Mental Health and Veterans

United Way of the Capital Region

Focus Care Council on Health
INTRODUCTION
Mental health does not discriminate against anyone. Unfortunately, the stigma often prevents many people from receiving care. However, it is that very care that can lead an individual down the path to recovery. One group that has been especially vulnerable has been our military, both those in active duty and veterans.

Throughout our county’s history, our rights and freedom, as well as those of citizens from other countries, have been defended by the men and women who have joined the armed forces. Whether in times of peace or war and conflict, these brave men and women have left their homes and risked their lives to defend our homeland and ensure the basic rights we enjoy as Americans (Williamson & Mulhall, January 2009).

For many of us, our reference points for the return of our veterans are the news clips we see on the evening news. Often times, we don’t hear about the struggles they face upon returning home. Returning soldiers are often changed forever as a result of their military service and need assistance to deal with their experiences and acclimate to civilian life.

As early as 1919, doctors were beginning to recognize and track the invisible wounds of war. “Shell shock,” as it was commonly referred to, was noted for the first time during World War I. It was indicated by symptoms such as anxiety and fatigue. At that time, there was little science could do in terms of treatment. We now know that with screening and treatment, veterans’ mental health issues can be effectively treated (Williamson & Mulhall, January 2009).

- Since 2001, 2.4 million active duty and reserve military personnel were deployed to the wars in Iraq and Afghanistan.
- Of this group, 30 percent - nearly 730,000 men and women – will have a mental health condition requiring treatment.
- Studies have shown that 18.5 percent of all veterans from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) have Post-traumatic Stress Disorder (PTSD).
- Another 11.6 percent of those, without PTSD or major depression, suffer from other mental health disorders (National Council for Behavioral Health, 2012).

Post-traumatic Stress Disorder (PTSD) can occur after an individual has been through a trauma – something horrible and scary that one sees or experiences. During this type of event, an individual may think their life or the lives of others are in danger.

Experts think PTSD occurs:
- In about 11-20 percent of veterans of the Iraq and Afghanistan wars.
- In as many as 10 percent of Gulf War (Desert Storm) veterans.
- In about 30 percent of Vietnam veterans (U.S. Dept. of Veterans Affairs, PTSD: National Center for PTSD, 2013).
The conflicts in Iraq and Afghanistan have also resulted in an increase in veterans who have experienced traumatic brain injuries (TBI). The Department of Defense and the Defense and Veteran’s Brain Injury Center estimate that:

- 22 percent of all combat casualties from these conflicts are from brain injuries, as compared to 12 percent of combat casualties among Vietnam veterans.
- 60 to 80 percent of soldiers who have other blast injuries may also have traumatic brain injuries (Summerall, 2013).

Veterans are far more likely to experience homelessness than their civilian peers and rates of mental illness among the homeless are high (Williamson & Mulhall, January 2009).

- Veterans comprise 1 in 5 homeless Americans – 1 in 3 homeless men are vets and 58.9 percent of homeless vets are minorities.
- Veterans of Iraq and Afghanistan have an unemployment rate approximately 40 percent greater than the general population.
- The Department of Housing and Urban Development’s 2013 Annual Homeless Assessment Report estimates that 57,849 veterans were homeless on a single night in 2013.
- The veteran homeless population is comprised of veterans who served in wars and conflicts from World War II through the present.
- In the Capital Region in 2013, 13.88 percent (44) of the total homeless population included in the Capital Area Coalition on Homelessness’ 2013 Point In Time Survey were veterans. (Homelessness, 2013).
- While research indicates that veterans who served in the late Vietnam and post-Vietnam era are at greatest risk of homelessness, veterans returning from the recent conflicts in Iraq and Afghanistan often have severe disabilities that are correlated with homelessness.
- Homeless women veterans are far more common now than in any other time in the past (National Alliance to END HOMELESSNESS).

In 2011, more than 1.3 million veterans received specialized mental health treatment from the Veterans Administration (VA) for mental health related issues (U.S. Department of Veterans Affairs, Office of Public and Intergovernment Affairs). However, those who have injuries (such as combat-related mental health wounds) that do not become evident until later may not have access to the same veterans benefits as others when seeking treatment through the Veterans Administration (VA). Currently, veterans who have been out of the service for more than five years lose their priority status for mental health treatment.

**POST-TRAUMATIC STRESS DISORDER (PTSD)**

According to the U.S. Department of Veterans Affairs, PTSD is not rare. About 60 percent of men and 50 percent of women experience at least one trauma in their lives. Women are more likely to experience sexual assault and child sexual abuse, while men
are more likely to experience accidents, physical assault, combat, disaster, or to witness a death or injury (U.S. Dept. of Veterans Affairs, PTSD: National Center for PTSD, 2013).

Experiencing trauma doesn’t necessarily mean you will develop PTSD. Even though over half of us will experience some type of trauma during our lives, a much smaller number will develop PTSD. In the United States, about 7 to 8 percent of the population will have PTSD at some point during their lives. About 5.2 million adults have PTSD during a given year. About 10 percent of women develop PTSD during their lifetime as opposed to 5 percent of men (U.S. Dept. of Veterans Affairs, PTSD: National Center for PTSD, 2013).

