had slightly higher overall rates of a probable diagnosis.

It is important to note that, although veterans have higher rates of PTSD and major depression than does the general population, they have relatively typical rates of alcohol misuse and low rates of illicit drug usage. However, there still might be a substantial number of veterans who would benefit from addiction-related services, and such services might be an important part of the successful treatment of some cases of PTSD or depression.

Our assessment of the unmet need for, utilization of, and adequacy of mental health services indicated considerable room for improvement in veterans' utilization and quality of mental health services received. Many veterans believe that they had an unmet need for mental health services during the past year or that they could be helped by counseling or substance abuse treatment. Overall, more than half of the sample either had a self-assessed need for treatment or were currently suffering from a probable psychiatric disorder. Among the group with some need for treatment, only a third had sought mental health services during the past year. Although our data do not allow us to determine with any certainty why two-thirds of veterans in our sample who needed mental health treatment did not seek treatment, respondents did endorse several barriers. The most-frequently endorsed barriers were side effects of medication, as well as concerns about possible discrimination against individuals receiving mental health treatment. These findings suggest that increasing utilization of treatment might require ensuring the availability of alternatives to pharmacotherapy. These concerns about drug treatment might also explain the finding that veterans are much more likely to seek care from psychologists and counselors than from medical doctors. The widely endorsed concerns among veterans about possible workplace discrimination against those who get mental health treatment might be more difficult to address. However, it might be helpful to educate veterans about the confidentiality of VA medical services, as well as recent changes to the security-clearance process, that might reduce the likelihood of such negative outcomes from treatment.

Even when veterans sought mental health care, the treatment received was often less than what would be considered minimally adequate. This could happen for many reasons. For example, they might have been assessed but not referred into any regular treatment; they might have been referred into treatment but never showed up; or they might have started treatment but dropped out for some reason (e.g., medication side effects or counseling that was difficult to schedule). It is worth noting that our definition of "minimally adequate" is less than what has been empirically shown to be effective. Thus, even though a respondent received minimally adequate care by definition, he or she might not have received any type of evidence-based treatment.

In interpreting these findings, it is important to note that our data do not directly address *why* so few veterans are getting sustained treatment for their mental health problems and even fewer are getting high-quality, evidence-based treatments. This problem is not unique to vet-

erans' communities and is at least as common in studies of civilian and active-duty military samples (Wang et al., 2005; Schell and Marshall, 2008). Indeed, much of the mental health care received by veterans in our sample was delivered by civilian providers. However, there are certainly elements of the health care system that might discourage sustained, high-quality treatment that might serve as points for intervention (e.g., shortages of mental health professionals trained in evidence-based therapies, long wait lists and wait times for entry into treatment, delivering treatment at more-convenient locations or times). Additional research would be necessary to assess and quantify these factors' respective influences on the quality of care. However, our data clearly demonstrate that there is room for improvement of the completeness and quality of the mental health care received.

Although high levels of mental health problems were the most-striking difference between the veteran sample and the general population, this community also has other significant needs. The veterans' overall level of physical functioning and role limitations due to physical health were worse than typically found among similar individuals in the general U.S. population. It appears that this is primarily attributable to a small number of veterans who have substantial functional limitations that are unusual for people of their age.

In addition, some veterans suffered from occupational and financial problems. The unemployment rate among veterans was notably worse than that of the general New York population. While this might not be surprising, given that veterans are undergoing career transitions as they reintegrate back into civilian life, high unemployment is certainly a substantial threat to veterans' overall psychological and physical well-being. Relatively high rates of unemployment suggest that job placement services, as well as education and vocational programs, might be a welcome and effective means to improve veterans' well-being. Given the availability of federal funding for veterans' educational benefits, such interventions might also be more feasible than alternative efforts to assist veterans. Indeed, a substantial number of veterans in the sample have already taken advantage of these benefits, and many have attended college in the past year.

In contrast to the veterans surveyed, their spouses were quite similar to the general population in terms of their overall health and well-being. They do not appear to be at increased risk for major depression, alcohol abuse, drug use, physical health limitations, or unemployment. When asked about a range of common life hassles, few spouses reported being greatly bothered by them. However, 44 percent did report having problems dealing with their veteran spouse's mood changes, and 42 percent reported being worried about the possibility of future military deployments. Thus, they might have some significant veteran-specific sources of life stress, even if their overall well-being is relatively normal. However, it is important to note that, even within a population that is not at elevated risk for problems, there are some individuals who have serious mental or physical health problems who might benefit from clinical treatment or social services. In addition, our assessment of veterans' spouses occurs, on average, nearly four years after their last deployment. The fact that their mental health was good at the time of this study does not imply that they would not have benefited from additional social services during the time of deployment or when the veteran initially reintegrated into civilian life.

In sum, this needs assessment finds that New York veterans are at risk for problems across several different domains of well-being: psychological, physical functioning, and financial. Relative to the general population, these risks are most severe for PTSD and major depression. However, a significant number of veterans also struggle with serious problems related to physical functioning and employment. Addressing these needs is a complex problem that involves

not only the VA but also other public-sector programs run by the state or local governments, as well as the civilian health care system—in which a substantial fraction of veterans’ health care is provided. Our earlier work on the “Invisible Wounds” study, which included a system-level analysis of care, suggested that improvements in mental health outcomes for veterans require increasing access to high-quality care. To do this, we recommended that some of the barriers to seeking treatment be addressed and that the institutional characteristics that make it difficult for veterans to access or sustain high-quality, evidence-based treatment be modified. These recommendations are well suited to New York state’s efforts to address veterans’ needs as well.

Report Summary and Conclusions

This study draws on the findings from qualitative interviews, as well as a quantitative needs assessment of veterans and their spouses residing in New York state.

Chapter Two presented results from qualitative interviews with veterans and their family members. The interviews were designed to (1) document how veterans and their family members think about the challenges they face; (2) gather opinions about the availability, quality, and comprehensiveness of available programs and services; and (3) elicit innovative ideas for improvement. After interviewing a diverse group of veterans and family members across the state, we observed several common themes. In particular, veterans and family members reported a range of mental health concerns following veterans' return from Iraq or Afghanistan, difficulties reconnecting with friends and family, and problems finding jobs commensurate with their skills. There was also a shared perception that it is extremely difficult to navigate the existing system of benefits and services across both VA and non-VA providers, including difficulties determining (1) what services are available, (2) whether the services would be helpful for veterans' specific problems, (3) where the services are available, (4) who is eligible to receive them, and (5) how to apply. Finally, there was general agreement on several suggestions for improvement, including improving military out-processing and subsequent outreach and educational efforts to increase utilization of existing services; expanding VA services to reduce travel time, waiting times, and delays in scheduling appointments; and expanding programs to help families of veterans.

Although the opinions expressed in qualitative interviews should not be taken as representative or accurate descriptions of the challenges that veterans face or the quality of the care they receive, these interviews do provide important insight into veterans' beliefs and perceptions. It is important to document that veterans think that the system of care that serves them is difficult to understand, that it is time-consuming to navigate these systems, and that the quality of care is suspect and seen as highly variable. These perceptions are important because they likely inhibit the use of services that would help veterans meet the challenges they face, even if, by objective or comparative measures, the VA services are promptly delivered and of high quality.

In Chapter Three, we presented the results of the quantitative needs assessment that documented the health and well-being of both veterans and their spouses. We found that veterans are at high risk for problems across several different domains of well-being: psychological, physical functioning, and occupational. The most-significant finding was the high rates of mental health problems among veterans. Approximately 22 percent met criteria for a probable diagnosis of either PTSD or depression. In addition, 10 percent met criteria for both disorders, which suggests a relatively high level of functional impairment. Veterans' rate of PTSD was

at least eight times higher than that of similar individuals in the general population. Similar to most other research on utilization of mental health care, we found that many individuals with a need for treatment did not seek treatment and that many of those who sought treatment did not get a “minimally adequate dose” of treatment. The most-frequently endorsed barriers to treatment were side effects of medication, as well as concerns about possible discrimination against individuals receiving mental health treatment.

Although high levels of mental health problems were the most-striking difference between the veteran sample and the general population, there were other significant needs being faced by this community. The veterans’ overall level of physical functioning and role limitations due to physical health were lower than levels for similar individuals in the general population. In addition, the unemployment among veterans was notably worse than in the general New York population.

In contrast to the veterans surveyed, their spouses were quite similar to the general population in terms of their overall health and well-being. They do not appear to be at increased risk for depression, alcohol abuse, physical health limitations, or unemployment. However, asked to reflect on problems experienced at the time of the veteran’s return from his or her most-recent deployment, 44 percent of spouses did report having problems dealing with their veteran spouse’s mood changes, and 42 percent reported being worried about the possibility of future military deployments. Thus, spouses did experience some significant veteran-specific sources of life stress soon after the veteran’s return from deployment, even if their current overall well-being is relatively normal.

In the appendix, we present a review of veterans’ resources in the state of New York. The design of this review was influenced by the focus groups we conducted, in which participants expressed concern about overall complexity of the health and social-service systems that serve them. Rather than present this review of resources as a comprehensive database of providers and services, we have attempted to put together a guide or map to the systems of care. This is designed to help answer basic questions and navigate the maze of existing programs, agencies, and benefits. This resource guide attempts to educate veterans about (1) the signs and symptoms that indicate that they might benefit from mental or behavioral health services and (2) the three broad health systems that veterans and their family members might use to access or fund these services. In addition, we drafted a list of resources, with an emphasis on resources that are designed specifically for veterans. This list is presented both as a table, with information about the type of services or benefits provided and the geographic region served, and in brief narrative descriptions of the mission of each organization or agency.

Because our interviews revealed a high level of confusion and frustration with the available sources of information about veterans’ resources, we believe that this resource guide has the potential to be useful to the veteran community. However, to be most effective, this guide would benefit from additional revisions, professional formatting for ease of use, and expansions to ensure any new service providers are included. In addition, it would need to be regularly updated in order to maintain its usefulness to the veteran community.

Overall Conclusions

Looking across both the qualitative and quantitative needs assessments, several common themes emerge, allowing us to draw several conclusions.