According to the U.S. Department of Veterans Affairs (U.S. Dept. of Veterans Affairs, PTSD: National Center for PTSD, 2013), individuals are more likely to develop PTSD if they:

- Were directly exposed to trauma as a victim or witness.
- Were seriously hurt during the event.
- Went through trauma that was very severe or lasted a longer period of time.
- Believed they were in danger.
- Believed a member of their family was in danger.
- Exhibited a severe reaction during the event (crying, shaking, vomiting, or feeling separated from their surroundings).
- Felt helpless and could not help themselves or their loved one.

There is an increased risk of developing PTSD if an individual:

- Experienced an earlier life-threatening event or trauma (i.e. child abuse).
- Has another mental health problem or has family members who have had mental health problems.
- Recently lost a loved one (especially unexpectedly).
- Has little support from friends and family.
- Has recently experience stressful life changes.
- Drinks a lot of alcohol.
- Is a woman.
- Is poorly educated.
- Is younger.

When in the military, the risks of exposure to traumatic events increases. Military sexual trauma (MST) is another cause of PTSD. MST can happen to men and women and can occur during peacetime, training or war. The U.S. Department of Veterans Affairs reports that:

- Approximately 23 out of 100 women report sexual assault while in the military.
• 55 percent of women and 28 percent of men have experienced sexual harassment while in the military.

• Although MST is more common in female veterans, over half of all veterans with military sexual trauma are men (U.S. Dept. of Veterans Affairs, PTSD: National Center for PTSD, 2013).

**TRAUMATIC BRAIN INJURY (TBI)**

The diagnosis of Traumatic Brain Injury (TBI), associated with post-concussive symptoms and other comorbidities such as PTSD, can present unique challenges. There are no screening instruments available to reliably make the diagnosis and the “gold standard” remains an interview by a skilled clinician. Details of the original injury may be difficult to ascertain. Patients with moderate to severe TBI may have evidence of the relationship of their symptoms to their injury. However, those with mild TBI (mTBI) can be more difficult to diagnose. The brevity of the event causing the injury and an initial altered state of consciousness may cause the initial injury to go unnoticed, causing the patient to present later, when details may not be as clear. In other cases, the injury may be ignored during the chaos of combat (Summerall, 2013).

In general, the severity of a TBI is classified as mild, moderate, or severe. These terms are based on the nature of the injury itself, as opposed to the severity of the symptoms that are presented (Summerall, 2013).

In the civilian population, about 80 percent of TBIs are classified as mild TBIs (mTBI). They are primarily caused by falls, motor vehicle accidents, being struck by an object, and assaults. Immediately after the initial injury, 80-100 percent of patients experiencing mTBI will experience one or more symptoms of the injury (headache, dizziness, insomnia, impaired memory, lowered tolerance to noise and/or light). In most cases, these individuals will return to their previous level of function within 3-6 months. 10-15 percent may develop chronic post-concussive symptoms (Summerall, 2013).

In the military population, the primary causes of TBI differ somewhat. Primary causes of TBI in veterans of Iraq and Afghanistan are blasts, blasts plus motor vehicle accidents (MVAs), MVAs alone, and gunshot wounds. Exposure to blasts differs from other causes of mTBI and may produce different symptoms. Veterans may experience post concussive symptoms for longer than the civilian population, with some studies indicating that most will have symptoms 18-24 months after the injury. When coupled with other medical problems (comorbidity of PTSD, chronic pain and substance abuse) recovery from any single diagnosis can be more complicated (Summerall, 2013).

In cases of moderate and severe TBI, patients often have focal deficits and occasionally profound brain damaged. However, the severity of the initial injury does not correlate in a linear fashion with the severity of brain damage. Some of these patients make remarkable recoveries. They may need ongoing cognitive and vocational rehabilitation, case management and pharmacological treatment to return their highest level of functioning (Summerall, 2013).
According to Summerall, TBI of any severity can be disruptive to families. This may be due to the changing roles of family members in response to the patient’s difficulties. For this reason, immediate family involvement and education about this illness is crucial. Support to the family can improve outcomes when the patient’s recovery is not deterred by the deterioration of the family.

Patients with TBI should be referred for consultation with neurologists, neuropsychologists, and other specialized treatment providers as needed (Summerall, 2013).

**SUICIDE**

The suicide rate has increased over time for soldiers in all settings, including those who were never deployed, and those both previously and currently deployed. The suicide rate was highest among those who are currently deployed (18.3 deaths per 100,000) and dropped after deployment (15.9 per 100,000) (National Institute of Mental Health, 2011).

- When comparing soldiers who have never deployed to those currently deployed, the suicide rate increased among women (from 5.1 to 15.2 per 100,000) more so than men (from 14.8 to 21.1 per 100,000) (National Institute of Mental Health, 2011).
- Being married is associated with lower risk of suicide during deployment (e.g., 15 per 100,000 among those married compared to 24.5 per 100,000 among those never married) (National Institute of Mental Health, 2011).
- The small number of socio-demographic variables (e.g., sex, age, education, marital status, and race) and career-related variables (e.g., rank, time in service, and deployment status) considered so far show a meaningful concentration of risk of suicide, with 22% percent of suicide deaths occurring to the 5 percent of soldiers with the highest suicide risk profile (National Institute of Mental Health, 2011).
- Pentagon statistics show that an average of one military suicide occurred each day in the first six months of 2012, the fastest pace in the past ten years (Clifton, 2012). Military deaths from suicide outweighed combat deaths by a two-to-one ratio, a dramatic uptick since 2010 and 2011 when military suicides decreased from previous years (Burns, 2012).
- Suicide totals have exceeded U.S. combat deaths in Afghanistan in earlier periods, including for the full years 2008 and 2009 (Burns, 2012).
- A report released last year by the Center for a New American Security (CNAS) found that while the military and the Veterans Authority have taken admirable steps to improve suicide prevention and mental health counseling services serious obstacles remain. They include:
  - Frequent personnel transfers complicate efforts to provide consistent mental health services.
Personnel transfers occurring quickly after return from deployments hamper efforts to identify mental health conditions in the post-deployment period.

Soldiers are sometimes encouraged to provide untruthful answers in post-deployment mental health screening questionnaires.

A cultural stigma against mental health care persists in the armed forces (Harrell & Berglass, 2011).

Figure 1.1 shows the increase of suicides in the military from 2008-2012.

In 2012, United Way of the Capital Region commissioned a paper on the issue of veteran suicide through Messiah College (French, et al., 2012). In addressing the rising statistics of suicide within military personnel, research was broken down into three basic timeframes: pre-deployment, currently deployed, and post-deployment.

**Pre-Deployment**

The pre-deployment stage of the military career presents several important issues that should be considered when exploring potential contributing factors to veteran suicide. Through examining a variety of research, it is apparent that lack of mental health and substance abuse pre-screening as well as stress of relationships and finances present significant issues that should be considered.

In addition to the battery of tests that recruits must complete in order to join the military, background checks, credit checks and criminal records checks must be completed. The military restricts persons with a history of substance abuse from enlisting; urinary analysis and drug screenings are required, and criminal checks are performed to
identify any record of alcohol misuse, underage drinking or possession of illegal substances (French, et al., 2012).

**Potential Stressors:**
Over half of deployed soldiers in 2009 were reported to be 26 or younger and roughly 50 percent were married. A study conducted by the Center for Deployment Psychology suggests that this trend is significant because there is a potential that family structure adds additional stressors to the soldiers such as having children, a new spouse, significant other, pregnant wife at home, or children with special needs. This may affect the way they adapt and respond to stress (French, et al., 2012).

Another potential stressor of pre-deployment is financial struggle. There is significant research to suggest that financial benefits of employment may be incentivizing people to join the military. The year 2009 was one of the first years in which all recruitment quotas were easily met. “When the economy slackens and unemployment rises and jobs become scarcer in civilian society, recruiting is less challenging,” said Curtis Gilroy, the director of accession policy for the Department of Defense (Alvarez, 2009). Alvarez also points out that the GI Bill allows for a free public school college education for those who have been in active duty for three years or more.

The last stressor is mental health history. The United States Army is aware of this problem and in 1998 developed the Pre-Deployment Health Assessment (PreDHA), which is still used to help identify whether deploying soldiers currently struggle with mental illness, instead of determining whether they would struggle in the future (Hicks, 2011). However, the assessment may not accurately portray the number of active duty soldiers with a mental illness due to its self-reported nature.

a. **Recruits and Relationships**
   Relationships are another important factor to consider prior to deployment. Many couples struggle, especially in the weeks leading up to deployment. Family communication can be strained in anticipation of separation in the near future. During this time of pre-deployment, positive communication is crucial. It is beneficial for couples to attend workshops and seminars on building relationship resiliency so that they are better prepared for deployment (U.S. Army Medical Department, 2011).

   Stress resulting from anxiety about distance, finances, and management of household responsibilities can be significant. Couples should establish a support network of friends and family. Specific planning to communicate during deployment is also necessary so both people have the same expectations.

   There are many other emotions that accompany the pre-deployment stage, including shock, anxiousness, grief, denial, sadness, anger, distancing, resentment, loneliness, guilt and abandonment. To cope with these feelings, couples and families should think about various possible scenarios involving tension and how they could react towards them (Atova, 2007).
Prior to deployment, many soldiers decide suddenly to get married. This may be due to feelings of loneliness, desires for physical intimacy, fear, insecurity or greed. They often don’t think about long-term emotions or consequences. Rash marital decisions may easily lead to heartbreak, disappointment, divorce, depression, homicide and suicide (Nix, 2010).

b. Factors that may Increase Likelihood of Suicide

Military recruits enter the service with different levels of vulnerability to stress and trauma. There are factors in the military experience that can contribute to the likelihood that they will develop post-deployment stress injuries and substance use disorders. The Department of Veteran Affairs has identified many pre-deployment factors that may increase vulnerability to stress including worry and uncertainty, routine changes in deployment orders, multiple revisions of deadlines and locations, worrying about themselves and family members, and struggling to make all arrangements prior to leaving. There is increased stress on single parents and those who have not served before (Hoge, 2004).

Studies show that many recruits suffer from PTSD even before deployment, due to previous traumatic experiences. A study of personnel preparing for a peacekeeping mission found that 74 percent of participants reported prior traumatic experiences and 6 percent of those individuals could be classified as having PTSD (Stander, Merrill, Thomsen, & Milner, 2007).