First, it is clear that veterans' health and well-being are the responsibility of more than just the VA. We found in both our focus groups and survey that other clinical and social-service delivery systems are critically important for addressing veterans' needs. The majority of veterans have other sources of health insurance, and much of the care delivered to veterans in New York is either through the civilian health care system or through public-sector providers. Thus, when thinking about how to improve the utilization and quality of care for veterans, we need to think beyond making changes in the VA, looking at factors in the private health care system, such as severe restrictions on the amount of mental health care provided by some insurance, the availability of both counseling and drug therapy, the mental health screening and referral procedures of primary-care physicians, and the level of training in evidence-based treatments for PTSD among civilian providers.

While the VA health care system is tasked specifically with meeting veterans' needs, there will always be a large subset of veterans for whom the VA is a less preferred or less convenient source of care than civilian providers. For some veterans, this might be because the nearest VA clinic or medical center is inconveniently located, turning a weekly one-hour counseling session into a three- or four-hour trip. In addition, we found that about half of veterans prefer civilian providers, while half prefer VA care. If we wish to maximize treatment seeking and sustainment, it is important to provide care that meets the client's preferences. Thus, improving the quality of services for veterans will require changes in both the civilian and nongovernmental sectors as well.

A second theme that emerges across the two needs assessments and the resource guide is that the health care systems that serve veterans are extremely complicated. Getting veterans to access the benefits and services that are available to them will require, in many instances, personalized assistance. The VA system has complicated and changing eligibility and priority rules, and the locations and types of treatments that are available also change over time. Care and benefits available to a given veteran through state programs, local nonprofits, and private insurance are just as complicated. As such, additional efforts to provide navigation assistance to veterans are likely needed. These navigators should have knowledge of programs and services offered by the full array of providers in order to help veterans and their families most efficiently. Focus group participants widely praised the work of the new regional OEF/OIF care coordinators within the VA. However, (1) most veterans do not know about this resource, and (2) these coordinators are focused primarily on helping coordinate VA care and might not know about other resources or benefits available to veterans.

Better outreach is needed to connect veterans with these care coordinators who can provide personalized assistance across a range of service sectors. Such outreach is extremely difficult in the current system. While the VA does have regularly updated contact information for individuals who are enrolled in the health care system or receive VA benefits, the veterans who are most in need of assistance—those who have not yet enrolled in the VA—are extremely difficult to contact. The New York State Division of Veterans' Affairs does send out mailings to the full list of VA-eligible veterans using the same RONA information we used for sampling. However, we have learned in conducting this study that this contact information has substantial errors and omissions. It appears that these addresses are, in many cases, places that the veteran has not lived for many years. Perhaps more importantly, the list appears to omit the potentially large number of veterans who move to New York some time after becoming VA eligible. This severely hampers the ability of states, universities, and other nonprofit institutions providing services to veterans to perform effective outreach. It would greatly facilitate

outreach, both by the VA and by other agencies, if the contact list for VA-eligible individuals were regularly updated and centrally maintained. For instance, this could be accomplished by having the VA get regularly updated addresses from the databases maintained by the Social Security Administration or Internal Revenue Service.

A third theme that emerges across both the focus groups and the survey is that addressing the mental health needs of veterans will require a multipronged approach. It will require reducing barriers to seeking treatment; improving the sustainment of, or adherence to, treatment; and improving the quality of the care being delivered. Part of this might require addressing the barriers to care that veterans identified. Given the concerns among veterans about drug side effects, making sure psychotherapy is widely available across service sectors might be important. Addressing veterans' concerns about occupational discrimination against those who get treatment might be more difficult. However, it might be helpful to educate veterans about the confidentiality of VA medical services, as well as recent changes to the security-clearance process that reduce the likelihood of such negative outcomes from treatment. In addition to addressing these barriers, it might be critical to improve the overall quality of mental health care being delivered across all service sectors. This might require programs that increase screening in the civilian sector for the specific mental health problems that affect veterans (such screening is already standard in the VA), reduce wait times for counseling, increase the number of providers trained in the provision of evidence-based treatments for PTSD and depression, and provide mental health services at more-convenient locations and times. In addition to making these improvements in the quality of care, it might be important to educate the veteran population that high-quality and effective treatments are available. In this manner, veterans will be better informed of the opportunities for recovery.

Finally, many of the findings presented in this report have focused on mental health issues, which are consistent with the prominent role they played in both the qualitative and quantitative assessments, as well as the priority of these topics for our study sponsor. However, it is important to note that veterans have other serious needs. The current economic environment is extremely difficult for individuals who are making major career transitions and perhaps especially for veterans who are entering new professional areas. High unemployment is certainly a substantial threat to veterans' overall psychological and physical well-being. This suggests that job placement, education, and vocational programs might be a welcome and effective means to improve veterans' well-being. While the VA offers vocational rehabilitation for those who are eligible, additional job placement and vocational programs might be necessary. Similarly, there is a small, but important, subset of veterans who are facing substantial physical health limitations. Although there are disability benefits available to these individuals for limitations that can be shown to be service connected, there is likely a broader range of services that would benefit these individuals. Notably, they might benefit from educational or occupational assistance that allows them to become economically self-sufficient in spite of their physical limitations.

In conclusion, this study demonstrated that veterans residing in New York state confront several challenges. Mental health-related issues remain a major source of problems for the population, and additional efforts are needed to expand and enhance the type and quality of services available to them to meet current and future needs. At the same time, efforts to provide assistance in navigating benefits and services and transitioning to new employment opportunities will also be important.

Resource Guide for Veterans' Mental and Behavioral Health Services

Carrie Farmer, Terry L. Schell, Lisa H. Jaycox, and Terri Tanielian

This appendix contains two subsections. The first is a draft text of a resource guide designed to answer the basic questions veterans might have about mental and behavioral health care—such questions as, “How do I know when I might benefit from assistance?” “What are the different options for getting care?” and “How do I choose a provider?” The second section provides descriptions of the agencies and organizations in New York state that are designed either to provide these services or to assist veterans as they navigate these various systems of care. In drafting this resource guide, we drew from existing resources and literature available to consolidate helpful information for veterans and their families who reside in New York state. The format is based on other psychoeducational and health resources.

New York State Veterans' Guide to Care for Mental and Behavioral Health Problems

I am an OEF/OIF veteran and have been experiencing a lot of stress. Is this normal? How do I know whether I should get help with my problems?

Almost everyone who has spent time in Iraq or Afghanistan has experienced something very stressful, whether it was the separation from family or direct combat experiences. Studies of military personnel deployed to support these conflicts find that traumatic experiences—such as being attacked or ambushed, having to handle or uncover human remains, and knowing someone who was seriously injured or killed—are common. If you had similar experiences when you were in Iraq or Afghanistan, you are not alone.

There are many different types of reactions to these kinds of stress. Many returning military members might be forgetful and have trouble concentrating, might relive bad memories of traumatic events, or might have thoughts of death or suicide. Returning veterans might feel sad, hopeless, worthless, paranoid, anxious, guilty, or angry. In addition, returning veterans might have trouble readjusting to being back from deployment because they are trying to avoid situations that trigger flashbacks of traumatic experiences, do not want to socialize with others, have low energy, or use drugs or drink too much.

You might have some of these thoughts and feelings. It is good to remember that these are common reactions to abnormal events and that many veterans experience them. However, these thoughts, feelings, and behaviors can also lead to more-serious problems and might interfere with returning to a happy and productive life. They might be signs of post-traumatic stress

disorder (PTSD), depression, or substance abuse. There are well-developed treatment programs to help you deal with each of these problems.

PTSD. PTSD is a condition that people have after experiencing a disturbing event. Combat experiences—such as being shot at, handling dead bodies, or knowing someone who was killed—can trigger PTSD.

Symptoms of PTSD can include the following:

- *Reliving the event.* You feel that you are experiencing the event again—often with the same fear and shock you had when it took place. These kinds of flashbacks can be triggered by loud noises, seeing a traffic accident, or even watching a news report.
- *Avoiding situations that remind you of the event.* You try to avoid places or experiences that bring back memories of your terrible experience.
- *Feeling numb.* It seems like you don't have any feelings, and you might lose interest in relationships and activities.
- *Feeling on edge.* You get angry or annoyed very easily and you have a hard time sleeping, or you might overreact when something startles you.

Depression. Depression is a mood disorder that can interfere with your ability to work, sleep, eat, interact with others, and enjoy doing things that you used to like. Depression can also have long-term effects that make it hard for you to function with your family or in your job. It might also keep you from enjoying the good things in your life. Some of the most-common signs of depression include the following:

- feeling hopeless, sad, or “empty” most of the time
- losing interest or pleasure in activities that you used to enjoy
- lacking energy or feeling very tired
- having trouble sleeping or trouble staying awake
- experiencing unusual weight loss or weight gain
- feeling bad about yourself
- having trouble concentrating
- thinking about death or suicide
- moving or talking unusually slowly, or being fidgety and restless.

Substance Use and Abuse. Some veterans might find themselves drinking or using drugs to deal with their problems. This might help them forget about their problems for a little while, but alcohol or drugs often make problems worse. It's often hard to know when alcohol or drug use is becoming a problem. Here are some signs to look for:

- You feel guilty about your alcohol or drug use.
- Your family and friends comment on how much you are drinking.
- Your drinking or drug use makes it hard to live up to your responsibilities at home or at work.
- You need more alcohol or drugs to get the same effect.
- You have tried to cut down on your use but can't.

I want to talk to someone about the problems I'm having. Where do I start?

If you are currently upset and thinking about hurting yourself or others, please tell someone immediately. **You can get immediate help by calling the National Suicide Prevention Life-line (1-800-273-TALK) or by calling 911.** You can also ask for help from a family member or your health care provider.

There are several ways to find someone to talk with about your problems and receive treatment, if necessary. Health care providers, other veterans, and veterans' service organizations (VSOs) are good places to start.

Health Care Providers. You can talk in private with a health care provider, such as a doctor, nurse, psychologist, or other mental health professional. They know how to treat common post-deployment problems related to PTSD and depression. They can also help you find a mental health provider who specializes in treating your problems. Make an appointment specifically to discuss your symptoms.

To help a health care provider understand and treat your symptoms, take a list of questions and concerns with you to your appointment. As you go through the list together, take notes so that you can remember the provider's advice. It can also be useful to take someone you trust with you to this appointment to help you remember important parts of the discussion.