During Deployment

Although many soldiers are coming home from the wars in Afghanistan and Iraq physically healthy and stable, a considerable number of troops from OEF and OIF return with significant psychological damage or trauma. Over 22 percent of OEF/OIF veteran patients were diagnosed with potential post-traumatic stress disorder (PTSD), according to the Department of Veterans Affairs (Kang & Bullman, 2009). Since mental illness tends to be a risk factor for suicide, this high number of PTSD veterans cannot be ignored, as many of these veterans may be at risk for suicide. However, when looking at all OEF/OIF veterans (not just ones treated or diagnosed by the Department of Veterans Affairs) the risk of suicide is only slightly higher than that of the general American population (Kang & Bullman, 2009).

There is no denying that there has been an increase in suicide rates among active duty OEF/OIF soldiers (Jakupcak, Cook, Imel, Fontana, Rosenheck, & McFall, 2009). This increase could be contributed to a variety of reasons. A unique factor to the OEF/OIF conflicts is the multiple deployments many soldiers experience and the emotional injuries that develop from them (Swofford, 2012).

These emotional injuries may take the form of damaging a soldier’s concept of trust or ideas of right and wrong. A soldier may feel he/she failed under fire, that their commander was not a competent leader or that the decisions made by either the solider or commander during deployment were in conflict with the soldier’s moral truths. However a solider copes psychologically during deployment will stay with them when
they return home leaving the returning soldier feeling “hyper vigilant and trusting no one” (Swofford, 2012).

These feelings may translate into depression, as the soldier feel as though they have no one to talk to. They may also experience feelings of betrayal by those in power for having to go fight a war, guilt for surviving when others did not, or alienation from friends and family upon returning (Sontag & O'Leary, 2008). Despite their feelings, many soldiers choose to go without treatment. Only about half of the nation’s veterans seek assistance from the Veterans Affairs department (Daniel, 2012). Thus, another risk of suicide is born.

Research has shown that there is little importance on the specific war a veteran served in and suicidal tendency. However, there has been an increase in suicide rates among active duty members of OEF and OIF. The significant factor in veteran is exposure to combat. This is due to the habituation of killing and other violent patterns through exposure to warfare-like events (Brenner, Gutierrez, Cornette, Betthauser, & Staves, 2008). It is the length of time a veteran is exposed to combat and the violence level of that exposure that contributes to the likelihood of the veteran forming habits of a violent nature and/or becoming numb to violent warfare actions, such as killing. Becoming accustomed to warfare-like actions can lead to the development of an attitude of indifference to the life of others due to the action of taking another person’s life (Brenner et al., 2008). This indifference can also translate to the veteran’s own life, which has been found to lead toward possible suicide attempts.

Exposure to combat relates to the exposure of pain (Brenner et al., 2008). This exposure to pain through combat causes many veterans to use pre-existing coping mechanisms to deal with the pain. However, increases in combat exposure have been found to cause veterans to modify their coping strategies, most commonly dissociation with surroundings and emotions (Brenner et al., 2008). The habituation of a veteran to pain coupled with modified coping strategies can leave a veteran more prone to self-inflicted injury or substance use and abuse (Kang & Bullman, 1996). The increased use of these substances to overcome pain and fear can have adverse effects on the veteran’s ability to handle issues. The severities of these modifications and other behaviors directly correlate with exposure to combat, and in turn, exposure to pain and habituation to pain-related behaviors.

Veteran suicide rates can also be influenced by feelings of being a burden or of not belonging. Studies have shown that veterans have experienced feelings of burdensomeness when returning from active duty and assimilating back into civilian life (Ilgen, et al., 2012). This stems from a lack of familiarity with civilian life after exposure to military service rules and regulations. Some veterans have stated that it is frustrating to be unable to treat others in the “military manner” to which they have grown accustomed (Brenner, et al. 2008). After a veteran returns from active duty, he/she often feels cutoff from close relationships as the results issues related to communication and difficulty in maintaining relationships over distance.
Resources Available for Active Duty Families

Families worry about how their soldier is doing emotionally, physically, and mentally. It is extremely important for families and close friends to be made aware of the resources that are available to them. These family members and close friends of the active duty soldier need to know to support their soldier and how they can be on the lookout for warning signs that a soldier may be at risk for suicide. Families and friends also need to be informed of the resources available to them if their soldier on active duty commits suicide. Some of these potential warning signs are:

- Talking about wanting to die or commit suicide.
- Looking for a way to commit suicide such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated.
- Behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or isolating themselves.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings (National Suicide Prevention Lifeline).

A valuable resource for family members of active duty soldiers is the Veterans Crisis Line. On the Veteran’s Crisis Line website (www.veteranscrisisline.net), there is a designated link for family and friends of active duty soldiers. This resource offers free, confidential support from an experienced, caring VA responder via telephone, online chat and text message services. The responders at the Veterans Crisis Line are trained to help veterans’ families and friends through any crisis.

The Real Warriors Campaign is a “multimedia public awareness campaign designed to encourage help-seeking behavior among service members, veterans and military families coping with invisible wounds (Real Warriors Campaign, 2013). They suggest that family and friends of the active duty soldier use the ACE framework to guide their actions if they believe their loved one is considering suicide.

**A**
The ‘A’ stands for asking your warrior about suicidal thoughts. It is important to be informed of the signs of suicide when this question is asked, and this question should be asked directly, but calmly.

**C**
The ‘C’ stands for caring for your warrior. This means understanding that your loved one may be in pain, being non-judgmental as you listen, and actively listening for details.

**E**
The ‘E’ stands for escorting your warrior. The active duty soldier’s suicidal thoughts should not be kept a secret. 911 or the Military Crisis Line (1.800.273-8255) should be called.
The Tragedy Assistance Program for Survivors, also known as TAPS, is the 24/7 tragedy assistance resource for anyone who has suffered the loss of a military loved one, regardless of the relationship to the deceased or the circumstance of the death.

Suicide survivors are welcome at all TAPS events for families of suicide victims, there is a special suicide loss chat each month, and the organization holds an annual gathering for suicide survivors annually.

Resources for Active Duty Soldiers
There are a variety of resources offered to active duty soldiers. PTSD, substance abuse, and other mental disorders, have led to higher rates of suicide among active duty soldiers. The Pentagon published data in 2009 that showed that troops were hospitalized for mental health disorders more than any other reason ("NAMI," 2011). There are also surveys that point to data revealing soldiers displaying symptoms of a mental illness are being re-deployed. Redeployment through a mental illness puts soldiers at major risk for committing suicide.

The Department of Defense has worked hard to create resources for active duty soldiers. Hotlines (Suicide Prevention Hotline, the Veteran’s Crisis Line, Military One Source), the Deployment Health Clinical Center, counseling options, education on pre-deployment, deployment and post-deployment (also provided for families of soldier), Fleet and Family Support Centers, Chaplains, Suicide Prevention Coordinators, and other mental health offices are just a few of the resources readily available.

The biggest issue involves soldiers and family members recognizing the need to use the resources that are available. If mental disorders developed during deployment could be addressed sooner by offering counseling during deployment or before deployment, the suicide rate could decrease drastically.

Post-Deployment
Every day, 22 veterans take their own lives - that’s a suicide every 65 minutes. As shocking as this number is, it may actually be higher. This figure was released in February 2013 by the Department of Veterans Affairs. It is based on the agency’s own data and numbers reported by 21 states from 1999 through 2011. Those states that reported represent 40 percent of the U.S. population; however, the other states, including the two largest (California and Texas) and the fifth largest (Illinois) did not make data available (Basu, 2013).

“Recent evidence from veterans indicates that men with a substance use disorder are approximately 2.3 times more likely to die by suicide than those who are not substance abusers. Among women, a substance use disorder increases the risk of suicide 6.5-fold” (Ilgen & Kleinberg, 2011). These statistics are a reality for the veteran’s clinics and Veteran’s Affairs organizations. Sadly, these statistics have risen over the past 10 year with the recent wars in Iraq and Afghanistan.
Many veterans who return from duty turn to drugs and alcohol to escape reality. Sometimes their drug and alcohol use causes them to become violent; this includes how they commit suicide. Veterans diagnosed with a substance abuse disorder who commit suicide are more likely to do so by violent methods than by nonviolent methods (elements Behavioral Health). Many veterans who are dealing with substance abuse also have other problems they are unable to escape, such as increased aggressiveness, irritability, insomnia, and other uncharacteristic behaviors. Research continues to be completed every year and sources are becoming more available for veterans to receive help. “According to the Associated Press, veterans who sought counseling or medical treatment for their mental health in 2007 were less likely to commit suicide than those who did not seek treatment” (elements Behavioral Health).

Veterans seeking health care for their disorders or injuries must enroll with Veterans Affairs before receiving any health care services. The advantage to enrolling in this service is it requires an annual alcohol screening. “Department policy does require an annual alcohol screening, which is waived for veterans who drank no alcohol in the prior year. The VA offers medication and psychosocial interventions for substance use disorders, as well as acute detoxification care when necessary. Medication may be used to reduce cravings or to substitute for the drug of abuse.” (Bagalman, 2011).

Coming home from war is a difficult task and each returning individual must go through the proper debriefing before entering “normal” life situations. Issues occur when soldiers do not address what they are feeling and revert to negative depressants and actions like abusing drugs and alcohol. The suicide rate will continue to increase until awareness is raised throughout the United States.

Disabilities in Correlation with Veteran Suicide Rates
Veterans frequently have a stigma towards getting psychological help. (Brenner, Breeta, Adler, Wolfman, & Kemp, 2009). “Veterans identified their pre-injury selves as being service providers and caregivers, often with the context of military service. Post-injury they spoke of having to depend on others...Participants voiced the shared concern of being a burden to others.” (Brenner, Breeta, Adler, Wolfman, & Kemp, 2009). Because brain injuries or psychological injuries are not outwardly apparent, it is harder for veterans’ friends and families to know how to help. People may be unaware of how PTSD and TBI affect an individual and they may have unrealistic expectations of that person (Brenner, Breeta, Adler, Wolfman, & Kemp, 2009).

Research shows that “rehabilitation psychologists who provide treatment to patients shortly after a traumatic event have a prime opportunity to assist in the detection of PTSD symptoms, and facilitate early treatment intervention” (Barnes, Walter & Chard, 2012, p. 24). More attention should also be given to educating the general public about the psychological difficulties that many veterans are suffering with.
SUMMARY
Exposure to combat or war-like experiences, PTSD and TBI diagnoses, drug and alcohol abuse, are significant factors in veteran suicide risks. Further research, specifically regarding family support in correlation with veteran suicide, is needed as well as community education and awareness of the difficulty of assimilating back into civilian life. An increase in, and consistent follow-up of, screening and treatments is extremely important in addressing the veteran mental health and suicide epidemic.