You should not feel like you have only one chance to ask a health care provider for help. After your first appointment, you should set up another appointment so that you and the provider can follow up on your progress. If you decide to meet with a mental health specialist, you might meet on a regular basis (likely once a week) until your symptoms improve.

How you find a health care provider can vary depending on what kind of health insurance you have. In the sections below, we discuss the four major health systems that serve veterans seeking help for mental health symptoms, excessive alcohol use, or drug use:

- the U.S. Department of Veterans Affairs (VA)
- TRICARE insurance
- private, employer-sponsored insurance or Medicaid
- free or low-cost care for the uninsured.

VA Health Care. The mission of the VA is to serve America's veterans and their families by promoting the health, welfare, and dignity of all veterans in recognition of their service to this nation. The VA is the principal agency charged with providing veterans with medical care, benefits, social support, and lasting memorials. The VA is made up of a central office and three major organizations: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA). The VHA administers and operates the VA's health care system.

If you are within five years of separation from the military, you are likely to be eligible to receive cost-free health care from the VA, regardless of whether you sustained a service-connected injury or illness.

Eligibility for VA health benefits is based on a priority rating system in which every veteran is assigned a priority group (priority groups 1 through 8). Priority groups are determined by service-connected disabilities, current income, and other factors. These group numbers can sometimes be confusing because the highest-priority individuals—those who get the fastest service and most-generous benefits—have the lowest priority group numbers. For example, the highest-priority group (priority group 1) includes individuals with a 50-percent or greater

service-connected disability rating and veterans who are determined by the VA to be unable to work due to service-connected injuries. The lowest-priority groups (priority groups 7 and 8) include individuals who do not have service-connected disabilities and whose incomes are higher than individuals assigned to other priority groups. Currently, veterans in priority groups 1 through 6 receive VA health care free of charge. Veterans in priority groups 7 and 8 might have some co-payment for each visit.

All veterans with combat service after November 11, 1998, and who received an honorable or general discharge are eligible to receive cost-free health care through the VA for five years after separation from active military service, regardless of whether they have sustained a service-connected injury or illness. Veterans who meet this definition are assigned to priority group 6.

If you are a returning combat veteran and do not enroll with the VA to receive services during the five-year window, you will likely still be eligible for VA health care, but you might be assigned to a lower (i.e., higher-numbered) priority group (and get a less generous health benefit) depending on your service-connected disability status and income.

Enrolling in VA Health Care. To determine whether you are eligible for VA health benefits and to enroll in the VA health care system, you submit the 10-10EZ form.¹ If you have a service-connected disability, you might also be required to complete a medical evaluation to get into a lower-numbered priority group.

You can call the VA toll free at 1-877-222-VETS (8387), Monday through Friday between 8:00 a.m. and 8:00 p.m. Eastern time to ask about benefits or eligibility or to enroll. You can also go to a vet center (described below) or ask for help from a VSO (such as those listed under “Veterans’ Communities and VSOs” later in this section). Many of these organizations have counselors available to help you fill out the form and can answer any questions you have about your eligibility for these benefits.

For those recently returning veterans seeking information online, the VA operates a website specifically for OEF/OIF veterans with information about how and where to apply for benefits.² In particular, the section titled “How Do I Get Help?” includes information about VA benefit eligibility, types of care, and locations of care.

Navigating the VA Health Care System. In New York, there are 12 VA medical centers (VAMCs), located in Albany, Batavia, Bath, Bronx, Brooklyn, Buffalo, Canandaigua, Castle Point, Montrose, New York City, Northport, and Syracuse. Every VAMC has an OEF/OIF care management team to help coordinate the care of OEF/OIF veterans. Case managers, who are either nurses or social workers, coordinate patient care activities and help veterans navigate through the VA system. Transition Patient Advocates (TPAs) act as personal advocates while veterans move through the VA health care system.

The VHA also operates 38 community-based outpatient clinics (CBOCs; sometimes referred to as VA clinics) across the state, which provide the most-common outpatient services in nonhospital settings, including health and wellness visits and specialty mental health care.

¹ VA, “Application for Health Benefits,” VA Form 10-10EZ, June 2008. As of November 11, 2010: <https://www.1010ez.med.va.gov/sec/vha/1010ez/Form/vha-10-10ez.pdf>

² VA, “Returning Service Members (OEF/OIF),” September 3, 2010. As of November 11, 2010: <http://www.oefoif.va.gov/>

To find a VA health care facility near you, go to the VA's website.³

Vet Centers.⁴ In addition, the VA operates many vet centers throughout the state. These are local sources of mental health care, counseling, and support and are often closer to your home than VAMCs. Vet centers play a critical role in providing mental health services for those who do not qualify for high-priority access to VA health care. Any veteran who has served in a war zone is eligible for care at a vet center. The centers offer individual and group counseling, marital and family counseling, bereavement counseling for family members, medical referrals, assistance in applying for VA benefits, employment counseling, military sexual-trauma counseling, alcohol and drug abuse assessments, outreach, and community education. Services are offered at no cost to eligible veterans and their families, and there is no limit on the duration or frequency of services.

There are currently 15 vet centers in New York: Albany, Babylon, Binghamton, Bronx, Brooklyn, Buffalo, Middletown, New York (Manhattan and Harlem), Rochester, Staten Island, Syracuse, Watertown, White Plains, and Woodhaven.

Veterans can contact vet center staff during regular business hours at a toll-free phone number, and some vet centers have extended hours to facilitate counseling for those who work during the day. Vet center staff typically consists of four or five members, including a team leader who supervises an interdisciplinary team of social workers, nurses, or counselors. Most vet center counselors and team leaders (73 percent) are veterans themselves and have experienced readjustment issues firsthand. Vet center counselors do not offer inpatient care or provide medical prescriptions, but they will refer veterans to a VA hospital if they detect a serious mental or physical health problem.

To maintain confidentiality, vet center records are separate from VA administrative benefits and medical records.

Finally, it is important to realize that services you can get through VA health care and vet centers exist *above and beyond* the services you can receive through TRICARE insurance, private insurance, or public assistance programs. For example, you can get some treatment paid for by your insurance company and still get additional treatments at VA facilities. Veterans with health insurance might choose to go to a convenient, local doctor for medication to help with their mental health symptoms but also go to a vet center or VAMC for counseling. In short, the VA can be used to help expand or extend any other health insurance you might have. It might also give you a wider choice of health care providers and locations than would otherwise be available to you. You might also find that some treatments cost less for you at the VA than if you were to use some other health insurance you might have, so it might be a good idea to check both. It is important to note, however, that, when you get treatment using a mix of VA and non-VA providers, you should always make sure both sets of providers are aware of the other treatments.

TRICARE. Upon separation from service (e.g., through retirement), many veterans might retain eligibility for TRICARE, the health plan of the Military Health System. Members of the reserve and guard might also be eligible to purchase TRICARE after their transitional benefit expires.

³ VA, "Locations: New York," July 23, 2010. As of November 11, 2010: <http://www2.va.gov/directory/guide/state.asp?STATE=NY&dnum=ALL>

⁴ VA, "Vet Center," October 5, 2010. As of November 11, 2010: <http://www.vetcenter.va.gov/>

Beneficiaries have two primary TRICARE options: a health maintenance organization (HMO)-like plan called *TRICARE Prime*, which delivers care through military hospitals and clinics and contracted civilian network providers; and a fee-for-service plan called *TRICARE Standard*. Within the standard plan, beneficiaries can exercise a preferred provider option (PPO), *TRICARE Extra*, which requires that an individual use in-network providers but lowers the out-of-pocket co-payment costs to 15 to 20 percent of standard costs.⁵ Individuals eligible for TRICARE Standard/Extra might also receive care at a military treatment facility at no charge on a space-available basis.

For retirees stationed far from installations, TRICARE civilian networks are an important source of mental health care. In addition, several different TRICARE benefit programs also help fill potential gaps in health insurance coverage for reserve-component service members.

TRICARE beneficiaries can identify locally based providers for treatment through a central referral process that can be accessed by web or by phone. For many veterans, the nearest TRICARE provider will be closer to them than the nearest VA medical center and might be a more-convenient source of care. TRICARE will reimburse for a maximum of two psychotherapy sessions per week in any combination of individual, family, or group sessions. Eight sessions are provided without the need for referral from a primary-care doctor.

If you have TRICARE insurance, you can access information about your TRICARE benefits based on your plan type and find a provider who accepts TRICARE in your area by visiting the TRICARE website.⁶

Private Health Insurance or Medicaid. If you are a veteran who has employer-sponsored or other private health insurance, mental health treatment and counseling might be available through your health plan. You can call your health insurance company for details about your benefits and how to find a provider. For many types of insurance, you might also speak to your primary-care doctor for a referral to a mental health specialist who is covered in your plan.

Some employers also have an employee assistance program (EAP). These programs typically offer confidential, free counseling. There might be limits to how many sessions are provided, but the EAP can be a good resource for finding mental health care in your area. Ask your employer or check with your human resources department to learn whether your employer has an EAP and whether it offers veteran-specific services.

In addition, mental health treatment is available through Medicaid for those individuals who qualify (please check with your specific plan for details). Medicaid is a type of government-sponsored insurance for individuals with low income, and many veterans qualify for this type of insurance. Finding a mental health care provider who accepts Medicaid can sometimes be challenging. For help finding a mental health care provider, contact your local department of social services.⁷

⁵ TRICARE, "TRICARE Benefit at-a-Glance," September 22, 2010. As of November 16, 2010: <http://www.tricare.mil/mybenefit/ProfileFilter.do?purI=%2Fhome%2Foverview%2FWhatIsTRICARE%2FTRICAREBenefitAtAGlance>

⁶ Military Health System, "TRICARE," undated website. As of November 11, 2010: <http://www.tricare.mil/>

⁷ New York State Department of Health, "Local Departments of Social Services," undated web page. As of November 11, 2010: http://www.health.state.ny.us/health_care/medicaid/ldss

Free or Low-Cost Mental Health Care. Most veterans can get treatment through the VA, and many can also get treatment from civilian providers using other types of insurance. However, there might be situations in which a veteran needs help and cannot practically use the VA services, is no longer eligible for them, or would prefer not to use them. It is important to realize that, even if you do not have health insurance, there are often free or low-cost treatment options and support groups in your local community.