Resources
Dauphin County Veterans Affairs: Provides information on medical care, federal and state Benefits, the Persian Gulf War Bonus, Veterans Retraining Assistance Program and other information and resources. Phone: 717.780.6357.

Veterans’ Affairs Office in Cumberland County: Provides assistance, counseling, and education to veterans on their resources and rights. Phone: 717.240.6178.

Online Resources
• National veteran’s website (www.va.org) provides resources to educate veterans on warnings signs of depression and suicide.
• There are additional websites available that describe suicide risks and allow one to do a free self-assessment.
• There is a phone number for a veteran’s crisis line on the website.
• Overall, there is plenty of information available online for veterans to assess themselves.

Counseling Resources
• Counseling is available at the majority of Veterans Affairs offices including the one located in Cumberland County. Many offer specific programs on PTSD, however this location does not.
• Counseling for veterans is also available at the American Red Cross in Cumberland County.

Stigmatization
• Even though there are locations for PTSD treatment as well as suicide prevention and counseling, the majority of veterans do not end up seeking or going to counseling, even though they are aware that this is a problem.
• Resources are widely available for veterans to educate themselves further on the issues, but more resources should be established that specifically focus on PTSD issues.
• Counseling is not a requirement and veterans are often afraid to go to counseling due to the level of stigmatization related to it.

International Resources
The International Association for Suicide Prevention (IASP), www.IASP.info: The IASP is an organization of professionals and volunteers from over 50 countries. It has an official relationship with the World Health Organization with suicide prevention. The aim
of the program is to bring together interested people in research, prevention and policy, who can share information and expertise in suicidal behavior and prevention worldwide.

**National Resources**

**American Foundation for Suicide Prevention** - This organization has compiled a bibliography on suicide, suicide prevention, and surviving. They also provide a listing of resources.

**American Association of Suicidology** - This a non-profit organization dedicated to the understanding and prevention of suicide. This site is designed as a resource for anyone concerned about suicide, including AAS members, suicide researchers, therapists, prevention specialists, survivors of suicide, and people who are in crisis.

**Giveanhour.org** - Give an Hour is a non-profit organization focused on meeting the mental health needs of military service men and women and their loved ones who are affected by mental health issues and Post Traumatic Stress Disorders. The organization has amassed a network of over 1,700 mental healthcare professionals to offer pro bono treatment. The mental health professionals provide one hour of treatment free per week for service men and women and their families. Contact website for a list of local providers.

**National Council of Suicide Prevention** - This program provides a framework for ways to prevent suicide and for the development of services and programs. It is organization and focused on being a catalyst for social change by helping to transform attitudes, policies, and services nationally.

**The National Organization for People of Color against Suicide (NOPCAS, Inc.)** - This organization is focused on raising awareness and education among people of different ethnicities. They also aim to develop prevention, intervention, and post-intervention services for these populations.

**The Soldiers Project** - The Soldiers Project is a group of licensed mental health professionals who offer free psychological treatment to military service members (active duty, National Guard, reserves and veterans) who served in Iraq and/or Afghanistan. There is no cost, and there is no limit on the number of sessions provided. Therapy is focused to the client's needs. The professionals are in private practice, they can see veterans prior, during, and after their return from deployment. They can also keep in touch with veterans via phone or the internet if needed. The project has counseling services located in New York, Sacramento CA, Chicago, Southern California, Long Island, and Northwest Pennsylvania.

**Wounded Warrior Program** - This non-profit national organization focuses on helping retuning veterans adjust to civilian life and find mind, body, and economic restoration. The program also provides an engagement component, which connects veterans to needed resources and aid in political and social empowerment. The Combat Stress Recovery Program (CSRP) addresses the mental health and cognitive needs of warriors returning from war. CSRP provides services at key stages during a warrior's
readjustment process. The program’s mental health program particularly addresses PTSD.

**Hotline Resources**

**Crisis Intervention** - This hotline provides immediate help for acute mental health problems such as suicide. They provide listening, referrals, and can call authorities for emergencies. Phone: 717.232.7511 or 1.888.596.4447.

**Contact Helpline** - The hotline provides 24/7 listening, and agency information and referrals for residents of Dauphin, Cumberland and Perry Counties. Phone: 1.800.932.4616 or dial 211.

**National Suicide Hotline** - Hotline provides a free suicide prevention service available to anyone in suicidal crisis.

**Vet2Vet Veterans Crisis Helpline** - This hotline is manned by veteran peer trained counselors. The program certifies crisis centers to take these specialized calls using QPR (Question, Persuade and Refer) for law enforcement and veterans specifically. They provide resource data bases for crisis centers to use. They also provide the public with educational brochures to returning and current veterans.

**Veterans Crisis Line** - The Veterans Crisis Line connects veterans in crisis to resources in their area. The online web page helps educate veterans and their families about the warning signs of depression, and suicidal behavior.

**The Kristin Brooks Hope Center - Program Manager of the National Hopeline Network** - Kristin Brooks Hope Center is a non-profit organization that is focused on suicide prevention and depression awareness education. One of KBHC’s direct services is the National Hopeline Network 1.800.SUICIDE (784.2433). This network connects people who are depressed or suicidal to an American Association of Suicidology (AAS) or CONTACT USA certified crisis center nearest to where the caller is located.

**Psychiatric Emergency Response Network (PERN)** - To maximize scarce resources and integrate suicide prevention into private and public health plans, the Psychiatric Emergency Response Network is designed to help improve rescue outcomes from calls made to 1.800.SUICIDE, 911, 211 and anyone who needs to send help to a caller in crisis. The organization works toward networking all the mobile response teams in the U.S. so that the mental health professionals in the local community are the first responders instead of the police.

**Online Resources**

**IMAlive** - Provides online support to people in crisis who are unwilling or unable to make phone calls to The Hopeline Network.

**Other Websites** - Many websites for veterans provide online information for finding mental health services in the persons’ local area.
Local Resources in Dauphin, Cumberland, and Perry Counties

Adams Hanover Counseling Services (also serves Dauphin County): This agency provides group counseling for veterans. They also have a 24/7 crisis team who are available by phone and can make house visits if necessary to assess if hospitalization is needed. Outpatient referrals are also made.

Harrisburg and Camp Hill Vet Centers (Dauphin and Cumberland) - These centers provide counseling for veterans and families of service men and women who have died.

Lebanon County Veterans Administration Medical Center (VAMC) Community-Based Outpatient Clinics (Dauphin and Cumberland) - Lebanon VAMC provides acute inpatient medical, surgical and behavioral health care. The hospital is available to veterans in all counties including Dauphin, Perry, and Cumberland. Six Community Based Outpatient Clinics (CBOCs) are located in Camp Hill, York, Reading, Lancaster, Pottsville, and Frackville. An outreach clinic is also available at Fort Indiantown Gap and administrative support is given to two veterans centers located in Dauphin and Lancaster counties. This is in addition to the primary care clinics located on the main campus in Lebanon. The CBOCs provide a variety of health services. The behavioral health services offer group and/or individual therapy such as: psychiatry, psychology, substance abuse, PTSD, geriatrics, and memory disorders.

There are several current VA facilities that require more mental health staff to keep up with the number of veterans that require these services, and the VA is working quickly to meet the needs. This is due to the rise in Post-traumatic Stress Syndrome (PTSS) and other mental health issues among the veteran population, and the increased need for services. This includes growth needs for the Veterans Crisis Line, and the anticipated increase in Compensation and Pension/Integrated Disability Evaluation System exams.

Pennsylvania Office of Mental Health & Substance Abuse Services - This agency provides services including outpatient, partial, residential, short-term inpatient hospital care, emergency crisis intervention services, and counseling, information, referral and case management services. They also have PTSD services.

Roxbury Treatment Center (Only inpatient treatment center for veterans in PA) - This is the only mental health and drug and alcohol abuse inpatient/outpatient facility that has an inpatient unit specifically for veterans. The physical environment of the unit is designed in a military fashion, with surroundings that are familiar and comfortable to the veterans. The treatment center is located in Shippensburg.

Veterans' Court - Dauphin County - The Dauphin County Veterans' Court Program is specifically designed for veterans involved in the criminal justice system. A trained mentor is paired with a veteran participant to provide support as he/she navigates through the court system and treatment process. Mentors and participants are paired by service whenever possible. The program offers support for veterans in the court system by spending one-on-one time with the veteran on a regular basis to provide an opportunity to discuss concerns and receive support from another veteran. The mentors
are also able to link veterans to services in the community at large. They also provide mental health and trauma counseling by mental health professionals.

**Medical and Disability Resources for Veterans**

**VA Specific Health Programs for Veterans**  
(As briefed by the US Department of Veterans Affairs  
http://www.va.gov/health/programs/index.asp)

- **Caregivers/Caregiving** - Support and services for those who care for veterans.
- **Chaplain** - Attending to the spiritual health needs of veterans.
- **Community Living Centers** - Short-stay and long-stay nursing home care for veterans who are medically and mentally stable.
- **Fisher House** - A "home away from home" for families of patients receiving medical care at major military and VA medical centers.
- **Geriatrics & Extended Care** - Geriatric and extended care services for veterans including non-institutional and institutional options.
- **Homeless Services** - In our efforts to end veteran homelessness within the next five years, the VA offers a variety of resources, programs and benefits to assist veterans who are homeless.
- **Mental Health** - Maintaining and improving the health and well-being of veterans through excellence in health care, social services, education, and research.
- **MyHealtheVet** - Anywhere, anytime Internet access to VA health care information and services.
- **National Center for Post-traumatic Stress Disorder** - The center of excellence for research and education on the prevention, understanding and treatment of PTSD.
- **Prescriptions** - Online prescription refills provided through My HealtheVet (requires login).
- **Readjustment Counseling (Vet Centers)** - Offers services to eligible veterans and their families in an effort to aid their successful transition from military to civilian life.
- **Rural Health** - Improving access and quality of care for veterans living in rural areas.
- **Substance Abuse Programs** - Treatments addressing all types of problems related to substance use, from unhealthy use of alcohol to life-threatening addictions.
- **Veterans Crisis Line** - The Veterans Crisis Line (Dial 1.800.273.8255 and press 1) is a toll-free, confidential resource that connects veterans in crisis and their families and friends with qualified, caring VA responders.
- **Women Veterans Health Care** - Implementing positive changes in the provision of care for all women veterans.
- **Patient Advocates** - It is suggested that complaints, suggestions, or concerns be directly relayed first to the veteran’s specific treatment team. People in this team may include doctors, nurses, social workers, pharmacists, therapists, dietitians and other professionals that may come into direct contact with his/her own personal health care. If, after addressing an issue with the medical team, a veteran still does not feel that his/her concerns are being met, he/she may contact a VA Patient Advocate. “A Patient Advocate is an employee who is specifically designated at each VHA facility to manage the feedback received from veterans, family members
and friends. The Patient Advocate works directly with management and employees to facilitate resolutions” (www.va.gov). Patient Advocates may be contacted at local VA facilities.