Sliding-Scale/Low-Cost Providers. Some mental health care providers are willing to provide mental health care on a “sliding-scale” basis to individuals who do not have health insurance and are not able to afford care. This means that they charge their clients a different amount depending on their income, so that almost everyone can afford to pay. One resource for finding a mental health provider is the website for the American Psychological Association, which has a useful psychologist locator tool.⁸ Since providers usually offer free or sliding-scale therapy on a case-by-case basis, you might have to ask the provider directly whether he or she offers free or sliding-scale treatment.

Local colleges and universities with psychology or social-work training programs often maintain clinics that provide mental health care to the general public. For example, Columbia University offers free and low-cost outpatient mental health care for adults and children.⁹ Similarly, the Psychological Services Center at the University of Buffalo provides a broad array of psychological services, including counseling and therapy for individuals, couples, families, and groups.¹⁰

Finally, local governmental agencies and social-service agencies might also maintain lists of mental health providers that offer free or low-cost treatment. For example, the Federal Executive Board of New York City has compiled a list of resources for free or low-cost mental health care.¹¹

Community Mental Health Centers. Veterans needing free or low-cost mental health care can also seek treatment through the public mental health system. This is a system run by state and local governments to provide mental health services to those in need. New York State Office of Mental Health maintains a treatment locator tool on its website.¹² Family members seeking care can search for providers and clinics by county and type of service. Many veterans are likely seeking outpatient mental health treatment, and selecting “Outpatient: Clinic Treatment” from the list of program categories and subcategories yields a county-specific list of local community mental health centers that provide outpatient counseling.

⁸ American Psychological Association Practice Organization, “Psychologist Locator,” undated web page. As of November 11, 2010:
<http://locator.apa.org/>

⁹ Columbia University, “Programs and Services: Health Care: Mental Health Care,” undated web page. As of November 11, 2010:
http://neighbors.columbia.edu/pages/programsandservices/health_care_programs/mental_health.html

¹⁰ State University of New York, University at Buffalo, College of Arts and Sciences, Department of Psychology, “Psychological Services Center,” undated web page. As of November 11, 2010:
<http://www.psychology.buffalo.edu/resources/clinical/psc/>

¹¹ Federal Executive Board, “Mental Health,” undated web page. As of November 11, 2010:
http://www.newyorkcity.feb.gov/mental_health.htm

¹² New York State Office of Mental Health, “Find a Mental Health Program,” undated web page. As of November 11, 2010:
<http://bi.omh.state.ny.us/bridges/index>

Give an Hour. This organization is a national network of licensed mental health professionals who are willing to volunteer one hour of their time each week to provide free counseling to service members and families. You can look for a local provider through the organization's website.¹³ These providers are recruited through professional mental health organizations, professional publications, conferences and workshops, personal contacts, and websites. Give an Hour volunteers from the community check provider licenses, conduct community outreach, and coordinate volunteer opportunities for those service members and families interested in giving an hour back to the community. In addition to identifying sources of free counseling services, the Give an Hour website provides informational materials to service members and families, as well as to community members and care providers.

Veterans' Communities and VSOs. It can be helpful to connect with people who have served with you or who have had similar experiences. Your local VA might have a network you can use to contact other service members, or you can connect with others online through Iraq and Afghanistan Veterans of America (IAVA)¹⁴ or the discussion forums on Military.com.¹⁵ While these organizations do not provide formal treatment for mental or behavioral health problems, they do provide support groups, as well as advice and opinions about the various providers and health care systems. Similarly, VSOs, such as the American Legion, Veterans of Foreign Wars (VFW), the Wounded Warrior Project, and Disabled American Veterans, are active in most areas of the state and can be a valuable resource for veterans. VSOs can provide community, advocacy, and practical advice and assistance to veterans and family members. The VA previously maintained an online directory of VSOs that was searchable by location; this directory will be updated following the designation and implementation of a new process and policy to accredit VSOs.¹⁶

I am a family member of a veteran and I need some help. What can I do?

Family members of veterans might face many challenges and issues as their loved one reintegrates back into the family and into civilian life. Family members might want information about what to expect now that their loved one is home. This might include information about how to talk to their veteran about their experiences during deployment, how to find support for any service-connected problems, or how to get access to benefits and treatment for their veteran. Spouses of veterans might have concerns about their marriage, as well as about how the family and children are coping post-deployment. Parents and siblings of veterans might also have concerns about their role in helping their loved one reintegrate and find help. Some family members might also face their own health-related issues and need their own care. There are many different ways in which family members of veterans might find care. We provide a brief overview of these in this section.

¹³ Give an Hour, "Welcome to Give an Hour," undated web page. As of November 11, 2010: <http://www.giveanhour.org/skins/gah/home.aspx>

¹⁴ IAVA, undated home page. As of November 11, 2010: <http://iava.org/>

¹⁵ Monster, *Military.com*, undated web page. As of November 11, 2010: <http://www.military.com/>

¹⁶ VA, "Directory of Veterans Service Organizations," November 11, 2009. As of November 11, 2010: <http://www1.va.gov/vsso/>

Family Services Available Through the VA. While family members of veterans are not usually eligible to enroll in the VHA, the VA does offer some limited medical benefits to family members of veterans.¹⁷ In particular, family members might be eligible to receive care from the VHA by agreeing to share the cost of care through co-payments or deductibles.

In addition, family members are eligible for couples' or family counseling (for marital or family problems) through the VHA, as long as the veteran is receiving treatment. These services are limited to spouses and dependents of veterans but are fully covered for most veterans currently returning from OEF/OIF.

Military OneSource. Family members of veterans who are still affiliated with the reserve or National Guard can also use Military OneSource. Military OneSource is an information and consultation service offered by the Department of Defense to service members in the active and reserve components (regardless of activation status) and their families. Retired or separated service members and their family members are eligible to receive services at no cost for up to six months after separation. When a military member has an emotional, family, or adjustment problem, he or she can call a Military OneSource consultant for assistance. The consultants triage calls, referring the caller either to a counselor for six prepaid counseling sessions or, for those identified with a major mental disorder (including PTSD and major depression), to the appropriate medical care provider, which might be a VA hospital, TRICARE civilian provider, or other provider.

The six free counseling sessions are provided by a network of community specialty mental health providers, usually via office visits, but individuals who live in remote locations, lack transportation or adequate child care, or work overseas might receive counseling sessions over the telephone. Use of Military OneSource resources is confidential; use is not disclosed to the military, unless there is evidence that an individual might be a threat to themselves or others.

Services Through Your Employer or Health Insurance Plan. Although treatment through the VA is relatively limited for family members of veterans, ordinary health insurance plans that cover these family members usually provide some mental health care benefits. For individual counseling or treatment for behavioral health concerns, family members have several options, depending on their health insurance coverage.

- If you have employer-sponsored health insurance, treatment and counseling might be available through your health plan (please check your specific health plan for details about your benefits and how to find a provider).
- Some employers also have an EAP. These programs typically offer confidential, free counseling. There might be limits to how many sessions are provided, but the EAP can be a good resource for finding mental health care in your area. Ask your employer or human resources department about whether it has an EAP.
- If you have health insurance through Medicaid, treatment and counseling might be available through your health plan (please check with your specific plan for details). Finding a mental health care provider who accepts Medicaid can sometimes be challenging.

¹⁷ VA, "VA Health Care Eligibility and Enrollment: Benefits for Family Members," September 15, 2009. As of November 11, 2010:

<http://www4.va.gov/healtheligibility/familymembers/>

For help finding a mental health care provider, contact your local Department of Social Services.¹⁸

Other Community Resources. Family members of veterans are also eligible for many of the free and low-cost mental health services listed above, including university-based clinics, community mental health centers, and organizations, such as Give an Hour.

If you have yet to locate an individual provider through the resources described already, we suggest trying one or more of the following:

- You can ask your primary-care provider or the medical office that you visit for a recommendation.
- You can also ask your clergy, a trusted family friend, a teacher, or your school guidance counselor.
- You can go to any library and ask the reference librarian to help you locate a provider nearby.
- You can also look in your local telephone yellow pages under “physicians” to find mental health specialists, such as psychiatrists, psychologists, and social workers. The listings should include information about the type of provider (doctor, psychologist, or social worker) and his or her address and phone number. You can choose one based on location or your choice of provider type.

Now that I know where to get care, I have a choice of several mental health care providers. How do I choose one?

There are many different types of mental health providers from whom you can seek help in your area. These include psychiatrists, clinical psychologists, clinical social workers, and licensed professional counselors. There are also multiple ways to find individual providers in your area.

Mental health care providers include physicians (psychiatrists), psychologists, social workers, and masters-level counselors. Psychiatrists generally prescribe and manage medications for mental health problems and might also offer various forms of talk therapy, while psychologists, social workers, and counselors provide only talk therapy, either on an individual basis or with a group.

Once you have the name and contact information for several potential mental health providers, you might want to call each and ask several questions to ensure that you find a provider who is right for you. You can ask the provider questions about how long he or she has been practicing, whether he or she has experience working with veterans or their family members, and when the last time was that he or she worked with a veteran. If you have or think you might have PTSD, depression, or substance abuse, you should ask the provider about his or her experience working with veterans with those issues. If you begin to work with a mental health provider but then feel like the provider is not the best match for you, you should try to find a different therapist by asking for a referral to someone else or by going back to your list

¹⁸ New York State Department of Health, “Local Departments of Social Services,” undated web page. As of November 11, 2010:

http://www.health.state.ny.us/health_care/medicaid/lds

and trying someone new. Whether you get care in the VA or through insurance, you are not expected to “settle” for a provider who you do not think is a good match for you.

If you have never had an appointment with a mental health provider before, you might wonder what therapy is like. During your first appointment, you will likely be asked to explain what brings you into therapy (e.g., what is troubling you at this point in your life?), what kind of symptoms you might be experiencing (e.g., can't sleep, always thinking about some things, feel hopeless), and your family and general history. In follow-up appointments, you will talk with your therapist about your problems and will work together with her or him to find solutions and to better understand and manage your thoughts, feelings, and behaviors.

Where can I get more information?

You are not alone! There are many resources available to New York state veterans and their families to help you with a wide range of issues, including health care, education, employment, and housing. The next section includes a list of regional, state, and national resources designed to help veterans find mental health care, apply for benefits and other assistance, and connect with other veterans. In addition, many of the resources we have listed have counselors and advocates available to work with you to understand the benefits for which you are eligible, help you find mental health care if you need it, and help you reintegrate back into civilian society.

A Description of Mental Health Resources Available to New York State Veterans

In Table A.1, we list many available resources for New York state veterans and their family members. This is not an exhaustive list; it is possible that there are additional resources in local communities for which there was no information available through open search mechanisms. For each organization, we have provided the website and phone number (where available), as well as indicated the types of information or assistance the organization provides and whether the resource is available locally, statewide, or nationally. In the section that follows the table, the organizations are listed in alphabetical order with a brief description of each.

Each of these organizations might provide a variety of types of information or assistance for veterans. To help find those resources that are best suited for a veteran's needs, we have categorized these resources by four overlapping functions:

- *Provides benefit information:* The resource provides information about available veterans' benefits, assesses eligibility, or assists in applying for these benefits.
- *Educates about veterans' challenges:* The resource educates veterans and family members about problems and challenges veterans and family members might face.
- *Assists with finding help:* The resource connects veterans and their families with mental health care and other services, either through counselors or advocates or through an online information repository or search tool.
- *Connects veterans with other veterans:* The resource provides a way for veterans to connect with other veterans or for family members to connect with other veterans' family members, either virtually through online discussion forums or in person through support groups or other means.

Table A.1
Outline of Veterans' Resources in New York State

Resource	Type of Assistance Provided by Resource				Scope
	Provides Vet Benefit Info	Educates About Vets' Challenges	Assists with Finding Help	Connects Vets to Other Vets	
City University of New York (CUNY) Office of Veterans Affairs http://www.cuny.edu/about/resources/veterans.html (212) 290-5674	x			x	Local
Florence and Robert A. Rosen Family Wellness Center, North Shore–Long Island Jewish Health System http://northshorelij.com/NSLIJ/rosen (516) 562-3260		x	x		Local
Home Again: Veterans and Families Initiative http://www.homeagainveterans.org (646) 957-0853	x	x	x		Local
New York City Mayor's Office of Veterans Affairs (MOVA) http://nyc.gov/veterans (212) 442-4177	x		x		Local
Soldiers and Families Assistance Center at Fort Drum http://www.drummwr.com/SoldierandFamilyAssistanceCenter.htm (315) 772-7781	x		x		Local
Veteran's Mental Health Alliance of Long Island http://mhanc.org/?PageID=789 (516) 504-HELP	x		x		Local
Veteran's Mental Health Coalition of NYC http://www.mha-nyc.org/advocacy/veterans-mental-health-coalition.aspx			x		Local
Veterans Coalition of Orange County, N.Y. http://ocnyveteranscoalition.com/ (845) 294-2470			x		Local
Brain Injury Association of NYS http://bianys.org/bianys-veterans.htm (800) 288-8201		x	x		State
New York State Department of Labor http://www.labor.ny.gov/vets/vetintropage.shtm (888) 4-NYS DOL	x				State
New York State Division of Veterans' Affairs http://veterans.ny.gov (888) 838-7697	x		x		State
New York State Health Foundation http://nyshealthfoundation.org/section/resources/veterans_resources (212) 664-7656			x		State
New York State Office of Mental Health http://omh.state.ny.us (800) 597-8481		x	x		State
Veterans Health Information Clearinghouse http://www.health.state.ny.us/nysdoh/veterans	x		x		State

Table A.1—Continued

Resource	Type of Assistance Provided by Resource				Scope
	Provides Vet Benefit Info	Educates About Vets' Challenges	Assists with Finding Help	Connects Vets to Other Vets	
VOC http://VeteransOutreachCenter.org (585) 456-1081; (866) 906-VETS	x	x	x		State
WNY Heroes.org http://www.wnyheroes.org/resources.php 888-400-3892	x	x	x		State
American Legion http://legion.org (800) 433-3318	x		x	x	Nation
Blue Star Mothers of America http://bluestarmothers.org		x		x	Nation
U.S. Department of Veterans Affairs http://va.gov (800) 827-1000	x		x		Nation
Grace After Fire http://www.graceafterfire.org		x		x	Nation
Iraq and Afghanistan Veterans of America http://IAVA.org (212) 982-9699				x	Nation
Military OneSource http://militaryonesource.com (800) 342-9647	x		x		Nation
Military.com http://military.com	x			x	Nation
NAMI Veterans Resource Center http://www.nami.org/veterans (800) 950-NAMI	x	x	x		Nation
National Resource Directory http://www.nationalresourcedirectory.gov			x		Nation
National Suicide Prevention Lifeline Veterans Suicide Prevention Hotline http://SuicidePreventionLifeline.org/veterans (800) 273-TALK		x	x	x	Nation
New England Mental Illness Research, Education, and Clinical Center Veteran Recovery http://www.veteranrecovery.med.va.gov/		x		x	Nation
SAMHSA Mental Health Services Locator http://store.samhsa.gov/mhlocator			x		Nation
Service Women's Action Network (SWAN) http://www.servicewomen.org (212) 683-0015 ext. 324	x		x	x	Nation
Vet to Vet http://vet2vetusa.org (203) 623-0731				x	Nation

Table A.1—Continued

Resource	Type of Assistance Provided by Resource				Scope
	Provides Vet Benefit Info	Educates About Vets' Challenges	Assists with Finding Help	Connects Vets to Other Vets	
VFW http://vfw.org (816) 756-3390	x		x	x	Nation
Wounded Warrior Project http://woundedwarriorproject.org (877) TEAM-WWP	x	x	x	x	Nation

NOTE: MOVA = New York City Mayor's Office of Veterans' Affairs. SFAC = Soldier and Family Assistance Center. VOC = Veterans Outreach Center. NAMI = National Alliance on Mental Illness. SAMHSA = Substance Abuse and Mental Health Services Administration. SWAN = Service Women's Action Network.

Descriptions of Specific Resources

In this section, we describe many of the resources available to veterans and families in New York state, listed in alphabetical order.

American Legion. The American Legion is a national veterans' organization serving more than 2.6 million veteran members. The American Legion provides information about veterans' benefits; brings veterans together through conventions, meetings, and local activities; and serves as a veterans' advocate in national campaigns. It also operates Heroes to Hometowns, a transition program for severely wounded service members who served in Iraq and Afghanistan. Heroes to Hometowns establishes a support network and coordinates resources for those service members.

Blue Star Mothers. Blue Star Mothers is a nonprofit support organization for mothers of children who are serving or have served in the armed forces. There are currently chapters in Bloomfield, Delmar, Westfield, Elmira, and Holbrook, although there are also online discussion forums for members.

CUNY Office of Veterans Affairs. The CUNY Office of Veterans Affairs is dedicated to developing community and communication among veteran students and faculty, staff, and administration. CUNY Office of Veterans Affairs staff are available to meet with veteran students and potential students to assist them with enrolling in school, obtaining veterans' benefits (including tuition assistance), and find counseling resources. Online, the CUNY Office of Veterans Affairs website has information for current and potential veteran students about admissions, paying for school, services, a list of local VA representatives, links to local and national VSOs, and profiles of veteran students, staff, and faculty.

U.S. Department of Veterans Affairs. As described previously, the mission of the VA is to serve America's veterans and their families by promoting the health, welfare, and dignity of all veterans in recognition of their service to this nation. The VA is the principal agency charged with providing veterans with medical care, benefits, social support, and lasting memorials. The VA is made up of a central office and three major organizations: the VHA, the VBA, and the NCA. The VHA administers and operates the VA's health care system.

In New York, there are 12 VAMCs, located in Albany, Batavia, Bath, Bronx, Brooklyn, Buffalo, Canandaigua, Castle Point, Montrose, New York City, Northport, and Syracuse. The VHA also operates 38 CBOCs across the state, which provide the most-common outpa-

tient services in nonhospital settings, including health and wellness visits and specialty mental health care. In addition, the VA operates many vet centers throughout the state. These are local sources of mental health care, counseling, and support and are often closer to your home than VAMCs are. There are currently 15 vet centers in New York: Albany, Babylon, Binghamton, Bronx, Brooklyn, Buffalo, Middletown, New York (Manhattan and Harlem), Rochester, Staten Island, Syracuse, Watertown, White Plains, and Woodhaven.

To find a VA health care facility near you, go to the VA website.¹⁹

Florence and Robert A. Rosen Family Wellness Center. Located within the North Shore–Long Island Jewish Health System, the Rosen Family Wellness Center is a resource for Long Island and New York City metropolitan-area veterans and their families. The wellness center provides counseling, as well as workshops for stress reduction, parenting, employment, coping, and other areas that might be affected by post-return stress issues. The wellness center also has health screenings and referrals for additional services and treatments, indicating an integrative mental and physical health model. This last component is useful for veterans who take part in the workshops and other services but might otherwise neglect physical health monitoring and treatment.

Mental health screening and counseling are confidential, and the center is in a partnership with the Give an Hour organization to provide veteran-specific treatment.

The wellness center also operates a Family and Professional Resource Center, which provides information and referral resources pertaining to wellness, other physical and mental health needs, entitlements, advocacy, and other community supports for federal, state, and local law enforcement personnel, military personnel, and military personnel families.

Grace After Fire. Grace After Fire is a nonprofit support organization for women in all branches of the military, as well as female veterans, especially after returning home from deployment. This organization provides an online social network in which servicewomen reach out to other women in the military to share common experiences and offer one another peer support. Grace After Fire also maintains an online resource guide with information about mental health substance abuse, employment, housing, and other services. In addition, Grace After Fire operates Grace's List, a community-based goods and services exchange for female veterans.

This Internet-based support network ensures that servicewomen have 24/7 access to services whenever they have a need. In addition to peer support, this organization supplies emergency numbers for veterans in crisis and a way to contact mental health professionals through the website for help figuring out whether to seek care or for general questions about mental health problems faced by female veterans.

Home Again: Veterans and Families Initiative. Home Again is a program of the Jewish Board of Family and Children's Services and is funded by NYSHHealth. Home Again offers free counseling, referral, support groups, and education for Iraq and Afghanistan war veterans and their families in the New York City area. Services are provided at various locations in the New York City area and are available for veterans and anyone with whom a veteran is in a significant relationship, including spouses, children, parents, and unmarried companions. Home Again focuses on supporting family reintegration, helping veterans transition home, and helping veterans heal from combat trauma.

¹⁹ VA, "Locations: New York," July 23, 2010. As of November 11, 2010: <http://www2.va.gov/directory/guide/state.asp?STATE=NY&dnum=ALL>

Iraq and Afghanistan Veterans of America. IAVA is a nonpartisan and nonprofit national organization for veterans who served in Iraq and Afghanistan. IAVA is both an advocacy and community-building organization. IAVA operates a large online social network for veterans and coordinates events around the country, enabling veterans to get together locally. IAVA also maintains a resource directory for veterans, with links to health, mental health, education, employment, and other resources. In addition, family members and others who want to support veterans can join IAVA as supporters, allowing them to advocate for veterans' issues and receive information about IAVA events and other ways to support veterans.

Mental Health America. Mental Health America, a national nonprofit mental health advocacy organization, has developed a comprehensive online resource for locating mental health services, through the "Get Help" link on its website. Through this resource, veterans or family members can screen themselves for depression and other mental health conditions and obtain information about types of mental health treatments and how to pay for treatments. In addition, Mental Health America's fact sheet on finding treatment lists several resources for finding community mental health services and individual mental health providers, as well as links to specialized referral organizations, including several specific to veterans and their families.

Military.com. Military.com is a website for active-duty military personnel, veterans, and their families. The website contains information about benefits and services available to veterans, through its benefit section. The information can be filtered by duty status, which includes spouse and family, so this resource might be especially valuable for family members. In addition, military.com operates a popular discussion board, where veterans and family members can find informal support and information from other veterans.

National Alliance on Mental Illness. NAMI provides support for active servicemen and women, veterans, and the friends and family of those serving. Established in 1979, NAMI focuses on mental health issues and educating the American public about mental illness. NAMI provides resources specific to veterans' needs through its Veterans Resource Center, offering support in such areas as post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and female veterans' resources. Each topic contains links to further resources for each of these needs and points veterans to organizations and policies specific to each particular issue.

National Resource Directory. The National Resource Directory is a web-based repository of resources for veterans and their family members, as well as wounded service members. The website includes links to the services and resources of federal, state, and local governmental agencies; veterans' service and benefit organizations; nonprofit community-based and faith-based organizations; and academic institutions, professional associations, and philanthropic organizations. For assistance locating mental health treatment, veterans can filter information by state or territory. The resulting list includes mental health organizations and treatment facilities across the state, with a description of each resource and its relevance to veterans.

National Suicide Prevention Lifeline. The National Suicide Prevention Lifeline is a hotline (1-800-273-TALK) and website for information and immediate assistance for individuals considering suicide. For veterans and family members, the website offers information about veterans' mental health, a mental health resource locator (searchable by type of service and ZIP Code), and benefit information. Importantly, the organization maintains a live chat feature for veterans: Crisis counselors are available 24 hours per day, 7 days per week.

New York City Mayor's Office of Veterans' Affairs. MOVA advises the New York City mayor about issues that affect the military and veterans' community in the city. MOVA also

helps to provide and coordinate benefits and services for veterans and has developed partnerships with local VSOs. The MOVA website contains information on veterans' benefits and local initiatives, as well as a screening tool (ACCESS NYC) for benefit eligibility for more than 30 city, state, and federal human service programs.

New York State Department of Labor. The New York State Department of Labor is the state agency responsible for assisting those seeking employment and for ensuring workplace safety and fair wages for all those working in the state. For veterans, the department offers priority service at One-Stop Career Centers, which means that veterans are served by the first available person and are given first priority for jobs and training for which they are eligible. In addition, the One-Stop Career Centers offer career counseling, resume preparation, and referral to other agencies that can assist veterans. The department's website contains helpful links to employment and training resources for veterans, as well as information about veterans' benefits and employment laws protecting those in the military.

New York State Division of Veterans' Affairs. The New York State Division of Veterans' Affairs is a state-level government agency whose mission is to provide quality service, advocacy, and counseling for New York state veterans and their families to ensure that they receive benefits granted by law for their service to New York and the nation. The division coordinates state-level benefits for veterans, which include

- reduced or free tuition to veterans and family members matriculating at degree-granting institutions or vocational training programs in New York (e.g., Operation Recognition, Military Service Recognition Scholarships, Veterans Tuition Awards, Regents Awards)
- employment programs to facilitate hiring veterans with disabilities (Veteran Employees with Disabilities [under Section 55-c of the New York State Civil Service Law])
- tax relief and reduced rates on mortgages (New York Veterans' Property Tax Exemption, Homes for Veterans)
- reduced rates on hunting licenses and fishing permits
- state veterans' nursing homes, which are skilled-nursing facilities owned and operated by the New York State Department of Health for veterans and their dependents. They exist to provide high-quality care to all eligible veterans and dependents in need of skilled nursing care and rehabilitative services.

The division also oversees New York State Veterans Counselors and County Veterans Service Agencies (VSAs), which can help veterans and their families apply for benefits, navigate available resources, and find needed services. To find the closest veterans' counselor or county VSA, veterans can visit the division's website or call 888-VETSNYS.

The division's website provides information on both state- and federal-level opportunities and benefits available to veterans in such areas as education, housing, tax relief, and employment. The site offers veterans with tips on "what to do next" after discharge and can be the first stop for returning veterans as they navigate civilian life and learn about the benefits they are eligible to obtain.

The site also provides an overview of how to access benefits through the VA, including VA health care. This includes information about how to apply for disability benefits and how to enroll in VA health care. This process is important for any veteran, regardless of severity or urgency of specific service-connected medical needs. The site also provides links and informa-

tion for necessary VA forms and contact information for VA health care facilities (hospital and clinics), vet centers, and state offices and county-level veterans' services.

New York State Health Foundation. NYSHHealth is a private, statewide foundation that aims to improve New York's health care system by expanding health insurance coverage, containing health care costs, increasing access to high-quality services, and addressing public and community health. NYSHHealth's Initiative for Returning Veterans and Their Families addresses returning Iraq and Afghanistan veterans' reintegration needs and aims to strengthen collaboration between public and private sectors.

Through this initiative, NYSHHealth developed the NYSHHealth Resource Center on Returning Veterans and Their Families, an online resource. The resource center provides summary information and links to national, state, and local resources that focus on reintegration issues for returning veterans and their families. These resources include data sources, important publications, key organizations, and initiatives.

New York State Office of Mental Health. The New York State Office of Mental Health offers outreach, information and referral services, and counseling to support veterans and their families during deployment, reintegration, and post-deployment periods. The office has developed a booklet (also available online) in collaboration with the New York State Division of Veterans' Affairs and the VA that identifies the broad range of mental health services available in New York for veterans. In addition, the office's website includes a find-a-program feature that allows users to search for mental health treatment providers by location and type of service. Many veterans and family members are likely seeking outpatient mental health treatment, and selecting "Outpatient: Clinic Treatment" yields a county-specific list of local community mental health centers that provide outpatient counseling.

Service Women's Action Network (SWAN). Established in 2006, SWAN is a nonprofit organization that assists servicewomen and female veterans by offering support from fellow military women. Its mission is to help servicewomen readjust to civilian life after returning from deployment and to develop the leadership skills of female veterans. It also seeks to bring women's voices to the forefront of discussions on the military and veterans' affairs. Supporting the organization's mission to aid women in the military, the organization's website provides links to such relevant topics as VA health care, women in combat, and homeless female veterans.

Soldier and Family Assistance Center at Fort Drum. The SFAC at Fort Drum (Watertown, New York) conducts referral, liaison, and coordination with installation and local agencies to deliver nonmedical services to soldiers and their families. The SFAC coordinates a wide variety of resources, including veterans' benefits counseling, social-service assistance, and financial and career counseling. The SFAC serves active-duty soldiers who are assigned to the Warrior Transition Unit (WTU), veterans who have been medically retired through the WTU, and family members of fallen soldiers.

Substance Abuse and Mental Health Services Administration Mental Health Services Locator. SAMHSA is an administration within the U.S. Department of Health and Human Services (HHS). SAMHSA maintains a web-based list of mental health treatment providers, searchable by state, city, and type of service.

Although this is a comprehensive list, available information includes the name of the treatment provider, phone number, and address, and the person seeking care must call each provider for additional information about cost of treatment, experience working with veterans, and other important provider selection criteria.

The Traumatic Brain Injury and Military Veterans Services Project (Brain Injury Association of New York State). The TBI Training and Military Veterans Services Project, an initiative of the Brain Injury Association of New York State through a grant from the New York State Department of Health, is a resource for providers and families as they seek to understand the symptoms of, and treatment for, TBI. The website for this initiative provides information about TBI, including information about how it differs from PTSD, as well as publications and presentations about TBI and links to additional resources for veterans and family members.

Vet to Vet. Vet to Vet is a consumer/provider partnership program that utilizes veterans in recovery in a peer-counseling capacity to help other veterans. Vet to Vet is administered by veterans who themselves have been consumers of VA mental health services. Vet to Vet provides a six-week, peer-facilitator-training program that teaches veterans how to facilitate peer group sessions and introduce program learning topics. Vet to Vet support meetings use a semistructured curriculum and educational materials developed from the field of psychosocial rehabilitation. These materials are read and discussed during each group. The Vet to Vet program is based on the Illness Management and Recovery Model, which is an evidence-based program that helps individuals in recovery set goals, acquire life skills, and make progress toward those goals. Vet to Vet works in partnership with the mental health care system; mental health professionals and Vet to Vet group leaders hold regular consultative meetings.

Veterans Coalition of Orange County. The mission of the Veterans Coalition of Orange County is to unite the veterans' organizations throughout Orange County and find ways to collaborate across organizations for the benefit of all veterans. This organization seeks to improve veterans' day-to-day lives after they return home from deployment. Acting as a clearinghouse, the organization's website provides important links for all veterans, including services specific to New York, as well as services available through the federal government. Additionally, the site provides links to various veterans' organizations, including the American Legion, Disabled American Veterans, and Blue Star Mothers. Alongside each link, the site lists whether the organization is regional or national.

Veteran's Health Alliance of Long Island. The Veteran's Health Alliance of Long Island, a project of the Mental Health Association of Nassau County, is comprised of mental health and substance abuse providers; representatives from county, state, and federal government; the VA; vet centers; veterans' organizations; elected officials; and other stakeholders. The mission of the alliance is to promote the health and well-being of Long Island veterans and their families through advocacy and a broad array of services. The alliance conducts outreach to veterans and has produced a brochure (available on its website) of available services for Long Island veterans and their families.

Veterans Health Information Clearing House. The Veterans Health Information Clearing House provides informational resources for veterans and their families. The site enables users to browse specific topics, such as health benefits, information for Afghanistan veterans, and mental health services. Each main heading takes users to multiple links for services relevant to each area, both regional and national. Additionally, the site provides key points of contact on its main page for those looking for information on veterans' health care treatment and benefits.

Veterans Mental Health Coalition of New York City. The mission of the Veterans Mental Health Coalition is to promote the mental health and well-being of New York City service members, veterans, and their families through education, information, collaboration, and promotion of a comprehensive array of services. The coalition was formed between the Mental

Health Association of New York City, the National Alliance on Mental Illness of New York City, and the New York Academy of Medicine.

The coalition's website lists resources available to veterans in New York City, including resources for mental health and substance abuse treatment, education, housing, and community building.

Veterans of Foreign Wars. The VFW is a national veterans' organization serving approximately 2.2 million members worldwide. The mission of the VFW is to "honor the dead by helping the living," through veterans' service, community service, and advocating on behalf of veterans on issues related to national security and defense. The VFW provides information on veterans' benefits and conducts several programs to support active-duty troops, including farewell and welcome-home ceremonies and financial assistance to service members and their families who face economic hardship.

Veterans Outreach Center. The VOC, located in Rochester, New York, is the oldest community-based veterans' outreach effort in the nation. Opened in 1973 to support Vietnam veterans coping with their wartime experiences and to facilitate government benefits claims, the VOC has evolved to meet the contemporary and ever-changing needs of all veterans living in the greater Rochester area. The VOC

provides cost-free community-based and individually tailored supportive and clinical services to all veterans of the U.S. Armed Forces and their immediate families to ensure timely access to earned benefits while developing individual potential leading to successful reintegration into the community.²⁰

Veterans of all wars and military actions are welcome.

The VOC's physical location is home to care managers who can assess and refer veterans who are in need of mental health services to facilities run by the VA. The VOC runs a specific program for OEF/OIF veterans, Operation Welcome Home and Recovery, whose mission is early identification of veterans and family members needing treatment, effective assessments and referrals, the development of a continuum of services, and the guarantee of timely treatment for all veterans, service members, and their families. In addition, the VOC holds support groups for veterans and their family members and runs programs for female veterans (Project Reconnect). For veterans unsure about whether they need treatment, the VOC website includes links to a PTSD symptom checklist, the Alcohol Use Disorders Identification Test (AUDIT), and a Drug Abuse Screening Test (DAST). In addition, the VOC runs support groups for veterans and family members.

The VOC is also one of the lead agencies in forming a six-county regional coalition of independent service providers, called Help Base Greater Rochester, which is focused on meeting the needs of veterans, service members, and their families throughout the deployment cycle. The six-county area includes Monroe, Livingston, Ontario, Seneca, Wayne, and Yates counties. The organization maintains a website with current information about resources avail-

²⁰ Veterans Outreach Center, "The Mission," undated web page. As of November 16, 2010: http://www.veteransoutreachcenter.org/the_mission.asp

able to service members, veterans, and their families in the areas of housing, employment, education, health care, mental and emotional support, legal, financial, and other needs.²¹

Veteran Recovery. Veteran Recovery, a program of the New England Mental Illness Research, Education, and Clinical Center, provides peer-to-peer support for veterans. Also known as mutual support, this approach to recovery focuses on creating mutual respect among people. Within group support settings, veterans share their experiences and work together to support one another. Participants create this support through acknowledging their peers and considering others' viewpoints.

The organization's website provides resources for anyone who would like information about the Vet-to-Vet Program, including details of VA peer support and testimonials from veterans who have participated in Vet-to-Vet. These testimonials support the organization's mission to give voice to veterans. Additionally, this website supplies links for mental health, substance abuse, and other veterans' organizations' websites.

Western New York Heroes. WNY Heroes is an organization dedicated to providing veterans, members of the armed services, and the widows and children of deceased veterans with access to essential services and resources that support their lives and sustain their dignity. WNY Heroes provides monetary assistance and access to organizations supporting health and housing needs. Partners include the Mental Health Association of Erie County, WNY Veterans Homeless Housing Coalition, Horizon Health Services, and BlueCross BlueShield of Western New York.

The WNY Heroes website includes a "Veteran Resources" tab, which contains a list of resources for general support, family support, and information about housing, education, and benefits.

Wounded Warrior Project. The mission of the Wounded Warrior Project is to honor and empower those soldiers wounded in battle. It also seeks to raise public awareness about their needs and provide services specific to the needs of those who have been wounded or disabled. The Wounded Warrior Project serves disabled veterans, in part, by seeking legislative and policy changes based on input from wounded soldiers. This organization seeks to ensure that all disabled veterans have access to medical care and the other services that they need. The project also looks for opportunities to create new programs that will fulfill the needs of veterans.

The Wounded Warrior website contains links to the program's various services. These services include benefit counseling, coping and family services, and transition training, among others. Each main link takes users to a detailed page with information and contacts for that particular service and provides information on how veterans can become involved in each program.

²¹ Help Base Greater Rochester, undated home page. As of November 12, 2010:
<http://www.helpbasegreaterrochester.org/>

References

AAPOR—See American Association for Public Opinion Research.

American Association for Public Opinion Research, *Standard Definitions: Final Dispositions of Case Codes and Outcome Rates for Surveys*, revised 2009. As of November 15, 2010:
http://www.aapor.org/AM/Template.cfm?Section=Standard_Definitions&Template=/CM/ContentDisplay.cfm&ContentID=1819

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., Washington, D.C., 1994.

BLS—See Bureau of Labor Statistics.

Brazier, J. E., R. Harper, N. M. Jones, A. O’Cathain, K. J. Thomas, T. Usherwood, and L. Westlake, “Validating the SF-36 Health Survey Questionnaire: New Outcome Measure for Primary Care,” *British Medical Journal*, Vol. 305, July 18, 1992, pp. 160–164.

Brewin, Chris R., “Systematic Review of Screening Instruments for Adults at Risk of PTSD,” *Journal of Traumatic Stress*, Vol. 18, No. 1, February 2005, pp. 53–62.

Buchwald, Dedra, Tsilke Pearlman, Jovine Umali, Karen Schmalings, and Wayne Katon, “Functional Status in Patients with Chronic Fatigue Syndrome, Other Fatiguing Illnesses, and Healthy Individuals,” *American Journal of Medicine*, Vol. 101, No. 4, October 1996, pp. 364–370.

Bureau of Labor Statistics, “Databases, Tables, and Calculators by Subject,” undated web page. As of October 8, 2010:
http://data.bls.gov/PDQ/servlet/SurveyOutputServlet?data_tool=latest_numbers&series_id=LASST36000003
———, “Alternative Measures of Labor Underutilization for States, Fourth Quarter of 2009 Through Third Quarter of 2010 Averages,” last modified October 29, 2010. As of October 8, 2010:
<http://www.bls.gov/lau/stalt.htm>

Burnam, M. Audrey, Lisa S. Meredith, Terri Tanielian, and Lisa H. Jaycox, *Improving Mental Health Care for Returning Veterans*, Santa Monica, Calif.: RAND Corporation, RB-9451, 2009. As of November 10, 2010:
http://www.rand.org/pubs/research_briefs/RB9451/

Cohen, Jacob, *Statistical Power Analysis for the Behavioral Sciences*, 2nd ed., Hillsdale, N.J.: Erlbaum, 1988.

DoD—See U.S. Department of Defense.

DSM-IV—See American Psychiatric Association (1994).

Eibner, Christine, *Invisible Wounds of War: Quantifying the Societal Costs of Psychological and Cognitive Injuries*, Santa Monica, Calif.: RAND Corporation, CT-309, 2008. As of November 10, 2010:
<http://www.rand.org/pubs/testimonies/CT309/>

Grieger, Thomas A., Stephen J. Cozza, Robert J. Ursano, Charles Hoge, Patricia E. Martinez, Charles C. Engel, and Harold J. Wain, “Posttraumatic Stress Disorder and Depression in Battle-Injured Soldiers,” *American Journal of Psychiatry*, Vol. 163, No. 10, October 2006, pp. 1777–1783.

Harrison, Lana D., S. D. Martin, T. Enev, and D. Harrington, *Comparing Drug Testing and Self-Report of Drug Use Among Youths and Young Adults in the General Population*, Rockville, Md.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, SMA 07-4249, Methodology Series M-7, 2007.

HHS—See U.S. Department of Health and Human Services.

Hoge, Charles W., Carl A. Castro, Stephen C. Messer, Dennis McGurk, Dave I. Cotting, and Robert L. Koffman, “Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care,” *New England Journal of Medicine*, Vol. 351, July 1, 2004, pp. 13–22.

IAVA—See Iraq and Afghanistan Veterans of America.

Iraq and Afghanistan Veterans of America, undated home page. As of November 11, 2010:
<http://iava.org/>

Iverson, Grant L., Rael T. Lange, and Nathan D. Zasler, “Post-Concussive Disorder,” in Nathan D. Zasler, Douglas I. Katz, and Ross D. Zafonte, eds., *Brain Injury Medicine: Principles and Practice*, New York: Demos, 2007, pp. 373–406.

Jaycox, Lisa H., *Invisible Wounds of War: Summary of Key Findings on Psychological and Cognitive Injuries*, Santa Monica, Calif.: RAND Corporation, CT-307, 2008. As of November 10, 2010:
<http://www.rand.org/pubs/testimonies/CT307/>

Johnson, David R., “Assessing Marital Quality in Longitudinal and Life Course Studies,” in Jane Close Conoley and Elaine Buterick Werth, eds., *Family Assessment*, Lincoln, Neb.: Buros Institute of Mental Measurements, 1995, pp. 155–202.

Karney, Benjamin R., Rajeev Ramchand, Karen Chan Osilla, Leah B. Caldarone, and Rachel M. Burns, *Predicting the Immediate and Long-Term Consequences of Mental Health Problems in Veterans of Operation Enduring Freedom and Operation Iraqi Freedom*, Santa Monica, Calif.: RAND Corporation, WR-546-CCF, 2008. As of November 10, 2010:
http://www.rand.org/pubs/working_papers/WR546/

Kessler, Ronald C., Wai Tat Chiu, Olga Demler, and Ellen E. Walters, “Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication,” *Archives of General Psychiatry*, Vol. 62, No. 6, June 2005, pp. 617–627.

Kroenke, Kurt, Robert L. Spitzer, and Janet B. W. Williams, “The PHQ-9: Validity of a Brief Depression Severity Measure,” *Journal of General Internal Medicine*, Vol. 16, No. 9, September 2001, pp. 606–613.

Kroenke, Kurt, Tara W. Strine, Robert L. Spitzer, Janet B. W. Williams, Joyce T. Berry, and Ali H. Mokdad, “The PHQ-8 as a Measure of Current Depression in the General Population,” *Journal of Affective Disorders*, Vol. 114, No. 1–3, April 2009, pp. 163–173.

Löwe, Bernd, Kurt Kroenke, Wolfgang Herzog, and Kerstin Gräfe, “Measuring Depression Outcome with a Brief Self-Report Instrument: Sensitivity to Change of the Patient Health Questionnaire (PHQ-9),” *Journal of Affective Disorders*, Vol. 81, No. 1, July 2004, pp. 61–66.

Löwe, Bernd, Robert L. Spitzer, Kerstin Gräfe, Kurt Kroenke, Andrea Quenter, Stephan Zipfel, Christine Buchholz, Steffen Witte, and Wolfgang Herzog, “Comparative Validity of Three Screening Questionnaires for DSM-IV Depressive Disorders and Physicians’ Diagnoses,” *Journal of Affective Disorders*, Vol. 78, No. 2, February 2004, pp. 131–140.

Meredith, Lisa S., Andrew M. Parker, Ellen Burke Beckjord, Sarah J. Gaillot, Manan M. Trivedi, and Mary E. Vaiana, *Educating Military Personnel and Their Families About Post-Deployment Stress*, Santa Monica, Calif.: RAND Corporation, WR-544-CCF, 2008. As of November 10, 2010:
http://www.rand.org/pubs/working_papers/WR544/

Milliken, Charles S., Jennifer L. Auchterlonie, and Charles W. Hoge, “Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War,” *JAMA*, Vol. 298, No. 18, 2007, pp. 2141–2148.

Monster, *Military.com*, undated home page. As of November 11, 2010:
<http://www.military.com/>

- Post-Deployment Stress: What Families Should Know, What Families Can Do*, Santa Monica, Calif.: RAND Corporation, CP-535 (3/08), 2008. As of November 10, 2010:
http://www.rand.org/pubs/corporate_pubs/CP535-2008-03/
- Post-Deployment Stress: What You Should Know, What You Can Do*, Santa Monica, Calif.: RAND Corporation, CP-534 (3/08), 2008. As of November 10, 2010:
http://www.rand.org/pubs/corporate_pubs/CP534-2008-03/
- Pratt, Laura A., and Debra J. Brody, *Depression in the United States Household Population, 2005–2006*, Hyattsville, Md.: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, data brief 7, September 2008. As of November 10, 2010:
<http://purl.access.gpo.gov/GPO/LPS113063>
- Public Law 357, Servicemen's Readjustment Act, June 22, 1944.
- Public Law 103-353, Uniformed Services Employment and Reemployment Rights Act, October 13, 1994.
- Public Law 108-189, Servicemembers Civil Relief Act, December 19, 2003.
- Public Law 110-252, Supplemental Appropriations Act, June 20, 2008.
- Ramchand, Rajeev, J. Miles, Terry L. Schell, Lisa H. Jaycox, G. N. Marshall, and Terri Tanielian, "Prevalence and Correlates of Drinking Behaviors Among Previously Deployed Military and Matched Civilian Populations," *Military Psychology*, forthcoming.
- Ramchand, Rajeev, Terry L. Schell, Benjamin R. Karney, Karen Chan Osilla, Rachel M. Burns, and Leah B. Caldarone, "Disparate Prevalence Estimates of PTSD Among Service Members Who Served in Iraq and Afghanistan: Possible Explanations," *Journal of Traumatic Stress*, Vol. 23, No. 1, February 2010, pp. 59–68.
- Ramchand, Rajeev, Terry L. Schell, Lisa H. Jaycox, and Terri Tanielian, "Epidemiology of Trauma Events and Mental Health Outcomes Associated with War-Zone Deployment," in J. Ruzek, P. Schnurr, M. Friedman, and J. Vasterling, eds., *Veterans of the Global War on Terror. American Psychological Association*, forthcoming.
- SAMHSA—See Substance Abuse and Mental Health Services Administration.
- Schell, Terry L., and Grant N. Marshall, "Survey of Individuals Previously Deployed for OEF/OIF," in Terri Tanielian and Lisa H. Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, Calif.: RAND Corporation, MG-720-CCF, 2008, pp. 87–116. As of November 10, 2010:
<http://www.rand.org/pubs/monographs/MG720/>
- Schwab, K. A., B. Ivins, G. Cramer, W. Johnson, M. Sluss-Tiller, K. Kiley, W. Lux, and D. Warden, "Screening for Traumatic Brain Injury in Troops Returning from Deployment in Afghanistan and Iraq: Initial Investigation of the Usefulness of a Short Screening Tool for Traumatic Brain Injury," *Journal of Head Trauma Rehabilitation*, Vol. 22, No. 6, November–December 2007, pp. 377–389.
- Stansfeld, S. A., R. Roberts, and S. Foot, "Assessing the Validity of the SF-36 General Health Survey," *Quality of Life Research*, Vol. 6, 1997, pp. 217–224.
- Steele, J. L., N. Salcedo, and J. Coley, *Service Members in School: Military Veterans' Experiences Using the Post-9/11 GI Bill and Pursuing Postsecondary Education*, Washington, D.C.: American Council on Education, 2010.
- Substance Abuse and Mental Health Services Administration, results from the 2009 National Survey on Drug Use and Health, detailed tables, c. 2010. As of November 10, 2010:
<http://www.oas.samhsa.gov/NSDUH/2k9NSDUH/tabs/TOC.htm>
- Tanielian, Terri, *Invisible Wounds of War: Recommendations for Addressing Psychological and Cognitive Injuries*, Santa Monica, Calif.: RAND Corporation, CT-308, 2008. As of November 10, 2010:
<http://www.rand.org/pubs/testimonies/CT308/>
- , *Assessing Combat Exposure and Post-Traumatic Stress Disorder in Troops and Estimating the Costs to Society: Implications from the RAND Invisible Wounds of War Study*, Santa Monica, Calif.: RAND Corporation, CT-321, 2009. As of November 10, 2010:
<http://www.rand.org/pubs/testimonies/CT321/>

Tanielian, Terri, and Lisa H. Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, Calif.: RAND Corporation, MG-720-CCF, 2008. As of November 10, 2010:

<http://www.rand.org/pubs/monographs/MG720/>

Tanielian, Terri, Lisa H. Jaycox, Terry L. Schell, Grant N. Marshall, M. Audrey Burnam, Christine Eibner, Benjamin R. Karney, Lisa S. Meredith, Jeanne S. Ringel, and Mary E. Vaiana, *Invisible Wounds of War: Summary and Recommendations for Addressing Psychological and Cognitive Injuries*, Santa Monica, Calif.: RAND Corporation, MG-720/1-CCF, 2008. As of November 10, 2010:

<http://www.rand.org/pubs/monographs/MG720.1/>

TRICARE, "TRICARE Benefit at-a-Glance," September 22, 2010. As of November 16, 2010:

<http://www.tricare.mil/mybenefit/ProfileFilter.do?puri=/home/overview/WhatIsTRICARE/TRICAREBenefitAtAGlance>

U.S. Department of Defense, *Military OneSource.com*, undated home page. As of November 11, 2010:

<http://www.militaryonesource.com/>

U.S. Department of Health and Human Services, "Delayed Update of the HHS Poverty Guidelines for the Remainder of 2010," *Federal Register*, Vol. 75, No. 148, August 3, 2010, pp. 45628–45629. As of November 10, 2010:

<http://aspe.hhs.gov/poverty/10fedreg.shtml>

U.S. Department of Veterans Affairs, "Release of Names and Addresses (RONA)," August 6, 2010. As of November 11, 2010:

<http://www.rms.oit.va.gov/RONA.asp>

U.S. Statutes at Large, Vol. 43, p. 121, Adjusted Compensation Act, 1924.

VA—See U.S. Department of Veterans Affairs.

Wang, Philip S., Michael Lane, Mark Olfson, Harold A. Pincus, Kenneth B. Wells, and Ronald C. Kessler, "Twelve-Month Use of Mental Health Services in the United States: Results from the National Comorbidity Survey Replication," *Archives of General Psychiatry*, Vol. 62, No. 6, June 2005, pp. 629–640

Ware, John E., Kristin K. Snow, Mark Kosinski, and Barbara Gandek, *SF-36 Health Survey: Manual and Interpretation Guide*, Boston, Mass.: Health Institute, New England Medical Center, 1993.

Weathers, F., J. Huska, and T. Keane, *The PTSD Checklist Military Version (PCL-M)*, Boston, Mass.: National Center for PTSD, 1991.

Weathers, F. W., B. T. Litz, D. S. Herman, J. A. Huska, and T. M. Keane, , *The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility*, paper presented at the International Society for Traumatic Stress Studies, San Antonio, Texas, 1993.

Wechsler, Henry, Andrea Davenport, George Dowdall, Barbara Moeykens, and Sonia Castillo, "Health and Behavioral Consequences of Binge Drinking in College: A National Survey of Students at 140 Campuses," *JAMA*, Vol. 272, No. 21, 1994, pp. 1672–1677.

Wong, Eunice C., Grant N. Marshall, Terry L. Schell, Marc N. Elliott, Katrin Hambarsoomians, Chi-Ah Chun, and S. Megan Berthold, "Barriers to Mental Health Care Utilization for U.S. Cambodian Refugees," *Journal of Consulting and Clinical Psychology*, Vol. 74, No. 6, December 2006, pp. 1116–1120.