**Online Resources**

**MyHealtheVet.com** – Offers health care research information as well as common conditions associated with veterans. It offers links to Healthy Living Centers, Disease and Condition Centers, and the Mental Health Medical Library. MyHealtheVet is designed to help make veterans make informed decisions about their own personal health care. It keeps track of medications, appointments, and prescription information as well as keeping record of personal health history.

**MaketheConnection.net** - A public awareness campaign that encourages veterans and their loved ones to be able to securely and privately connect with resources and other veterans across the nation and around the globe. It provides search engines for finding services and resources nearest to them as well as other ways to get connected. It provides information about physical and mental health symptoms and conditions, not only as an educational tool but also as a tool to find help if necessary. It offers advice to veterans and their loved ones as to how to help veterans in crisis and many, many more resources.


**Veteran Crisis Line Online Chat:**

- “If you’re a veteran in crisis or concerned about one, responders at the Veterans Crisis Line online chat offers help that can make a difference. Caring, qualified VA professionals are standing by to provide free and confidential support. Use the Veterans Chat to get online support anonymously, 24 hours a day, 7 days a week, 365 days a year —even if you’re not registered with VA or enrolled in VA health care. Responders will work with you to help you get through any personal crisis, even if that crisis does not involve thoughts of suicide.”

**Veterans Crisis Text Line:** 838255

**Local VA Medical Centers**

**Pennsylvania Medical Centers (none exist in Perry, Dauphin or Cumberland counties)**

- James E. Van Zandt Altoona VA Medical Center - [www.altoona.va.gov](http://www.altoona.va.gov)
- VA Butler Healthcare - [www.butler.va.gov](http://www.butler.va.gov)
- Coatesville VA Medical Center - [www.coatesville.va.gov](http://www.coatesville.va.gov)
- Erie VA Medical Center - [www.erie.va.gov](http://www.erie.va.gov)
- Lebanon VA Medical Center - [www.lebanon.va.gov](http://www.lebanon.va.gov)

For a list of full services available see [www.lebanon.va.gov/services/](http://www.lebanon.va.gov/services/).
Local VA Outpatient Clinics (in Cumberland, Dauphin or Perry counties)
Camp Hill VA Outpatient Clinic (595GA)
25 N 32\textsuperscript{nd} Street
Camp Hill, PA
Phone: 717.730.9782

\textbf{Services Available:}
Primary Medical Care (men and women)
Women’s Health Care (including annual breast and pelvic exam)
Endocrinology
Renal
Podiatry
Optometry
Physical Therapy
Occupational Therapy
Home Oxygen Therapy (service is coming soon)
Neurology (follow up evaluation via telehealth)
Dermatology (telehealth)

\textbf{Educational Services:}
Diabetes Education
Cardiac Risk Reduction
Lifestyle Changes (diabetes, cholesterol, blood pressure)
MOVE! (weight loss)
Nutrition
Anger Management (service coming soon)

\textbf{Support Services:}
Social Work Services
Female Veterans Support
Vietnam Veterans’ Support
Pharmacy Counseling (service coming soon)
My HealtheVet Assistance

\textbf{Laboratory Services:}
Laboratory Testing
Finger Stick Coumadin Testing (service coming soon)
Immunizations

\textbf{Behavior and Health Services} (group and/or individual therapy available)
Psychiatry
Chapter 1 VA Health Care Benefits - Outlines all major health care benefits entitled to eligible veterans, dependents, and survivors. All veterans who served in active duty may be eligible for benefits as well as National Guard and Reserves who were called to active duty by a Federal order.

Minimum Duty Requirements - “Veterans who enlisted after Sept. 7, 1980, or who entered active duty after Oct. 16, 1981, must have served 24 continuous months or the full period for which they were called to active duty in order to be eligible. This minimum duty requirement may not apply to veterans discharged for hardship, early out or a disability incurred or aggravated in the line of duty” (www.va.gov).

Includes registry information for medical programs such as Veteran Health Registries – Gulf War Registry, Depleted Uranium Registries, Agent Orange Registry, and Ionizing...
Radiation Registry – which provide free medical screenings and evaluations as deemed necessary.

Veterans may receive:
- Prosthetics and Sensory Aids
- Home Improvements and Structural Alterations
- Services for the Blind and Visually Impaired
- Mental Health Care
- Outpatient Dental Treatment
- Nursing Home Care
- Emergency Medical Care in Non-VA Facilities
- Online Health Services
- Foreign Medical Services
- Caregivers

A full copy of Chapter 1 VA Health Care Benefits may be found at http://www.va.gov/opa/publications/benefits_book/benefits_chap01.asp
Resources:


