



OREGON VETERANS'

Behavioral Health Services Improvement Study:
Needs Assessment & Recommendations Report



PREPARED BY
THE REDE GROUP
IN JUNE 2019



OREGON DEPARTMENT
of VETERANS' AFFAIRS

Acknowledgments

June 2019

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Submitted by:



Jill Hutson
Alex Muvua
Emily Drum, MPH
Erin Charpentier, MFA
Kate Marsi, MSW, MPH
Stephanie Young-Peterson, MPH
Robb Hutson, MA

In collaboration with:

Bonnie Gee Yosick, LLC
ELE Consulting, LLC

Bonnie Gee Yosick, MBA
Eric Einspruch, PhD

Acknowledgments:

We gratefully recognize the contributions of these collaborators on this report:

Sheronne Blasi, MPA
Royce Bowlin, MS
David Greaves, PhD
Holly Heiberg, MPP
Michael Morris, MA
Jeff Scroggin
Laurie Skillman, JD
Mitch Sparks
Emily Watson, MPA



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Over the course of this project, 4,659 veterans gave their time and energy to inform this study. They completed surveys, shared their experiences in interviews, participated in photo shoots, and met for focus groups. They shared personal stories of illness, stigma, treatment, health, and recovery. Most of all, they shared their hope—hope for a better behavioral health system for themselves and for all the veterans who will follow them home.

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Acronym List

DATASETS

APAC	All Payer All Claims
BRFSS	Behavioral Risk Factor Surveillance System
MOTS	Measures and Outcomes Tracking System
NSDUH	National Survey on Drug Use and Health
OVSAR	Oregon Vital Statistics Annual Reports
CPMS	Client Process Monitoring System
TEDS	Treatment Episode Data Sets

DIAGNOSES & TREATMENTS

CPT	Cognitive Processing Therapy
DBT	Dialectical Behavior Therapy
EMDR	Eye Movement Desensitization and Reprocessing
MST	Military Sexual Trauma
PTSD	Posttraumatic Stress Disorder
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury

HEALTH CARE FACILITIES & PROGRAMS

CBOC	Community-Based Outpatient Clinic
CCBHC	Certified Community Behavioral Health Clinic
CMHP	Community Mental Health Program
SBHP	Star Behavioral Health Provider
VCP	Veterans Choice Program

ORGANIZATIONS

CCO	Coordinated Care Organization
CDC	Centers for Disease Control and Prevention
DoD	Department of Defense
ODVA	Oregon Department of Veterans' Affairs
OHA	Oregon Health Authority
SAMHSA	Substance Abuse and Mental Health Services Administration
VISN	Veterans Integrated Service Network
VA	U.S. Department of Veterans Affairs
VHA	Veterans Health Administration

MISCELLANEOUS

LGBTQI	Lesbian/Gay/Bisexual/Transgender/Queer/Intersex
OTH	Other-Than-Honorable [discharge status]
PTE	Potentially Traumatic Event

A portrait of a man with a goatee and a dark baseball cap, wearing a dark t-shirt. The image is overlaid with a semi-transparent teal color. The man is looking directly at the camera with a neutral expression. On the t-shirt, the text "PPPS Transformation" is visible in white. On the sleeve, the words "Justice" and "ice" are partially visible. A solid orange horizontal bar is located to the left of the main text.

EXECUTIVE SUMMARY

PPPS
Transformation

Justice
ice

Executive Summary

INTRODUCTION

Underscoring the state's commitment to supporting the 10% of Oregon adults who have served in the U.S. military, the 79th Oregon Legislative Assembly prioritized the behavioral health of Oregon veterans by charging the Oregon Health Authority (OHA) and the Oregon Department of Veterans' Affairs (ODVA) to identify and fund programs and services that improve their behavioral health outcomes. In response, OHA commissioned this report to assess veterans' access to adequate and appropriate behavioral health services across the state.

The key findings in this study are derived from research conducted through literature review; analysis of national and state datasets; structured interviews with Veterans Health Administration (VHA) and non-VHA providers and local and national Tribal representatives; and a statewide online questionnaire survey and focus groups with Oregon veterans. These findings highlight the unique issues Oregon veterans face in accessing behavioral health care, dispel some perceptions about veterans' behavioral health while reinforcing others, and illustrate the ways in which the current behavioral health system impacts veterans and the providers who serve them.

PURPOSE OF THE STUDY:

1. To describe the type and availability of behavioral health services for veterans in Oregon
2. To provide findings regarding facilitators of and barriers to delivery and use of behavioral health services for veterans in Oregon
3. To make recommendations for legislative or other changes that may result in better delivery, accessibility, and utilization of behavioral health services by veterans in Oregon

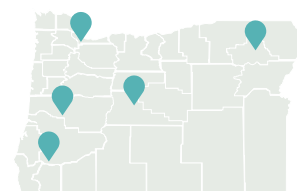
SCOPE OF THE STUDY:



VHA providers interviewed

63

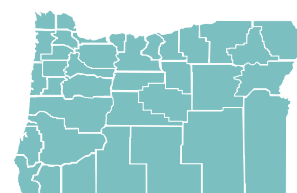
Veterans participated in nine focus groups in five locations



Non-VHA providers interviewed

3,915

Veterans from across the state completed online questionnaire surveys



Executive Summary

KEY FINDINGS & RECOMMENDATIONS

The findings and recommendations below are condensed from the final findings and recommendations of this report. Please refer to pages 83-96 of this report for the complete findings and recommendations in detail.

Veterans' role in designing systems improvements

FINDINGS

- Oregon veterans exhibit a strong desire to achieve behavioral health and wellness. However, the efforts of some are stymied by issues comprising two main categories: access and quality of care
- Veterans express a strong desire to improve behavioral health conditions for future veterans

RECOMMENDATIONS

1. By October 2019, OHA should present this report to veterans and key stakeholders at 15-25 small, community-based meetings throughout Oregon to share report findings and provide a forum for local-level problem solving
2. By June 2020, OHA should develop a mechanism to fund innovative, cross-sector, community-level projects that are designed to bridge gaps in services found in this report
3. By June 2020, ODVA and OHA should establish a veterans' behavioral health commission which is chaired by a veteran and whose membership comprises at least 75% veterans, with representation from rural, women, Tribal, and LGBTQI veterans

Consistent and sustainable coordinated access

FINDINGS

- Oregon currently does not have an adequate number of providers to support the behavioral health needs of the state's veterans
- Veterans who receive care through the VHA report slightly higher levels of satisfaction with services than those who receive care through other means
- Some veterans' trust in VHA behavioral health services has been undermined by the perception of a one-size-fits-all approach with an overreliance on pharmacological therapies, inability to choose their own providers, frustration with navigating logistics, and disappointment with previous VHA care experiences

RECOMMENDATIONS

4. OHA should continue to develop strong relationships with regional VA providers throughout VISN 20



Executive Summary

KEY FINDINGS & RECOMMENDATIONS

5. OHA, ODVA, and Portland VA Health Care System should collaborate to develop a comprehensive state- and federally-funded program to address veterans' needs through transition back to civilian life
6. Cross-agency collaboration among OHA, ODVA, and VA Health Care Systems in Oregon should drive increase of state and federal agency coordination across behavioral health systems

Outreach to improve access

FINDINGS

- Stigma around mental health and substance use is a major barrier to seeking behavioral health care for veterans. Stigma is embedded in military culture and communities-at-large and can be targeted at specific subgroups of veterans whose access to services may already be impacted by fear or discomfort in seeking services (e.g., women veterans, LGBTQI veterans)

RECOMMENDATIONS

7. OHA, ODVA, and the VA Health Care Systems in Oregon should collaborate to develop a cohesive, well-researched, and targeted education and outreach effort to destigmatize behavioral health issues and treatment using market tested, culturally-specific messages promoting care-seeking and demonstrating that Oregon is making veterans' behavioral health care a priority. Minimally the outreach effort should include:
 - Provider education
 - Mass communication with formative research testing
 - Programs highlighting and directing veterans to existing services
 - Outreach to community groups

As a component of this effort, OHA and ODVA should collaborate on a one-stop website that provides veterans and their families with basic navigational support

Quality of care

FINDINGS

- Both veterans and providers identify peer relationships as an essential aspect of behavioral health services
- Coordinated Care Organizations (CCOs) and Community Mental Health Programs (CMHPs) provide important services that could benefit veterans but report concerns about the level and quality of care available to veterans

Executive Summary

KEY FINDINGS & RECOMMENDATIONS

RECOMMENDATIONS

8. OHA should continue to develop and fund quality peer support models across the state and prioritize expanding culturally competent peer support for specific populations (e.g., rural, Tribal, combat, aged 34-and-under)
9. OHA should work with CCOs and CMHPs to collect veteran status data in Electronic Health Records and encourage and support CCOs in developing quality improvement strategies for veterans' behavioral health services

Cultural competency

FINDINGS

- ▬ Tribal representatives report a need for cultural competency in services, with an emphasis on a preference for traditional healing modalities and peer support as the most important factors in care-seeking behavior for Tribal veterans
- ▬ Variances exist in the specific needs and expectations of subgroups of veterans (e.g., age, gender, LGBTQI identity, etc.) that impact how those veterans seek care
- ▬ Some women veterans report that they are met with bias affecting their care when interfacing with VA Health Care facilities

RECOMMENDATIONS

10. The VHA and Vet Centers should promulgate plans to build capacity for cultural competency practices with measurable objectives that address the unique needs of groups of veterans

Provider outreach

FINDINGS

- ▬ The availability of publicly-funded non-VHA providers who are trained in the knowledge and skills to screen for and/or treat concerns specific to veterans and their families is limited, particularly in rural areas

RECOMMENDATIONS

11. OHA and ODVA should collaborate to increase the number of non-VHA providers with training in military or veterans' behavioral health issues to improve veterans' access to providers with the skills to identify their needs and to provide military trauma informed services



Executive Summary

KEY FINDINGS & RECOMMENDATIONS

12. OHA should conduct a review of evidence-based programs, such as the Star Behavioral Health Providers training, to offer providers a menu of programs that will provide them with the tools to provide culturally relevant care to individuals with military posttraumatic stress disorder (PTSD), traumatic brain injury, and military sexual trauma

Data and research

FINDINGS

- Some veterans' behavioral health outcomes, when compared to those of non-veterans, are counterintuitive when considered in light of differences (or lack thereof) in behavioral health characteristics between the two groups. For example:
 - Veterans are less likely than non-veterans to report they have been told they have depression but more likely to die by suicide
 - Veterans and non-veterans have similar tobacco and alcohol use, but veterans are more likely to die in opioid-affiliated occurrences
- Publicly funded non-VHA providers do not have comprehensive systems in place to identify veterans, a significant gap in access to quality data that impacts the state's ability to evaluate improvements in behavioral health systems
- More research into behavioral health conditions and treatments for veterans with other-than-honorable discharge (OTH) status is necessary in order to adequately serve this group
- VHA providers report administrative and other challenges with the purchased and referred care systems. Providers at individual VHA facilities also report they are unable to provide some services that are considered essential to best practices for veterans' behavioral health care

RECOMMENDATIONS

13. OHA should further investigate age-specific trends in substance use and other suicide and opioid mortality risk factors, specifically in veterans aged 34 and younger. OHA should continue to monitor veterans aged 75 and older
14. OHA should establish data systems to routinely gather veteran status, health status, behavioral health, and health care information about Oregon's veterans, with particular attention paid to those at greater risk due to social determinants of health

Executive Summary

KEY FINDINGS & RECOMMENDATIONS

15. The VA should establish a method for monitoring the effects of changes in purchased and referred care such as the Veterans Choice Program. Areas of inquiry should include an analysis of whether or not administrative issues present a barrier to non-VHA providers who may otherwise be qualified or interested in serving veterans

Special considerations: Suicide

FINDINGS

- ↓ Veterans aged 18-34 are at the highest risk for suicide in Oregon and are more vulnerable the more recently they have been discharged from service

RECOMMENDATIONS

16. OHA and ODVA should continue efforts to improve and coordinate suicide prevention programs specific to the veteran population pursuant to current strategic initiative articulated in:
- VA's National Strategy for Preventing Veteran Suicide
 - Oregon Public Health State Health Improvement Plan
17. Recognizing the critical role of innovation in problem solving and systems change, OHA, ODVA, and the VA Health Care Systems in Oregon are encouraged to seek out and embrace promising innovative practices. OHA and ODVA could, for example, collaborate to develop artist-in-residence programs with the intention of decreasing suicide risk by exploring creative solutions to welcome returning veterans home and assist their transition back into their communities

Special considerations: Military sexual trauma

FINDINGS

- ↓ Veterans' capacity for care-seeking is impacted by both a military culture of behavioral health stigma and the effects of trauma. In older female veterans especially, the effects of long-held trauma and related secrecy are compounded. Female veterans with military sexual trauma report discomfort or fear at VHA facilities, and providers report a need for more community-based, gender-specific care options
- ↓ Both male and female veterans experience military sexual trauma, however, a high percentage (at least 50%) of female veterans in Oregon have experienced military sexual trauma. There are no inpatient military sexual trauma treatment programs within the state, and female veterans report in greater proportion than male veterans feeling that they have needed behavioral health services and did not receive them



Executive Summary

KEY FINDINGS & RECOMMENDATIONS

RECOMMENDATIONS

18. OHA, ODVA, and VA Health Care Systems in Oregon should improve access to treatment for military sexual trauma by reconfiguring clinical spaces and intake processes, increasing the number of providers who are specially trained to identify and treat military sexual trauma, and conducting a cost analysis study for establishing an inpatient option in Oregon. Residential options must provide separate sleeping areas for men and women

Special considerations: Housing

FINDINGS

- Key informants from the VHA, CMHPs, and CCOs interviewed for this report identified housing insecurity and homelessness as a serious challenge in providing care to veterans
- The stability, quality, safety, and affordability of housing affects health outcomes at the individual and population levels

RECOMMENDATIONS

19. Like all social determinants of health, housing must be a consideration in efforts to improve behavioral health outcomes. ODVA, OHA, and the VA Health Care Systems in Oregon all support or provide resources and information for veterans experiencing homelessness; in addition, OHA should continue efforts (building on current work with CCOs) to prevent housing insecurity and homelessness, systemically



INTRODUCTION

Introduction

Oregon veterans: an overview

Oregon veterans have served in peacetime and wartime, spanning five eras of service (World War II, Korean War, Vietnam War, peacetime, and the Gulf War/post 9-11) and four generations. And, while most veterans are male, nearly 8.5% of the state's total veteran population comprises women, the fastest growing cohort of veterans.¹ Oregon's veteran population is diverse in terms of age, gender identity, race, ethnicity, sexual orientation, and geographic location.

This report focuses on U.S. veterans, with both honorable and other-than-honorable discharge status, who served as full-time members of the Air Force, Army, Coast Guard, Marine Corps, or Navy. Veterans of the Oregon Army National Guard who qualify for VA benefits are also included.

Figure 1 on the following page provides an overview of Oregon's veteran population.

OREGON DEPARTMENT OF VETERANS' AFFAIRS DEFINITION OF "VETERAN"

For the purposes of most VHA health benefits and services, a veteran is anyone who served on active military duty and who was discharged or released under conditions other than dishonorable. Under certain circumstances, the dependents or survivors of a veteran may qualify for benefits as well.

In general, active military service means full-time service, other than active duty for training, as a member of the Army, Navy, Air Force, Marine Corps or Coast Guard, or as a commissioned officer of the Public Health Service, Environmental Science Services Administration, or National Oceanic and Atmospheric Administration.

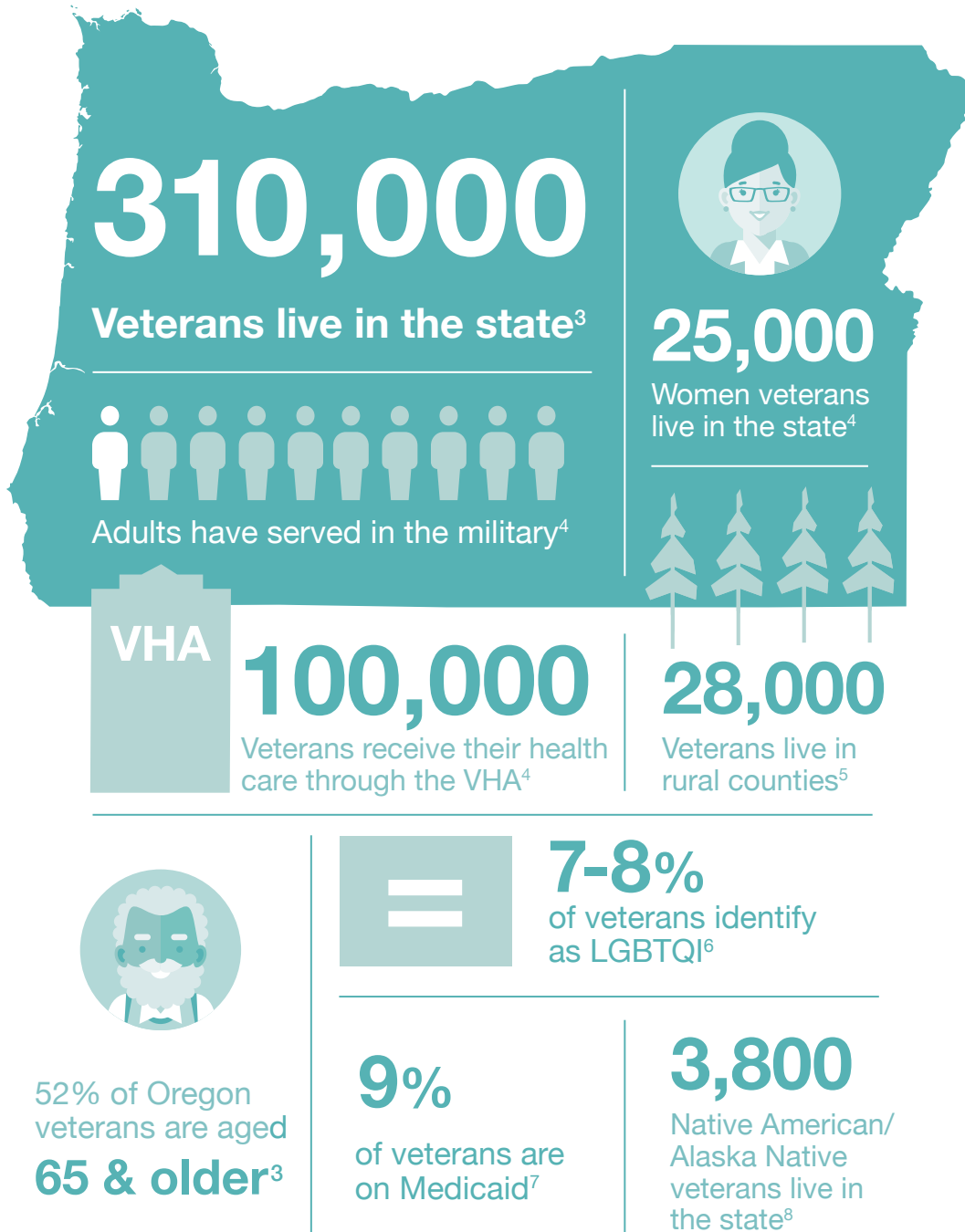
Under the law, active duty does not normally include attendance at a school under military orders or normal military training as a reserve officer or member of a reserve or National Guard unit. However, members of a reserve or National Guard unit that is called to active duty under presidential orders (also known as being "activated" or "federalized") may be eligible for benefits.²

notes:

1. State Summaries Oregon (2017). Retrieved from https://www.va.gov/vetdata/docs/SpecialReports/State_Summaries_Oregon.pdf
2. Oregon Department of Veterans' Affairs. Retrieved from: <https://www.oregon.gov/odva/Resources/Pages/Who-Is-A-Veteran.aspx>

Introduction

Figure 1: Oregon veterans: an overview



- notes:
- 3.State Summaries Oregon (2017). Retrieved from https://www.va.gov/vetdata/docs/SpecialReports/State_Summaries_Oregon.pdf
 - 4.2017 Oregon Department of Veterans' Affairs Annual Report
 - 5.VetPop2016_County
 - 6.Estimate from Williams Institute (2011)
 - 7.BRFSS 2016
 - 8.US Census, 2014

Introduction

Background

One in 10 Oregon adults has served in the U.S. military.⁹ These veterans' lives are impacted not only by their experiences in the military but also by the environment and systems in place to support them in leading healthy lives once they are discharged. A recent national study of veterans of Operations Iraqi Freedom, Enduring Freedom, and New Dawn showed that initial screenings don't always lead to diagnoses of posttraumatic stress disorder (PTSD), depression, alcohol and substance use disorders, bipolar disorder, or schizophrenia, and the risk for these behavioral health disorders varies significantly based on age, gender, and race/ethnicity.¹⁰ Oregon is committed to protecting the behavioral health of its diverse population of veterans and providing access to the services they need to thrive as individuals upon their return to civilian life.

The 79th Oregon Legislative Assembly declared the behavioral health of the state's veterans a priority, charging the Oregon Health Authority (OHA) and the Oregon Department of Veterans' Affairs (ODVA) to identify and fund programs and services that improve their behavioral health outcomes. In response, OHA commissioned this report to assess veterans' access to adequate and appropriate behavioral health services, contracting with Rede Group and its partners, ELE Consulting, LLC, and Bonnie Gee Yosick, LLC, (hereafter known collectively as "Rede Group") to conduct this study.

Purpose of the study:

- 1 To describe the type and availability of behavioral health services for veterans in Oregon**
- 2 To provide findings regarding facilitators of and barriers to delivery and use of behavioral health services for veterans in Oregon**
- 3 To make recommendations for legislative or other changes that may result in better delivery, accessibility, and utilization of behavioral health services by veterans in Oregon**

notes:

9.State Summaries Oregon (2017). Retrieved from https://www.va.gov/vetdata/docs/SpecialReports/State_Summaries_Oregon.pdf

10.Ramsey, Christine, et al (2017). "Incidence of Mental Health Diagnoses in Veterans of Operations Iraqi Freedom, Enduring Freedom, and New Dawn, 2001–2014", American Journal of Public Health. 107(2): pp. 329-335.

Introduction

Systems analysis

The “systems overview” on the following pages outlines the main elements currently in place to serve the behavioral health needs of Oregon’s veteran population. This high-level overview outlines publicly-funded services. It is important to note that most veterans in Oregon (approximately two out of three) receive physical and behavioral health care services through the private sector, usually paid for through private insurance. Therefore, private sector care is a critical component of the overall system in place to meet veterans’ behavioral health needs. However, information and data about private sector care provided to veterans is very difficult to obtain primarily because it is not routinely collected or reported by health care systems.

In this study, a survey of more than 4,600 veterans, 609 of whom received care outside the Veterans Health Administration (VHA), found very little difference between satisfaction with care among veterans who received care from the VHA and those who received care from the private sector. However, the survey results also indicated that some veterans were avoiding VHA care because of poor past experiences or lack of access. Further, this report focuses some attention on public sector resources, as they are likely to serve the most vulnerable populations, and they are the institutions that OHA can most directly influence. It should be noted, however, that a lack of actionable data from the private sector does not equate to an absence of issues related to accessing quality behavioral health care. As emphasized in this report, more data about veterans’ behavioral health experiences inside and outside the VHA system is warranted.

Understanding the systems overview

The overview on the following pages was developed in collaboration with OHA, the Portland VA Health Care System, and ODVA. It describes a complex network of publicly-funded entities that support veterans’ behavioral health needs and describes critical factors that can affect a veteran’s access to quality care. The overview is organized by main “payer” (i.e., behavioral health care payer) groups. The pathways to each payer group are scaled to represent estimates of the proportion of veterans receiving care from the payer group. For example, approximately 100,000 Oregon veterans receive their care through the VHA pathway, significantly more than receive care through the “Medicaid & Uninsured” and “Tribal Health” pathways depicted in the overview.



Private Insurance



FACTORS THAT MATTER

Veterans often experience difficulty navigating this complex system—further complicated by the intersection of providers, payers, treatments, and multiple diagnoses.



FACTORS THAT MATTER

With few exceptions, the VHA only serves honorably discharged veterans from the Air Force, Army, Marines Corps, Navy, or Coast Guard.

FACTORS THAT MATTER

Geographic location, gender identity, sexual orientation, transportation, and long wait times may limit a veteran's access to appropriate behavioral health services.



FACTORS THAT MATTER

Housing & immigration status may prevent some veterans from accessing Medicaid.

Medicaid & Uninsured

State Hospitals
2 in Oregon:
-Salem
-Junction City

Hospitals/EDs
70 in Oregon



Tribal Health



FACTORS THAT MATTER

Oregon law directs ODVA to provide aid & assistance to federally recognized Indian Tribes in Oregon for programs & services to Tribal veterans.

Related Government Agencies

U.S. Department of Veterans Affairs (USDVA)

Oregon Department of Veterans' Affairs (ODVA)

**Figure 2: Behavioral health services for Oregon veterans:
A systems overview**

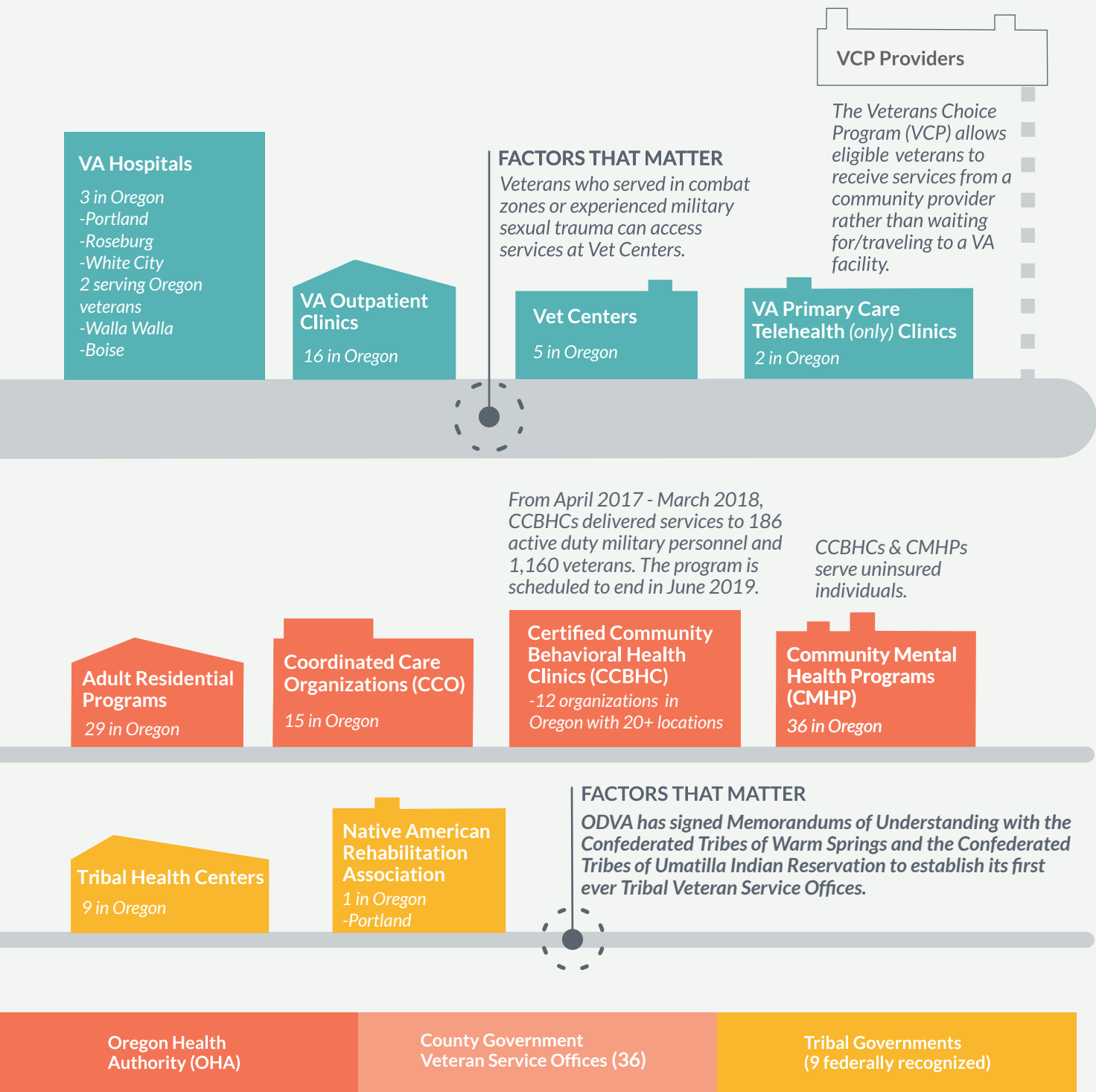
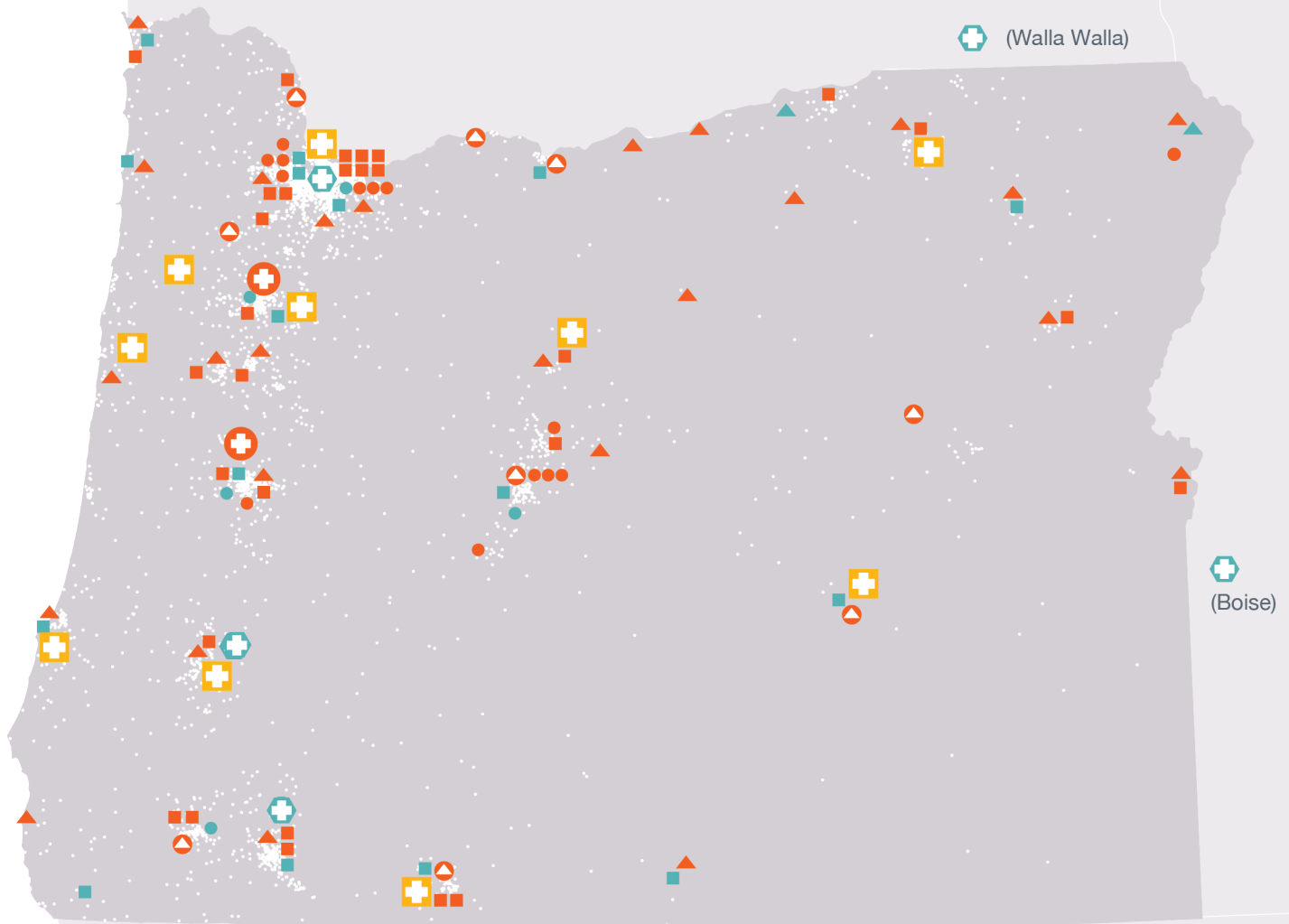












Figure 3: Behavioral health facilities with veteran population



Veteran population ¹¹

1 dot = 100 Veterans

-  VA Hospitals (3 in OR, 2 serving OR veterans)
-  VA Outpatient Clinics (16)
-  Vet Centers (5)
-  VA Primary Care Telehealth Outpatient Clinics (2)
-  State Hospitals (2)
-  Adult Residential Programs (29)
-  CCBHCs (12, some with multiple locations)
-  CCBHC/CMHP (9)
-  CMHPs (27)
-  Tribal Health Centers/Clinics (10)

This map compares the geographic location of VHA and other publicly funded behavioral health facilities with the distribution of Oregon’s veteran population. Unsurprisingly, facilities are clustered around densely populated areas of the state.

notes:
 11. U.S. Census Bureau.
 Veterans Statistics
 Oregon. <https://www2.census.gov/library/infographics/2015/comm/vets/a>

Introduction

Initiatives to improve behavioral health services for Oregon veterans

This study is part of a larger effort by OHA to prioritize the behavioral health needs of the state's veterans. OHA's current veterans' behavioral health initiatives include:

- 1. IMPROVING CONTINUITY OF CARE:** OHA's Public Health Division is using funding from the Garrett Lee Smith Suicide Prevention Grant to identify veterans at risk of suicide, provide referrals and treatment, and improve behavioral health continuity of care. Subgrantees have reported the following activities with the VA or veteran-serving organizations:
 - **DESCHUTES COUNTY HEALTH AND HUMAN SERVICES:** Deschutes County Suicide Prevention Office partnered with the Deschutes County Veterans' Services Office as well as the Crook County Veteran Services Office and Crook County Prevention and Health Promotion program to develop a radio ad and social media ads promoting the Veterans Crisis Line. Additionally, a regional partner in Jefferson County, BestCare Prevention, gained approval for an adapted version of the Connect Suicide Prevention/Intervention training for veterans and their families. The training was implemented for the first time in the community, and Deschutes County helped promote this training. The Central Oregon Suicide Prevention Alliance includes member organizations serving veterans
 - **JACKSON COUNTY MENTAL HEALTH:** Jackson County has provided suicide prevention and mental gatekeeper training (Mental Health First Aid and Applied Suicide Intervention Skills Training) to local VA staff. Working with local Veterans Affairs has been beneficial in helping to target prevention efforts toward veterans who are under 24 years old. Jackson County Mental Health has partnered with the VA's suicide prevention coordinator, and there is an ongoing dialogue between suicide prevention coordinators to work together on the Jackson County Suicide Prevention Coalition
 - **JOSEPHINE COUNTY (THROUGH THE LOCAL MENTAL HEALTH AUTHORITY, OPTIONS FOR SOUTHERN OREGON, INC.):** Josephine County is partnering with White City Veterans Affairs to offer suicide prevention gatekeeper training (Question, Persuade, Refer) for the staff and veterans who are in the residential program. Options for Southern Oregon, Inc. has a contract with TRICARE to treat veterans' dependents and is contracting with TriWest to serve veterans in the Veterans Choice Program (VCP) model
 - **UMATILLA COUNTY PUBLIC HEALTH:** The county Youth Suicide Prevention Group includes representation from Umatilla County Veteran Services. Both county VA officers have completed suicide prevention gatekeeper training

Introduction

- **WASHINGTON COUNTY PUBLIC HEALTH:** A representative from the VA serves on both the Suicide Prevention Council and the Suicide Fatality Review Board. In addition, the Washington County Disability, Aging & Veteran Services program received one-time funds from ODVA and collaborated with the county suicide prevention coordinator to develop opportunities for greater awareness and discussion about veteran suicide prevention and behavioral health supports
2. **OFFERING RENTAL ASSISTANCE:** OHA contracts with organizations in Clackamas, Columbia, Jackson, Marion, Polk, and Yamhill counties to provide rental assistance to veterans with severe and persistent mental illness and others who are at risk of homelessness, transitioning from a hospital or a licensed facility, or at risk of reentering a hospital or licensed facility. The program covers 152 rental assistance vouchers and includes supports for veterans through peer support specialists and residential housing specialists. Veterans who qualify for the program receive move-in assistance with costs such as deposits and application fees as well as monthly rent subsidies. This unique support structure gives veterans the choice of whether to participate and ensures that those who do have the behavioral health and housing readiness services needed to qualify for and stay in housing, as the program is not transitional and not a “Section 8” program; all housing is provided through the private sector housing stock.
 3. **LAUNCHING PEER-DELIVERED BEHAVIORAL HEALTH SERVICES:** OHA, in partnership with ODVA, has launched a Veteran Behavioral Health Peer Support Specialist Pilot Program to provide peer-delivered services to veterans through three pilot sites. Services are being offered as an adjunct to the established county behavioral health care services. Organizations participating in the pilot program are Yamhill Health and Human Services, Deschutes County Health Services, and BestCare Treatment Services, Inc.
 4. **DIRECTING THE IMPLEMENTATION OF NEW INVESTMENTS:** OHA hired a Veterans Behavioral Health Care Liaison in October of 2018. This position manages the implementation of legislative guidance and works internally within OHA to integrate and coordinate veteran behavioral health policy and practices, as well as in collaboration with ODVA, VA, community partners, and local county, state, and federal officials to improve behavioral health care and outcomes for Oregon’s veterans. The liaison works to develop and improve policies and procedures which enhance coordination while researching and spreading best practice behavioral health treatment modalities.

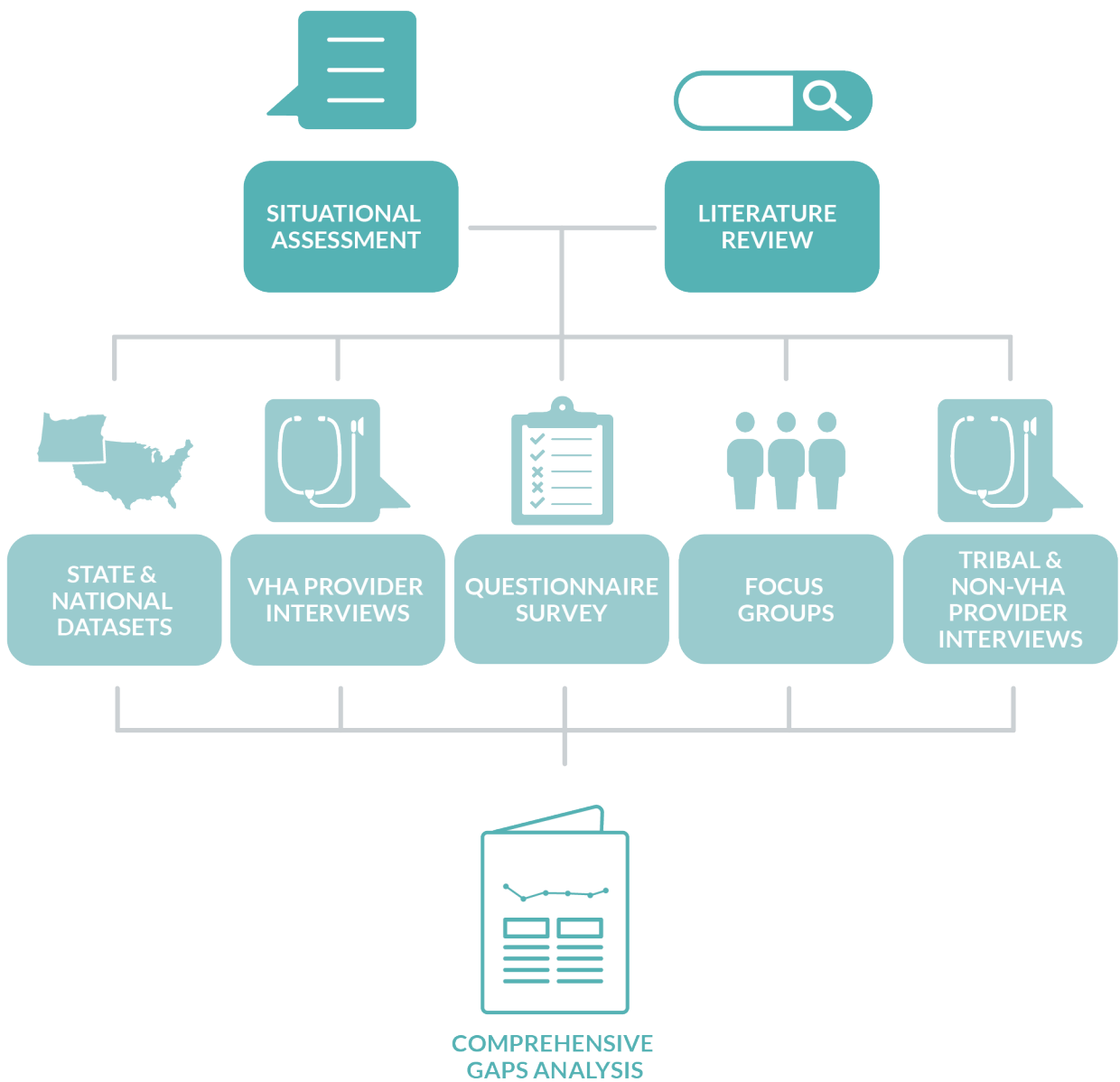
Introduction

5. **OFFERING SUICIDE PREVENTION TRAININGS:** OHA is in the process of developing culturally appropriate, evidence-based suicide prevention trainings for providers who serve veterans across the state. Trainings are intended to align with national best practice models and efforts as well as to engage health care providers in conversations focusing on prevention, intervention, postvention, and treatment. Trainings will include content on military cultural competency and will emphasize the needs of Oregon's unique military service population.
6. **ENGAGING TRIBES AND URBAN NATIVE AMERICANS:** Working in tandem with ODVA, OHA is engaging Oregon Tribes to identify and address the needs of veterans within Tribal communities. These efforts include increasing the ability of Tribal veterans' access to federal and state benefits by establishing specific veteran advocacy offices. Efforts are underway to establish a joint partnership with the VA's Office of Tribal Government Relations to partner with Tribal health clinics to blend VA behavioral health services with current and available services. ODVA is providing grants and technical assistance with organizations who advocate for Tribal veterans who live in an urban setting.
7. **ADVOCATING FOR UNDERSERVED VETERANS:** ODVA is advocating for veterans' behavioral health (supports) through specialized work with traditionally underserved veterans. Focused advocacy includes Tribal, women, LGBTQI, homeless, aging, and incarcerated veterans.
8. **IMPLEMENTING TRAUMA INFORMED CARE:** The OHA Health Systems Division adopted the Trauma Informed Services Policy¹² in 2014, which requires all state and community behavioral health providers who are licensed by or receiving funding from OHA to be informed about the effects of psychological trauma, assess for symptoms and problems related to trauma, and provide services to facilitate recovery in accordance with Oregon Administrative Rules. This policy extends to services provided to any veteran who may be accessing care by OHA licensed or funded organizations. The policy is designed to:
 - Promote resiliency, health, and wellness for those who have experienced trauma, as well as for their families
 - Create a minimum standard of care in addressing the impact of trauma for those serving individuals with behavioral health challenges
 - Establish a standard to provide treatment in a trauma informed manner
 - Increase access to effective and appropriate services for individuals who have experienced trauma
 - Mitigate vicarious traumatization of treatment providers and others working with traumatized individuals

notes:
12. Retrieved from <https://www.oregon.gov/oha/HSD/AMH/Trauma%20Policy/Trauma%20Policy.pdf>

Introduction

Figure 4: Components of the study



Introduction

SITUATIONAL ASSESSMENT

Methods

As a first step in this project, the Rede Group conducted a situational assessment of behavioral health services for veterans in Oregon. The purpose of a situational assessment is to gather high-level information about the subject matter to ensure the study design and implementation is informed by current conditions, as described by subject matter experts. The situational assessment included two group interviews with leaders from OHA, ODVA, and the Portland VA Health Care System and six individual structured interviews with stakeholders and key informants who were identified as having extensive knowledge about veterans services and who hold diverse administrative and leadership positions throughout the state. Rede Group interviewed key informants from the following organizations:

- OHA, Public Health Division
- OHA, Health Policy and Analytics Division
- Portland VA Health Care System
- Association of Oregon Community Mental Health Programs
- Portland Vet Center
- Association of Oregon Counties

Rede Group collaborated with OHA, ODVA, and the Portland VA Health Care System to develop open-ended interview questions about Oregon's veteran population and the behavioral health system that serves it.

Rede Group also collaborated with key stakeholders to create the systems overview on pages 20-21.

Situational assessment

Interviews with state-level veterans' services subject matter experts discussed challenges with the existing infrastructure for behavioral health case management for veterans and a need for better long-term strategies, not only for case management but also for managing both inpatient and outpatient behavioral health care.

Interviewees also articulated a need for the availability, particularly in rural areas, of more peer-to-peer support, support groups, and other non-clinical behavioral interventions. One interviewee expressed a general lack of familiarity with the broader needs of older veterans and where they seek services.



We're kind of at the mercy of the federal-level policy. Our relationships have improved. We're doing things together like the SBHP training that helps behavioral health providers learn military culture and certain clinical interventions.

—Interviewee

Introduction



The main issue is not that people aren't trying or competent, and it's not because the level of resource isn't there. I would say it's an issue around coordination functions, access issues, and case management.

— Interviewee

We're currently talking with our commissioners about a pretty big need for health care outreach and navigation at the service level with individual veterans, and then at a higher level, more of a system level.

— Interviewee

If you're in Portland, we have a gigantic VA Hospital, but if you live in, say, Columbia County, which is outside of Portland, it would be harder to access these services just because you're a little farther away.

— Interviewee

SITUATIONAL ASSESSMENT

Some interviewees said that reframing alcohol and drug use prevention efforts through a series of systems-level interventions aimed at modifying advertising, promotion, and pricing strategies around alcohol and tobacco would be beneficial. Interviewees also suggested that addressing the opioid epidemic may have very real implications for veteran populations.

Not surprisingly, this situational assessment found that delivering services to veterans in more rural areas of the state (i.e., outside the Portland metro area, the Willamette Valley, and the U.S. Interstate 5 corridor) is significantly more challenging. Respondents stated they believe that this difference is due to provider shortages in rural and frontier counties and some pointed to social isolation as a potential compounding factor. Patient population saturation, even within the metro area, creates barriers to service delivery, especially for those veterans seeking behavioral health specialty care.

Civilian providers in the state lack adequate knowledge of military culture and behavioral health issues unique to veterans. Several interviewees mentioned Star Behavioral Health Providers (SBHP), a national evidence-based training initiative for behavioral health professionals that places specific emphasis on understanding the unique needs of military personnel and their families. The training is offered in nine states, including Oregon.

An overarching theme acknowledged by all interviewees is that the most effective and cost-efficient services for veterans involve multiple layers of government, which inherently creates barriers to service access and delivery. Coordination of service delivery is difficult, particularly outside of Multnomah County and the Portland catchment area, as responsibilities and fiscal years differ among federal, state, and local governments. Interviewees also described coordination and translation of federal resources into tangible services for Oregon's veterans as both a challenge and a weakness in the existing system.

In general, both health and benefit data are challenging to procure from the VA. Interviewees identified other possible sources of de-identified data, including Certified Community Behavioral Health Clinics (CCBHCs) (for information on active duty status, prior military status, and veterans who have received TRICARE), the VA Portland Health Care System, and the National Center for PTSD.



METHODS & ANALYSIS

Methods & Analysis

Rede Group used a multifaceted approach to conduct a gaps analysis aimed at understanding the behavioral health needs of veterans and specifically assessing Oregon veterans' access to behavioral health services. This qualitative and quantitative data collection process included a literature review; review and analysis of state and national datasets; structured interviews with VHA providers, non-VHA providers, and representatives of Tribal organizations; focus groups with veterans; and an online questionnaire survey for veterans.

Literature review

As a foundational step for the study, Rede Group conducted a multi-phase review of the research literature to determine best practices for behavioral health treatments generally and specific to veterans in Oregon and the surrounding region (i.e., Washington, Idaho, and California).

This first phase of the review yielded a large volume of literature on behavioral health treatments for veteran populations, including many previous reviews of the literature resulting in compilations of best practices. In addition, federal agencies—particularly the VHA—have provided policy, guidance, and clinical practice documents that describe best practices. This phase focused on clinical behavioral health services (e.g., addiction and mental health therapy, psychiatric consultation, and medication management) rather than auxiliary support services (e.g., support groups and case management) and drew from scientific, peer-reviewed literature published since 2010, which was identified primarily through a search of PubMed, Google Scholar, and a general search of the Internet. This phase did not comprehensively address systems-level factors associated with the delivery of care and access to services (e.g., travel time, timeliness of appointments, and other logistical barriers).

In the second phase of the literature review, Rede Group focused on social determinants and systems-level factors that impact access to and delivery of behavioral health services for veterans, as well as peer-reviewed studies specific to Tribal veterans and veterans with other-than-honorable (OTH) discharges (excluding incarcerated individuals.) This phase drew from scientific, peer-reviewed literature primarily published since 2010 and identified through the ProQuest Social Services Abstracts database and Web of Science. Relevant government, academic, and industry reports were also identified for review through a targeted Internet search and from the State Library of Oregon. Finally, Rede Group queried National Institutes of Health for recently-funded research projects to assess current funding priorities for veterans' behavioral health services.

State and national datasets

General behavioral health data on veterans is difficult to obtain because many datasets do not include a veteran identifier, or they include a veteran identifier that is interpolated or unreliable. However, Rede Group identified a range of state and national datasets to explore for the data-gathering process.

KEYWORDS SEARCHED:

- behavioral health
- depression
- dishonorable discharge
- mental health
- military readjustment
- military sexual trauma
- other-than-honorable discharge
- posttraumatic stress disorder
- rural
- social determinants
- substance misuse
- substance use disorder
- suicide
- traumatic brain injury
- Tribe
- Tribal
- veterans

Methods & Analysis

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM DATA (BRFSS)

The BRFSS is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. It is a national telephone survey used to collect data about U.S. residents regarding their health-related risk behaviors, chronic conditions, and use of preventive services. Rede Group employed R statistical software to analyze and compare the population of veterans to non-veterans using 2016 BRFSS data, including demographic characteristics, health care access, substance use, and physical and mental health status. Please see BFRSS tables in Appendix A.

NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH)

The NSDUH is an extensive national survey on drug, alcohol, and tobacco use administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Substance Abuse and Mental Health Data Archive provides users the ability to do limited state-specific analyses on the data using an online analytic tool. Rede Group compared the population of veterans to non-veterans using some general behavioral health variables.

OREGON DEATH CERTIFICATE DATA

The OHA Center for Health Statistics provided Rede Group with death certificate data from years 2013 through 2017 on variables including veteran status, gender, race/ethnicity, and year, cause, and place of death. Rede Group reviewed the death certificate data alongside Oregon Vital Statistics Annual Reports (OVSAR) for years 2013 through 2017 to compare age-specific rates of suicide among the veteran and non-veteran populations. Rede Group recreated specific OVSAR data using raw population and death data from the VA and OVSAR.

Death certificate data were also examined using International Classification of Disease 10th revision (ICD-10) codes indicating opioid use as a contributing cause of death. 2016 population data from the National Center for Veterans Analysis and Statistics Vetpop were used to calculate age-adjusted rates of death with opioids as a contributing cause for veterans and for the population as a whole.

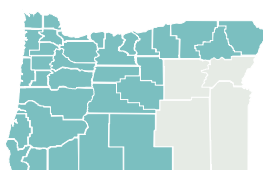
OTHER DATA SOURCES

Rede Group identified several other data sources that did not prove useful to this report. The All Payer All Claims (APAC) Database that houses administrative health care data for Oregon's insured populations does not identify veterans. The National Center for Veterans Analysis and Statistics and the Census Bureau include only limited behavioral health information. The Treatment Episode Data Set (TEDS) is maintained by SAMHSA using data collected by states receiving state alcohol and/or drug agency funds for substance misuse treatment systems. However, OHA informed Rede Group that Oregon's Client Process Monitoring System (CPMS) forms did not include a variable for veteran status. Oregon switched from CPMS to Measures and Outcomes Tracking System (MOTS) after June 2015. Rede Group attempted, unsuccessfully, to obtain data from MOTS for further analysis and use.

Methods & Analysis

11

INTERVIEWS
CONDUCTED



Counties where data
were collected

PROVIDERS
INTERVIEWED:

- VA Portland Health Care System
- Roseburg VA Medical Center
- Jonathan M. Wainwright Memorial VA Medical Center
- VA Southern Oregon Rehabilitation Center
- Community-Based Outpatient Clinics (CBOCs)
- Vet Centers

notes:

1. VHA Handbook, Version 1160.01 (Uniform Mental Health Services in VA Medical Centers and Clinics). (2015). Retrieved October 16, 2018, from <https://www.va.gov/vhapublications/publications.cfm?pub=2>
2. Dedoose Version 8.0.44, (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC (www.dedoose.com)

VHA provider interviews

Rede Group conducted 11 in-depth, structured interviews with health care administrators and providers from VHA facilities throughout Oregon about services provided at VHA facilities within their catchment areas. Interviews were also conducted with Community-Based Outpatient Clinics (CBOCs) and Vet Centers in the state.

Results of the situational assessment and the first phase of the literature review informed development of the interview guide in combination with the VHA clinical practice handbook for behavioral health service and access requirements.¹ Rede Group interviewed administrators and providers about services pertaining to:

- Substance Use Disorders
- Posttraumatic Stress Disorder
- Traumatic Brain Injury
- Suicide
- Depression
- Military Sexual Trauma
- Readjustment services

Additionally, Rede Group asked administrators and providers to reflect on strengths, challenges, and weaknesses in service provisions at their respective facilities.

Interviews were recorded and transcribed to aid in accuracy of reporting, and Rede Group conducted a multi-phase qualitative analysis of the transcripts, in which each was coded by an analyst based on emerging themes using Dedoose qualitative analysis software² and reviewed by a second analyst to ensure accuracy. Then data across all interviews were analyzed to identify key themes and potentially important narratives. Additional data from interviews were entered into a categorical table detailing service provisions by facility. Using the table, the research team conducted a gaps and strengths analysis across all facilities.

Please see the list of facilities where interviews were conducted in Appendix B and a copy of the interview guide in Appendix C.

Focus groups

Rede Group conducted nine in-person focus groups with the intent to gather information from veterans concerning their experiences with VHA and non-VHA behavioral health care. One focus group for male veterans and one for female veterans was held in each location of Bend, Eugene, Portland, and Roseburg. One focus group for lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) veterans was held in Portland. Three additional individual phone interviews were conducted with female veterans in La Grande using a modified interview guide in lieu of a formal focus group. Veterans were recruited for the focus groups using social media, paper flyers posted at VHA facilities,

Methods & Analysis

and email invitations sent to 3,000 veterans for whom ODVA has limited power of attorney and through the ODVA GovDelivery listserv. Focus groups ranged in size from two to 11 people, and a total of 63 veterans, ranging in age from 24 to 76, participated. Interview questions were developed with input from the OHA and ODVA and were designed to gather descriptive accounts of accessibility, usage, and barriers to accessibility and usage of behavioral health care services.

A professional interviewer facilitated the focus groups using an open-ended interview protocol. Focus groups were recorded and transcribed to aid in accuracy of reporting, and Rede Group conducted a multi-phase qualitative analysis of the transcripts, in which each was coded by an analyst based on pre-determined and emerging themes using Dedoose qualitative analysis software and reviewed by a second analyst to ensure accuracy. Then data across all interviews were analyzed to identify key themes and potentially important narratives.

Please see the overview of focus group participants in Appendix K and a copy of the focus group interview guide in Appendix L.

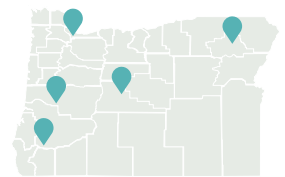
Questionnaire survey

Rede Group conducted an online questionnaire survey with a convenience sample of veterans in Oregon using a wide range of questions developed with input from OHA and ODVA. The survey was designed to gather data about Oregon veterans' access to and use of behavioral health services using VHA and non-VHA providers over the previous two years. A pilot survey was conducted with a convenience sample of nine veterans employed and selected by ODVA. The survey was then distributed via email invitation to veterans for whom ODVA has limited power of attorney, through the ODVA GovDelivery listserv, and through email lists generated through targeted outreach. Respondents were incentivized by an offer to enter a drawing for a small monetary reward upon completing the survey.

The survey received a total of 4,750 responses and was completed by 3,915 veterans, with representation from all Oregon counties. Rede Group tabulated the responses in aggregate. Both percentages and marginal totals were computed from the total number of respondents, as well as the total number of responses. Additionally, Rede Group analyzed responses for both categorical and multiple response variables. Variables were initially summarized using frequency tables. Next, cross-tabulation tables involving those variables were examined. Analyses were conducted in Excel. Rede Group compared variables by sex, health care payer, age, era of service, LGBTQI identification, geographic region, race/ethnicity, socioeconomic status, and educational attainment.

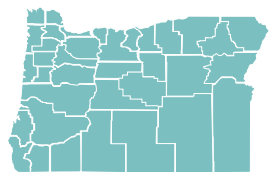
Please see a copy of the questionnaire survey in Appendix D, the survey logic pattern in Appendix E, and complete survey charts for select questions in Appendix F.

63
VETERANS
PARTICIPATED



Locations where
focus groups
were held

3,915
SURVEYS
COMPLETED



Survey responses
from all counties
in Oregon

Methods & Analysis

Tribal provider interviews

Rede Group conducted interviews with two Tribal organizations throughout Oregon, as well as with the Office of Tribal Government Relations in Washington, D.C.

Interview questions focused on behavioral health services provided, unique needs and conditions faced by Tribal veterans, special initiatives and staff training to support these services, perceptions of successes and weaknesses in the behavioral health systems serving veterans, and challenges that organizations face in serving veterans.

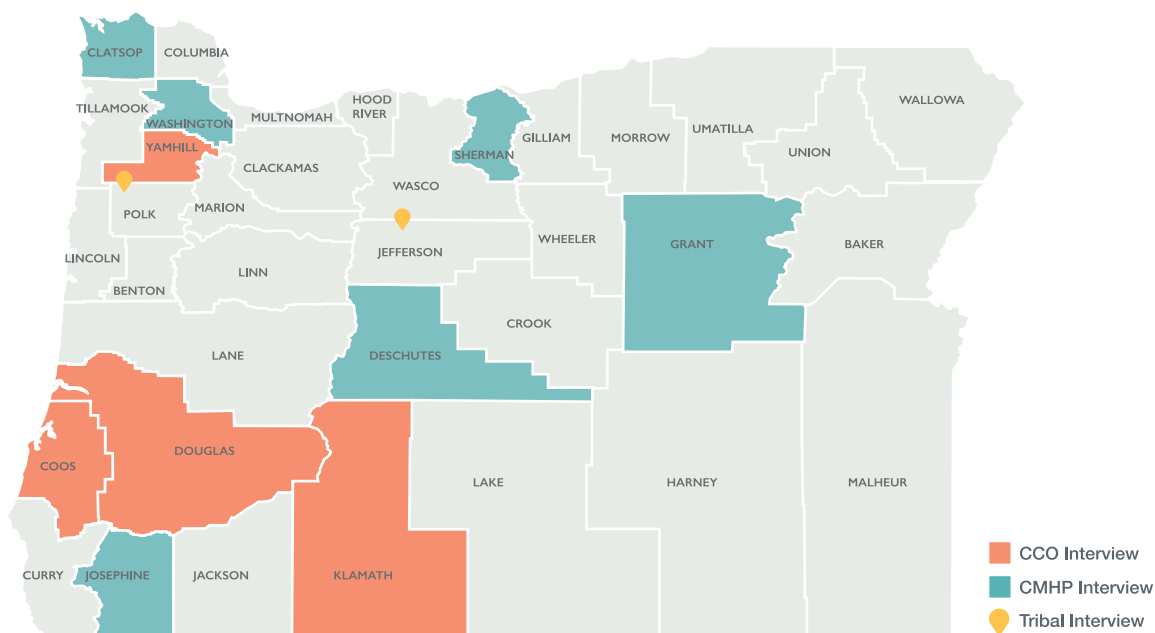
Please see a list of the Tribal providers interviewed in Appendix I, and a copy of the Tribal interview guide in Appendix J.

Non-VHA provider interviews

To review services available in non-VHA environments where veterans access behavioral health care, Rede Group conducted additional interviews with providers and administrators at facilities selected by means of randomized sampling methods. Structured 45-minute interviews were conducted with four Coordinated Care Organizations (CCOs), six Community Mental Health Programs (CMHPs), and the Chief of Mental Health and Homeless Operations for Veterans Integrated Service Network (VISN) 20. Interview questions focused on behavioral health services provided, special initiatives and staff training to support these services, perceptions of successes and weaknesses in the behavioral health systems serving veterans, and challenges that organizations face in serving veterans.

Please see a list of non-VHA providers interviewed in Appendix G, a copy of the non-VHA provider interview guide in Appendix H.

Figure 4: Location of Tribal and non-VHA provider interviews





RESULTS



Results

LITERATURE REVIEW

Phase 1

As noted in the Methods & Analysis section, many existing reviews of the literature have already resulted in documents that describe best practices for behavioral health (i.e., mental health and substance use) treatments for the veteran population. These reviews are complemented by federal policy, guidance, and clinical practice documents that describe best practices. Thus, the current review focused on drawing from these existing reviews and documents. Rede Group did not find documents in the literature that were specific to veterans in Oregon (or other states in the region.)

Two key documents provide overall guidance for providing behavioral health services to veterans. First, the “Guide to VA Mental Health Services for Veterans and Families” describes general principles that guide VHA behavioral health care for veterans.¹ These principles include:

- Focus on recovery
- Coordinated care for the whole person
- Mental health treatment in primary care
- Mental health treatment coordinator
- Around-the-clock service
- Care that is sensitive to gender and cultural issues
- Care close to home
- Evidence-based treatment
- Family and couple services

The Guide also describes how the VA is organized into VISNs. Each VISN has at least two medical centers, and each medical center has outpatient clinics on-site and CBOCs throughout the VISN. CBOCs are classified according to their size and provide treatment in several types of settings. The Guide also lists the minimum mental health services VHA medical centers and clinics are required to provide:

- Extended hours of care
- Emergency care
- Care for PTSD
- Care for schizophrenia, schizoaffective disorder, bipolar disorder, depression, and anxiety
- Care for substance use disorders (alcohol, drugs, prescription medications, tobacco)
- Homelessness services

The topics in the Guide are consistent with the longer list of components specified in the VHA Handbook 1160.01 “Uniform Mental Health Services in VA Medical Centers and Clinics.” The handbook defines “minimum clinical requirements for VHA Mental Health Services and delineates the essential components of the mental health program that is to be implemented nationally, to ensure that all veterans, wherever they obtain

notes:

1. United States Department of Veterans Affairs (2012). Guide to VA Mental Health Services for Veterans and Families. Retrieved from https://www.mentalhealth.va.gov/docs/MHG_English.pdf

Results

LITERATURE REVIEW

care in VHA, have access to needed mental health services.”² The VA and Department of Defense (DoD) have also issued the VA/DoD “Clinical Practice Guideline for the Management of Substance Use Disorders.”³ The Clinical Practice Guideline provides recommendations for the performance or exclusion of specific services. Guidelines exist for opioid therapy for chronic pain, management of pregnancy, assessment and management of patients at risk for suicide, management of depression, management of PTSD and acute stress disorder, and management of substance use disorders.

Rede Group based a review to determine best practices for behavioral health treatments (preventative, promotional, and direct care) for Oregon’s veteran population on specific topics from the project description in the OHA request to conduct this study. As noted above, considerable research exists on veterans’ behavioral health, and many reviews of the literature have already been conducted. Rede Group drew from the existing reviews, along with policy and clinical practice documents, to develop a list of best practice behavioral health treatments for the veteran population and used this list in conducting the gaps analysis of behavioral health services for Oregon veterans.

Please see Appendix M for the complete first phase of the literature review.

Phase 2

The second phase of the literature review focused on social determinants and systems-level factors affecting veterans’ access to behavioral health care, as well as peer-reviewed studies of Tribal veterans and those with OTH discharge status. In general, the research in these subject areas is limited. However, some guiding insights regarding veterans’ access to behavioral health care can be gleaned from the literature.

Social determinants

A study of formerly homeless veterans entering permanent supportive housing identified some characteristics related to care-seeking for behavioral health services. Veterans with a mental health counselor or other advice-giving member in their social network were more likely to use mental health services, as well as basic needs services. Veterans who reported being daily tobacco users were more likely to use mental health services than those who did not. Veterans with a lifetime diagnosis of schizophrenia, PTSD, anxiety, depression, or bipolar disorder were more likely to use mental health services, and those with a depression diagnosis were also more likely to use basic services than those without.⁴

Some of the factors impacting the transition back to civilian life for female veterans and their care-seeking behaviors differ from those of their male counterparts. These factors include lack of knowledge about VHA policies designed to support female veterans in VHA facilities that they often perceive as male-centered, as well as the availability of services and support systems, such as same-gender providers and therapy groups, specific to women’s mental health and/or military sexual trauma (MST). Evidence suggests that many female veterans avoid seeking care through the VHA because they are unaware

notes:

2. United States Department of Veterans Affairs (2015). Uniform Mental Health Services in VA Medical Centers and Clinics. VHA Handbook 1160.01. Retrieved from https://www.va.gov/VHApublications/ViewPublication.asp?pub_ID=1762.
3. United States Department of Veterans Affairs and United States Department of Defense (2015). VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders. Retrieved from <https://www.healthquality.va.gov/guidelines/MH/sud/VADODSUD-CPGRevised22216.pdf>.
4. Harris, T., et al. (2018). Moving Beyond Housing: Service Implications for Veterans Entering Supportive Housing. *Clinical Social Work Journal*, 46, 130-144.

Results

LITERATURE REVIEW

they have a right to request female-specific services and do not utilize Vet Centers due to a perception the centers primarily serve a population of older male veterans. Though social stigma is a factor impacting care-seeking for both male and female veterans, female veterans tend to internalize gender-specific social stigma, thus concluding their concerns are not important or severe enough for which to seek behavioral health services. For example, female veterans are more likely to have their health needs downplayed or overlooked by others, due to assumptions that they play less risky, non-combat roles in the military. They may also neglect their mental health needs due to internal or external pressures to return to roles as mothers and wives.⁵

Factors identified by providers in community mental health clinics as possible barriers to care-seeking in veterans with traumatic brain injury (TBI) included lack of knowledge about where to find services, a perception of high cost, and stigma (ranging from embarrassment, to fear of harming one's career, to a perception that others would see or treat one differently.) Providers reported that they did not use formal evaluation tools for TBI and/or mental health symptoms and that they generally used similar interventions with veterans to those they used with other patients. Providers identified distance, cost, and time as barriers to accessing training resources for working with veterans but reported a desire to understand more about military culture and TBI.⁶

A 2013 review by Pompili, et al, of the scientific literature regarding PTSD and suicide risk among veterans found a number of trends. Veterans with PTSD symptoms were at increased risk for suicidal ideation. The mortality of Vietnam veterans with PTSD was 71% higher than that of veterans without PTSD, with death by motor vehicle and suicide being the primary causes. Veterans of lower socioeconomic status and increased combat exposure showed increased risk for PTSD severity and aggressive behavior. Combat guilt was the most significant predictor of suicide attempts in Vietnam War veterans. PTSD was associated with a changed perception in veterans of themselves, and suicidal behavior was associated with more negative perceptions of the world. Risk for suicidal ideation persisted in some veterans long after their return to civilian life, even following treatment. Overall, combat exposure and multiple exposures to traumatic stressors increased veterans' risk for suicidal behavior.⁷ Veterans identifying as transgender had a rate of suicide-related incidents 20 times higher than that of other veterans utilizing VHA care.⁸

Tribal veterans

Limited research exists regarding Tribal veterans' access to behavioral health services. However, American Indian and Alaska Natives serve at a higher proportion than any other racial or ethnic group in the U.S. and are simultaneously the most underserved population. They also experience service-related behavioral health issues at a higher proportion. A study of the Tribal Veterans Representative (TVR) training program, which was developed to improve the knowledge of and access to VHA health care services by rural Tribal veterans found the program to be instrumental in increasing

notes:

5.Strong, J., et al. (2018). Female Veterans: Navigating Two Identities. *Clinical Social Work Journal*, 46, 92-99.

6.Matarazzo, B. B., et al. (2016). Barriers and Facilitators in Providing Community Mental Health Care to Returning Veterans with a History of Traumatic Brain Injury and Co-occurring Mental Health Symptoms. *Community Mental Health Journal*, 52(2), 158-164.

7.Pompili, M., et al. (2013). Posttraumatic Stress Disorder and Suicide Risk Among Veterans. *The Journal of Nervous and Mental Disease*, 201(9), 802-812.

8.Blosnich, J., et al. (2013). Prevalence of Gender Identity Disorder and Suicide Risk Among Transgender Veterans Utilizing Veterans Health Administration Care. *American Journal of Public Health*, 103(10), e27-e32.

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LITERATURE REVIEW

Tribal veterans' engagement with the system.⁹ A 2001 study (out of the general scope of this review but deemed relevant nevertheless) by Gurley, et al, found that Tribal veterans who sought behavioral health services were also more likely to have sought health care for physical issues. However, utilization of health care services for physical issues was higher than for mental issues.¹⁰

Rural veterans

A 2017 systematic review by Bumgarner, et al, of the literature on mental health care for rural veterans identified telehealth as the primary treatment focus of research studies. Findings indicate telehealth is effective as a mental health treatment for subgroups of rural veterans, such as Tribal veterans, older veterans, and families of veterans, and for managing PTSD, depression, and substance use. The systematic review identified limited research on CBOCs, community outreach, home-based services, intensive case management, collaboration with clergy, and peer support.¹¹

Other-than-honorable discharge

Because they have traditionally been ineligible for VHA health care, little research exists regarding usage of behavioral health services among veterans with OTH discharge status. However, a recent study utilizing data from the 2001 National Survey of Veterans found that veterans with OTH discharges were significantly younger, lower income, and less likely to have health care coverage than other veterans.

Analyses of responses to the survey's mental component questions revealed that, in the previous four weeks, veterans with OTH discharges were also significantly more likely to report having accomplished less due to emotional problems, not to have performed work as carefully as usual due to emotional problems, to have felt less calm and peaceful, and to have felt more downhearted and blue.¹² These findings suggest that this population will benefit from recent expansions of access to VHA health/ services, assuming accessibility for Oregon veterans, and underscore the importance of elements of the system outside the VHA that serve OTH discharged veterans. Additionally, more research regarding veterans with OTH discharge status, who also belong to other subgroups, is necessary.

Overall, more research is necessary regarding specific subgroups of veterans. However, the literature indicates that veterans experiencing PTSD are at higher risk for suicide, and female veterans are likely not receiving the behavioral care they need and may need specific support systems in place for addressing gender-specific trauma and behavioral health issues. Rural and Tribal veterans face similar geographic barriers to access, though Tribal veterans likely face additional barriers to care that should be addressed together with their communities. Finally, given recent changes to behavioral health care access for veterans with OTH discharges, this population should be prioritized to better understand and serve their behavioral health needs.

notes:

9. Kaufmann, L. J., et al. (2014). Tribal Veterans Representative (TVR) Training Program. *Journal of Community Health, 39*(5), 990-996.
10. Gurley, D., et al. (2001). Comparative use of biomedical services and traditional healing options by american indian veterans. *Psychiatric Services, 52*(1), 68-74.
11. Bumgarner, et al. (2017). Mental Health Care for Rural Veterans. *Journal of Rural Mental Health, 41*(3), 222-233. VADODSUDCPGRevised22216.pdf.
12. Tsai, J., PhD, & Rosenheck, R. A., MD. (2018). Characteristics and health needs of veterans with other-than-honorable discharges. *Military Medicine, 183*(5/6), E157.

Results

NATIONAL AND STATE DATASETS

Rede Group examined data from national and state datasets to compare veterans and non-veterans in terms of selected demographic and behavioral health characteristics. Key results from the analysis are reported in this section.

Except where otherwise noted, the results reported in this section come from BRFSS 2016 data. The Oregon BRFSS and OVSAR were two of the only sources that provided rigorously collected quantitative data allowing comparison between the two groups. The results and analysis outlined in this section provide important insight into Oregon veterans' behavioral health but are only one piece of the overall picture.

Demographics

Veteran respondents were more likely than non-veterans to be male (92% v. 43%). Veterans were more likely than non-veterans to be married (60% v. 51%), divorced (19% v. 12%), or widowed (9% v. 6%), while veterans were less likely than non-veterans never to have been married (9% v. 22%) or to be a member of an unmarried couple (2% v. 5%). Veterans were less likely than non-veterans to be employed for wages (34% v. 48%) and more likely to be retired (48% v. 18%). Veterans were also older than non-veterans (on average, 61 years of age v. 47 years of age).

Health insurance

Veterans were more likely than non-veterans to have any kind of health insurance (97% v. 90%). Veterans were less likely than non-veterans not to have seen a health care provider during the previous 12 months due to cost (5% v. 12%). Veterans were less likely than non-veterans to be enrolled in the Oregon Health Plan (9% v. 22%). Thus, access to insurance does not appear to be a barrier to overcoming gaps in behavioral health services for veterans.

Figure 6: Respondents with any kind of health insurance (BRFSS)

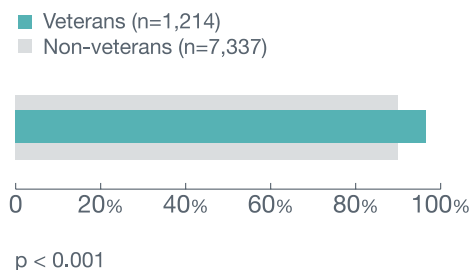
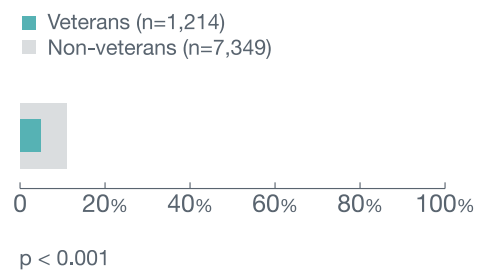


Figure 7: Respondents who have not seen a provider in the past year due to cost (BRFSS)



Results

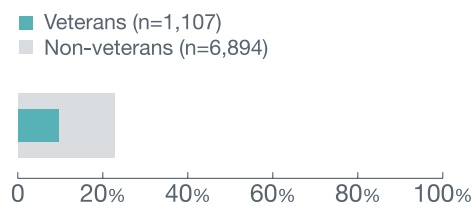
NATIONAL AND STATE DATASETS

Sadness, depression, and mental health

Veterans were less likely than non-veterans to report that they have been told they have a depressive disorder, including depression, major depression, dysthymia, or minor depression (18% v. 25%). Veterans were also less likely than non-veterans to report that their mental health was not good over the previous 30 days (on average, 3.3 v. 4.5 days).¹³ These results were supported by 2015-16 data from the NASDUH, in which veterans were less likely than non-veterans ever to have had several days or longer when they have felt sad, empty, or depressed (35% v. 39%). However, veterans were as likely as non-veterans ever to have had several days or longer when they felt discouraged about life (14%).

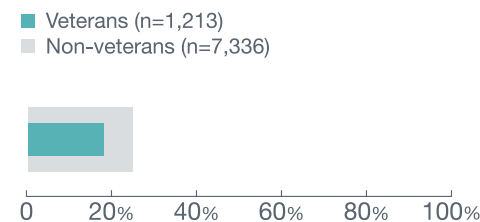
Veterans were more likely than non-veterans to report that in the previous 30 days their physical health was not good¹⁴ (on average, 5.4 v. 4.0 days), according to BRFSS, and were also more likely than non-veterans to report that their physical or mental health kept them from doing usual activities¹⁵ (on average, 6.7 v. 4.7 days). The latter is noteworthy for its contrast to the results in which veterans were less likely to report sadness, depression, or poor mental health than non-veterans. It is impossible to extricate from these data the extent to which either physical or mental health contributed to the decrease in veterans' ability to carry out usual activities. This difference does raise questions, though, about the link between physical and mental health. For example, a study of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans found that chronic widespread pain was associated with both PTSD and depression and that all three were associated with veterans' reduced capability to function in their daily work and home roles.¹⁶

Figure 8: Respondents who are currently enrolled in the Oregon Health Plan (BRFSS)



p < 0.001

Figure 9: Respondents who have ever been told they have a depressive disorder* (BRFSS)



*including depression, major depression, dysthymia, or minor depression
p < 0.001

notes

13. "Thinking about mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"
14. "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"
15. "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?"
16. Helena K. Chandler, Karen S. Quigley, Melissa Blatt, Ronald Teichman, Gudrun Lange, Chronic Widespread Pain, Mental Health, and Physical Role Function in OEF/OIF Veterans, Pain Medicine, Volume 10, Issue 7, October 2009, Pages 1174-1182

Results

NATIONAL AND STATE DATASETS

Figure 10: Mental/physical health status of respondents in past 30 days (BRFSS)

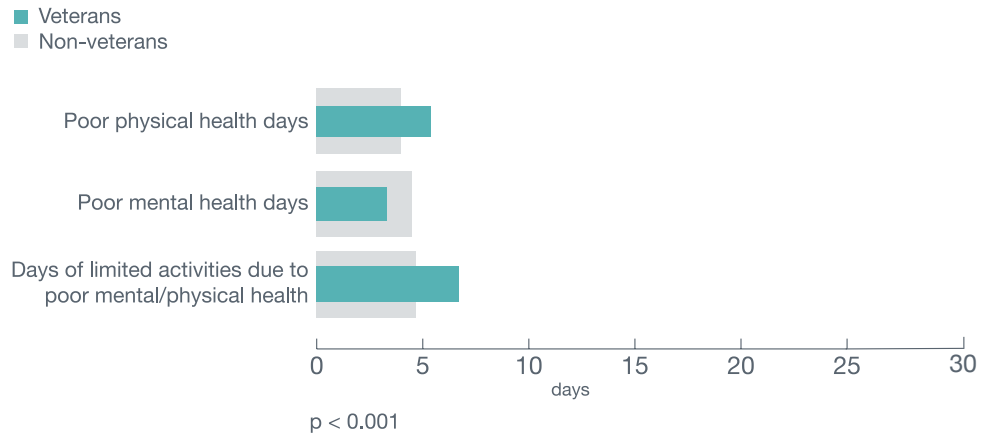


Figure 11: Respondents who have ever felt sad/empty/depressed for several days or longer (NASDUH)

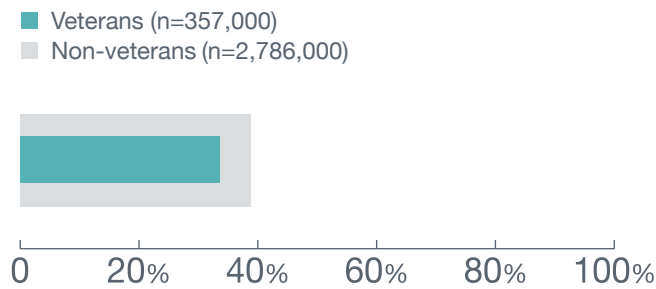
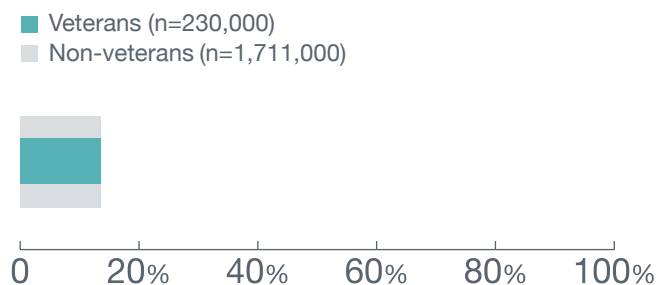


Figure 12: Respondents who have ever felt discouraged about life for several days or longer (NASDUH)



Results

NATIONAL AND STATE DATASETS

It is important not to overextrapolate these data to paint a sanguine picture of veterans' behavioral health. Depression is a risk factor for suicide¹⁷, and while these data overall indicate that Oregon veterans may be at lower risk for depression or sadness, the results reported in the next section indicate that they are more likely to die from suicide and opioid overdose than Oregon non-veterans. These results raise questions about why this difference exists, given that veterans may not experience some risk factors for suicide, such as depression and substance use disorders, at a higher proportion than non-veterans. One potential explanation could be related in part to the demographics of the BRFSS respondents, which will be discussed in more detail in the next section. A limitation of both BRFSS and NSDUH is that they are self-reported surveys, and another potential explanation could be that the difference in reported mental health outcomes is actually attributable to a difference in reporting. For example, as reported in Rede Group's analysis of veteran focus groups provided in a later section, mental health stigma is a barrier to seeking treatment for some veterans. Causation should not be implied from BRFSS or NSDUH data, however, and more research is necessary to determine why the difference exists.

Suicide

As noted in the previous section, Oregon veterans appear to be at lower risk than non-veterans for sadness or depression. Yet death certificate data and OVSAR¹⁸ indicate that the mortality rate for Oregon veterans is nearly five times higher than for non-veterans. (It should be noted that this difference could be attributed to the larger proportion of veterans in older age groups.) The overall male veteran suicide rate in Oregon was markedly higher than for male non-veterans, and age-specific suicide rates were higher for veterans than non-veterans across all age groups that Rede Group analyzed from 2013 to 2017, the most recent year for which data were obtained.¹⁹

Prior to 2015, the greatest difference in age-specific suicide rates between male veterans and male non-veterans was among those in the 75+ age group. Beginning in 2015, the trend shifted, and the greatest difference in age-specific suicide rates between male veterans and male non-veterans was among those aged 18-34 with the second greatest in the 35-54 age group. Though the suicide rates for those aged 18-34 and 35-54 are now higher than that of veterans aged 75+, older veterans continue to be at high risk for suicide, and the rate will remain high as that population ages. While behavioral health remains an important consideration for veterans aged 75+, this group is also at higher risk than younger veterans for chronic disease and health concerns related to aging.

According to these data, Oregon's youngest male veterans are at higher risk for suicide than their non-veteran peers. In fact, in 2016, the suicide rate among male veterans in the 18-34 age group was more than three times higher than that of male non-veterans of the same age (80.2 and 25.0, respectively). The rate dropped to 2.7 times higher in

notes:

17. Henriksson M., Aro H., Marttunen M., Heikkinen M., Isometsä E., Kuoppasalmi L., and Lönnqvist J.: Mental disorders and comorbidity in suicide. *American Journal of Psychiatry* 1993; 150: pp. 935-940
18. Oregon Vital Statistics Annual Reports (2013-2017). Retrieved from <https://www.oregon.gov/oha/PH/BIRTHDEATH-CERTIFICATES/VITALSTATISTICS/ANNUALREPORTS/VOLUME2/Pages/index.aspx>
19. All Oregon veteran population estimates used for calculating crude death rates were obtained from the VA VetPop Veteran Population Model. Rates are per 100,000 population and are for male veterans over age 18.

Results

NATIONAL AND STATE DATASETS

2017 (88.4 and 32.4, respectively). Evidence suggests that the risk of suicide for veterans is highest in the first year after separation from the military and decreases with time, though it remains significantly higher than for non-veterans.²⁰ It is unlikely that the sample used in the BRFSS survey was representative of the population of Oregon veterans at highest risk for suicide, which could contribute to the discrepancy between veterans' decreased risk for depression or sadness, as indicated by BRFSS results, but increased risk for suicide. On average, veteran respondents were 61 years old, and thus likely to have been out of the military for longer. They were also more likely to be married and less likely never to have been married than non-veterans. Having social ties, such as marriage, is a protective factor against suicide,²¹ and some young veterans beginning the transition from military to civilian life may lack robust social networks.

Due to small numbers, Oregon does not calculate cause-specific mortality rates for female veterans. Thus, Rede Group examined national suicide reports for trends related to female veterans and suicide. According to the VA, the overall population of female veterans nationwide is expected to steadily increase over the next 30 years,²² and, likely with it, the suicide rate for female veterans. The national age-adjusted suicide mortality rate for female veterans in 2016 was 1.8 times greater than that for female non-veterans. Though the difference in risk for suicide between female veterans and non-veterans is not as high as the difference between male veterans and non-veterans, the trend is consistent: female veterans are at higher risk for suicide than female non-veterans. Given the common trends, female veterans in Oregon, like their male counterparts, are highly likely to be at higher risk for suicide.

notes:

20. Tim Bullman, Aaron Schneiderman & Robert Bossarte (2018). Suicide Risk by Unit Component among Veterans Who Served in Iraq or Afghanistan, *Archives of Suicide Research*, 22:1, 1-10.

21. Duberstein, P. R., Conwell, Y., Conner, K. R., Eberly, S., Evinger, J. S., & Caine, E. D. (2004). Poor social integration and suicide: Fact or artifact? A case-control study. *Psychological Medicine*, 34(7), 1331-1337

22. VA VetPop Veteran Population Model. https://www.va.gov/vetdata/veteran_population.asp

Figure 13: Suicide rate by age and veteran status (2017)

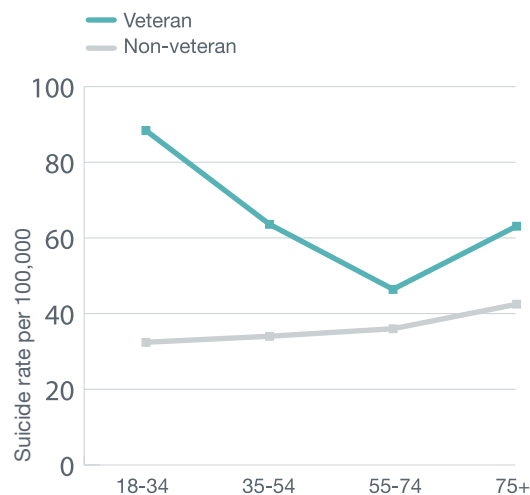


Table 1: Suicide Deaths by age range and veteran status (2017)

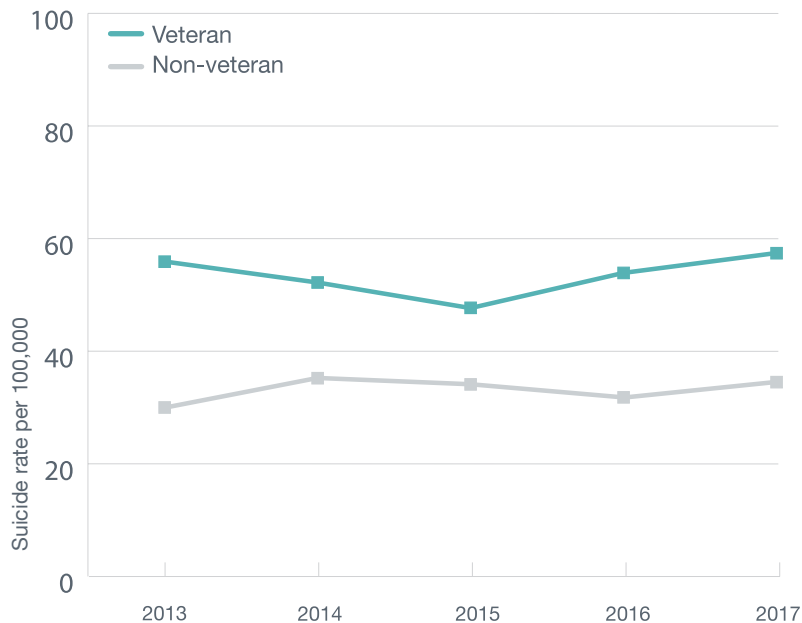
		Veteran	Non-veteran
Total (18+)	No.	159	445
	Rate	57.2	34.3
18-34	No.	18	144
	Rate	88.4	32.4
35-54	No.	36	161
	Rate	63.6	34.0
55-74	No.	61	118
	Rate	46.4	36.0
75+	No.	44	22
	Rate	63.1	42.5

Suicide rate per 100,000

Results

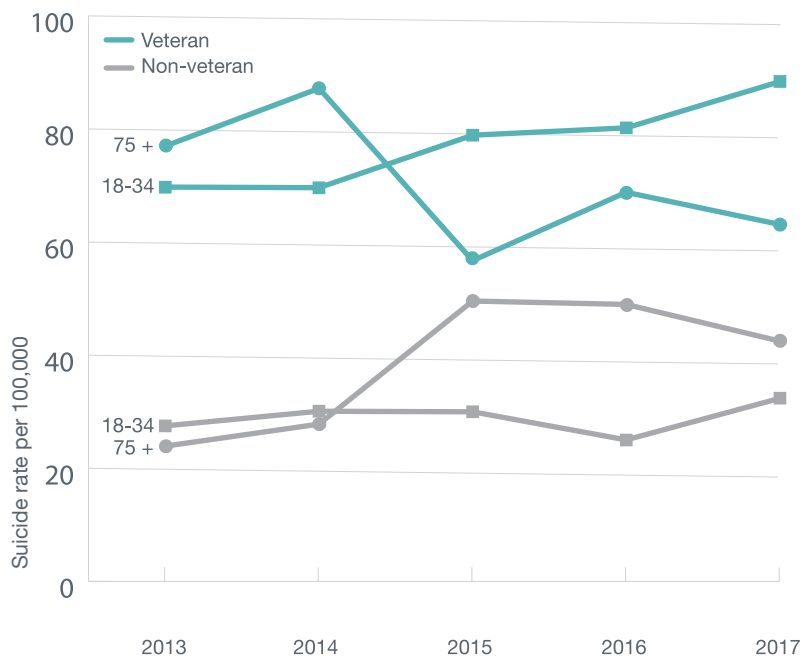
NATIONAL AND STATE DATASETS

Figure 14: Suicide rate by veteran status (2013-2017) (USDVA)



source:
 Veteran population estimates used for calculating crude death rates for all years were obtained from the US Department of Veterans Affairs, Vet Pop State Data Tables

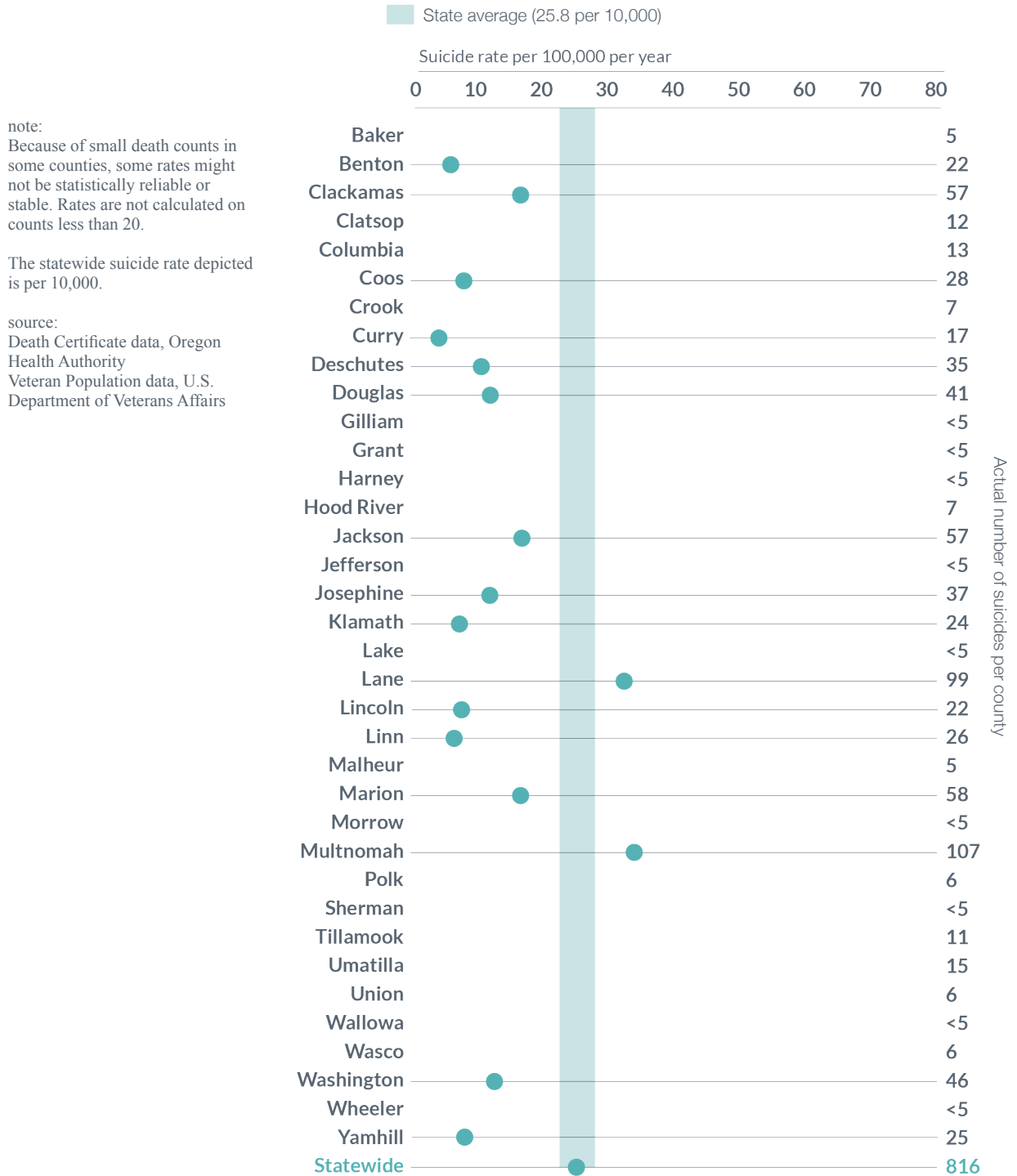
Figure 15: Suicide rate among the 18-34 and 75+ age groups by veteran status (2013-2017) (OVSAR)



source:
 Oregon Vital Statistics Annual Reports (OVSAR) 2013-2017. Retrieved from <https://www.oregon.gov/oha/PH/BIRTH-DEATHCERTIFICATES/VITALSTATISTICS/ANNUALREPORTS/VOLUME2/Pages/index.aspx>

Results

Figure 16: Veteran suicides and rates by county, Oregon (2013-2017) (OHA, USDVA)



Results

NATIONAL AND STATE DATASETS

Alcohol and Tobacco

According to BRFSS, veterans and non-veterans had similar current alcohol use (60% for both) and heavy drinking²³ (6% v. 8%). However, veterans were less likely than non-veterans to report binge drinking²⁴ (12% v. 17%).

In a report of suicides among Oregon veterans between 2008 and 2012,²⁵ investigating officers and medical examiners reported suspecting alcohol use prior to one in three suicide deaths among veterans aged 18-54 years.

Veterans and non-veterans had similar current tobacco use for both smoking (18% v. 16%) and use of smokeless tobacco (5% v. 4%).

Figure 17: Respondents who have used alcohol in the past 30 days (BRFSS)

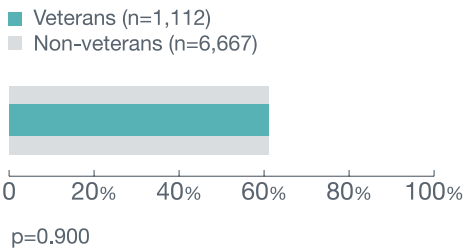


Figure 18: Respondents who have reported heavy drinking (BRFSS)

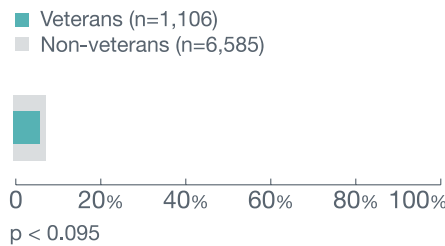


Figure 19: Respondents who have reported binge drinking (BRFSS)

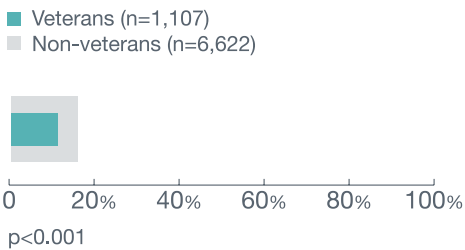


Figure 20: Current smoking status of respondents (BRFSS)

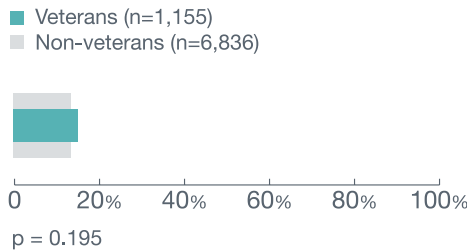
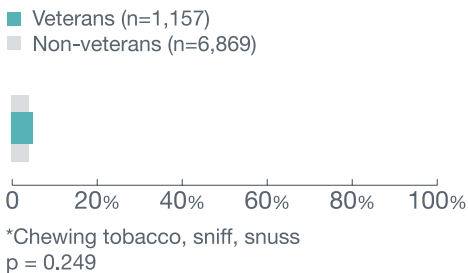


Figure 21: Current smokeless tobacco status of respondents (BRFSS)



notes

- 23. Adult men having more than two drinks per day and adult women having more than one drink per day
- 24. Men having five or more drinks on one occasion and women having four or more drinks on one occasion
- 25. Shen X, Millet L. (2014). Suicide Among Oregon Veterans. Oregon Health Authority. <https://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/INJURY-FATALITYDATA/Documents/NVDRS/suicide-among-oregon-veterans-2008through2012.pdf>

Results

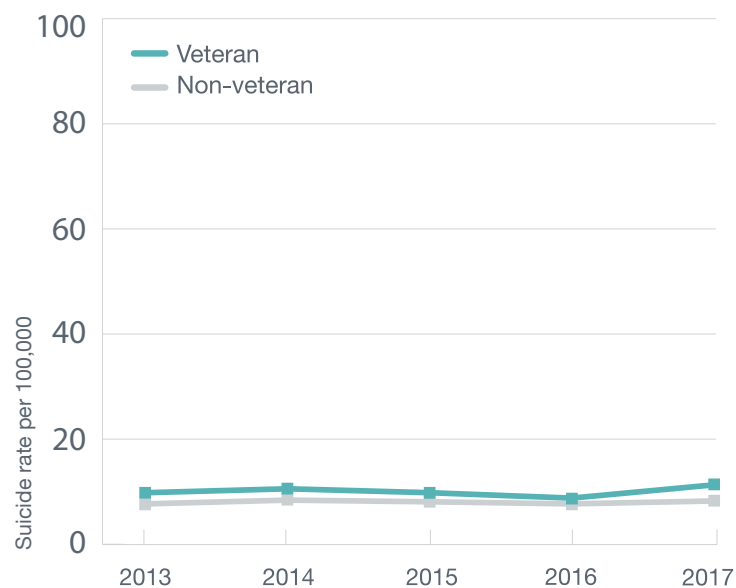
NATIONAL AND STATE DATASETS

Opioids

Recent reports from SAMHSA note that specific subgroups of veterans have higher prevalence rates of some types of substance use.²⁶ SAMSHA found that nationwide, among those aged 18 to 25, veterans had higher past year rates of nonmedical use of pain relievers, methamphetamine use, and alcohol abuse or dependence than nonveterans. The findings regarding the nonmedical use of pain relievers is consistent with several other studies that have demonstrated that veteran younger adults have increased risk of nonmedical use and misuse of pain relievers than their older counterparts. However, limitations in sample size obviated Rede Group's ability to reliably report age-specific data using Oregon BRFSS.

According to statewide death certificate data, veterans had a higher opioid-affiliated mortality rate than non-veterans across all years of interest (2013-2017). The difference in rates was greatest in 2017, for which the veteran mortality rate was 1.37 times higher than the rate for non-veterans (11.4 and 8.3, respectively). The second greatest difference in rates was observed in 2013, when the veteran mortality rate was 1.29 times higher than the rate for non-veterans (9.8 and 7.6, respectively). These results suggest a need for more resources for research and treatment in this area.

Figure 22: Mortality with opioids as contributing factor by veteran status (2013-2017) (OSVAR)



notes:

26. Substance Abuse and Mental Health Services Administration (November 2016). Center for Behavioral Health Statistics and Quality Data Review: Prevalence of Past Year Substance Use and Mental Illness by Veteran Status in a Nationally Representative Sample. Retrieved from: <https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-VeteranTrends-2016/NSDUH-DR-VeteranTrends-2016.pdf>.

Results

NATIONAL AND STATE DATASETS

Military sexual trauma

In a 2016 questionnaire survey of 580 Oregon self-identified women veterans conducted by Rede Group for the Women Veterans Health Care Study, 59% of respondents reported experiencing sexual assault, rape, or harassment while on active duty. Of those respondents, 65% reported not receiving service-connected benefits for military sexual trauma or PTSD.²⁷ Results of the National Health and Resilience in Veterans Study indicate prevalence of military sexual trauma overall among male and female veterans is 7.6%. However, the prevalence among female veterans was higher than among male veterans (32.4% v. 4.8%) and was highest among veterans aged 18-29. Military sexual trauma was associated with higher rates of major depressive disorder, PTSD, generalized anxiety disorder, suicidal ideation, history of suicide attempts, and decreased cognitive functioning and quality of life, as well as more use of mental health treatment.²⁸ The relationship between PTSD and military sexual trauma is discussed further in the next section. A national study of veterans receiving VHA care found that veteran men who had reported military sexual trauma during screening had a risk for suicide that was one-fifth higher than veteran men who had not reported military sexual trauma and that veteran women reporting military sexual trauma during screening had a risk for suicide that was one-third higher than veteran women who had not.²⁹

PTSD

Results of the National Health and Resilience in Veterans Study also provide a snapshot of PTSD trends. 87% of respondents in that study reported lifetime exposure to at least one potentially traumatic event (PTE), with an average of 3.4 different lifetime PTEs. Sexual abuse in adulthood had the highest conditional probability of PTSD (35%), supporting the correlation between military sexual trauma and PTSD reported in the previous section.³⁰ Veterans with mental health diagnoses in general, but in particular PTSD, are more likely to utilize VHA non-mental health medical services, including the emergency department. Veterans with PTSD diagnoses were 55% more likely to use emergency services than those with no mental health diagnosis and more than three times as likely to utilize inpatient services.³¹

notes:

27. Rede Group. (2016). Women Veterans Health Care Study. Oregon Department of Veterans' Affairs. <https://www.oregon.gov/odva/Connect/Documents/FinancialReports/2016%20ODVA%20Women%20Veterans%20Health%20Care%20Study.pdf>
28. Klingensmith, K., Tsai, J., Mota, N., Southwick, S. M., & Pietrzak, R. H. (2014). Military sexual trauma in US veterans: Results from the National Health and Resilience in Veterans Study. *The Journal of Clinical Psychiatry*, 75(10), e1133-e1139.
29. Kimerling, Rachel et al. (2016). Military Sexual Trauma and Suicide Mortality. *American Journal of Preventive Medicine*, Volume 50, Issue 6, 684 - 691.
30. Wisco, B. E., Marx, B. P., Wolf, E. J., Miller, M. W., Southwick, S. M., & Pietrzak, R. H. (2014). Posttraumatic stress disorder in the US veteran population: results from the National Health and Resilience in Veterans Study. *J Clin Psychiatry*, 75(12), 1338-1346.
31. Cohen, Beth E (2010). Mental Health Diagnoses and Utilization of VA Non-Mental Health Medical Services Among Returning Iraq and Afghanistan Veterans. *Journal of General Internal Medicine*, 25(1): 18-24.

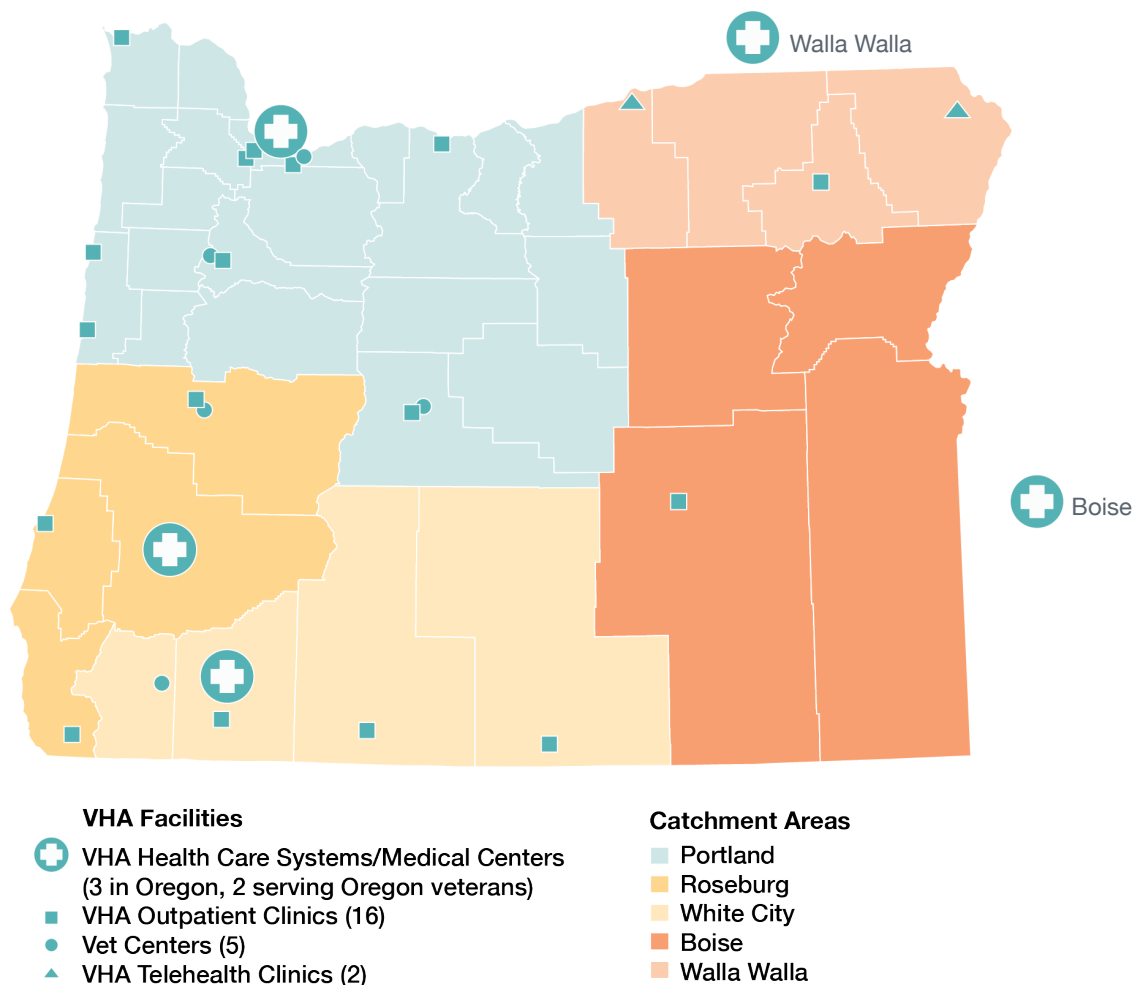
Results

VHA PROVIDER INTERVIEWS

SCOPE:
11 in-depth
structured
interviews with
VHA providers
across the state

The VHA provides behavioral health services to veterans in Oregon through 26 VHA facilities. These facilities include Health Care Systems, Medical Centers, CBOCs, outpatient clinics, and Vet Centers. Vet Centers are available to a subset of the veteran population who have served in a combat zone, experienced military sexual trauma, served as a part of a mortuary affairs crew, or served on a drone crew (i.e. operators of remotely piloted aircraft). Vet Centers provide counseling services, outreach, and referral services to these veterans and their families. VHA facilities are separated into five distinct catchment areas: Boise, Portland, Roseburg, Walla Walla, and White City. Catchment areas expand into neighboring states, and veterans can obtain services outside of the state of Oregon when needed.

Figure 23: VHA facilities and catchment areas serving Oregon veterans



Results

VHA PROVIDER INTERVIEWS

In structured interviews, Rede Group asked VHA providers if their facilities provided a list of clinical services outlined in the VHA Handbook.³² Questions focused on services provided for substance use disorder (SUD), PTSD, suicide, military sexual trauma, and depression.

Availability of services

Interviewees answered questions about whether their VHA facilities offered each of the services listed in Table 2 (A negative response did not necessarily mean that the facility never provides that service but that, for example, the service is not currently offered due to a vacant position or other logistical reason.) In Table 2, a dark green cell indicates services that are provided at all facilities in the catchment area; an orange cell identifies gaps in services where one-third or fewer of the facilities in that catchment area provide the service; and a light green cell indicates services that are provided at greater than one-third, but not all, of the facilities in the catchment area. Short- and/or long-term inpatient residential treatment for SUD, PTSD, and military sexual trauma; secured inpatient care for mental disorders; and emergency departments or 24/7 urgent care services are gaps in services that appear across the state.

Table 2: VHA Services Provided & Provider Training by Catchment Area

- Services/trainings offered at all facilities in the catchment area
- Services/trainings offered at greater than one-third, but not at all of the facilities in the catchment area
- Services/trainings offered at one-third or fewer of the facilities in the catchment area

Conditions	Services & provider training	Portland	Roseburg	Walla Walla	White City
Substance Use Disorder (SUD)	Services for SUD			-	
	Pharmacotherapy/medications				-
	Individual counseling			-	
	Group counseling			-	
	Short- and/or long-term inpatient residential treatment	-	-	-	-
	Opioid withdrawal, stabilization, and treatment	-		-	-
	Tobacco screening				
	Nicotine addiction screening				

notes:
 32. United States Department of Veterans Affairs (2015). Uniform Mental Health Services in VA Medical Centers and Clinics. VHA Handbook 1160.01. Retrieved from https://www.va.gov/VHApublications/ViewPublication.asp?pub_ID=1762.

Results

VHA PROVIDER INTERVIEWS

Conditions	Services & provider training	Portland	Roseburg	Walla Walla	White City
Post-traumatic Stress Disorder (PTSD)	Diagnostics, assessment, treatment, and services				
	Pharmacotherapy/medications				
	Individualized counseling				
	Group counseling	-		-	
	Counselors trained specifically on understanding, treatment, and management of patients who are experiencing PTSD				
	Short- and/or long-term inpatient residential treatment	-	-	-	-
	Traumatic brain injury diagnoses, assessment, and evaluation				-
Suicide	Suicide assessment, intervention, and management				
	Pharmacotherapy/medications				
	Psychotherapy or counseling				
	Follow-up services including phone contact, case management, and/or home visits				
	Counselors receive ongoing suicide assessment, prevention, and intervention training and educational opportunities				
	Mandatory training for counselors				
	Secured, inpatient care for mental disorders	-	-	-	-
	Agreements with appropriate agencies or hospitals to arrange for involuntary hospitalization			-	-
	Procedure to facilitate access to national suicide prevention hotlines				
	Emergency departments or 24/7 urgent care	-	-	-	-

Results

VHA PROVIDER INTERVIEWS

Conditions	Services & provider training	Portland	Roseburg	Walla Walla	White City
Military Sexual Trauma (MST)	Counselors trained to screen and treat patients experiencing PTSD, SUD, major depression or other mental health challenges as a result of MST				
	Short and/or long-term inpatient residential programs with specialized MST treatment	-	-	-	-
	Specialized outpatient mental health services focused specifically on sexual trauma	-		-	-
	Specifically trained sexual trauma counselors			-	-
	Designated contact person for MST-related issues				
Depression	Treatment for depression				
	Pharmacotherapy/medication				
	Individualized counseling				
	Group counseling			-	

notes:

The Boise VA Health Care System did not participate in this assessment.

Some very small Community Based Outpatient Clinics may not be required to provide certain specialty services.

In addition to the services listed in Table 2, all Vet Centers interviewed (four out of four) reported providing readjustment counseling and outreach services, individualized and group military readjustment counseling services for veterans and their families, and bereavement counseling for families who experience an active duty death.

Results

VHA PROVIDER INTERVIEWS

Accessibility of services

Although a service may be provided at one or more facilities in the catchment area, it can be difficult for veterans to access services if they are not located near the VHA facility offering the needed service.

When a service is not available at a VHA facility, veterans are referred to another VHA facility that provides those services or to a local provider in their community through purchased and referred care, such as the VCP. Veterans are eligible to receive services through the VCP if there are no available appointments at a VHA facility within 30 days, or if a VHA facility is more than 40 miles away. The availability of VCP-approved community providers may further limit veteran access to services.

Gender-specific care

Interviewees reported that many sites of care have gender-specific individual and group counseling services available, and make an effort to honor a veteran's preference to see a provider of a particular gender whenever possible. However, limited staff and resources can make this challenging in some locations, particularly in outlying clinics. When gender-specific care is not available to a veteran for a particular service, veterans are referred to other clinics—within the VHA, VCP affiliated, or community providers in private practice—staffed with providers of the appropriate gender. These referrals may, however, involve prohibitive travel for the veteran. Interviewees also reported a need for more community-based, gender-specific options in Oregon, particularly for military sexual trauma.

“ One challenge is having enough clinical staff to provide the frequency of service to veterans requiring all types of mental health services. We are chronically understaffed.”

—VHA provider

“ [Distance for patient travel] is certainly an issue, especially for patients where their closest clinic is a CBOC, but they may still be hours away from that CBOC. That's definitely an issue.”

—VHA provider

Results

VHA PROVIDER INTERVIEWS

Barriers and challenges

In addition to multiple choice questions regarding services offered, interviewees responded to open-ended questions about the challenges they faced in providing behavioral health services. The following section describes themes arising from the open-ended portion of the survey.

The challenges to providing behavioral health care services to veterans identified by VHA providers fell into six distinct categories:

All interviewees (11 of 11) reported **recruitment and retention** of qualified staff as a challenge. The reasons include:

- Hard to draw and keep staff in rural areas (six of 11)
- Current understaffing creates poor working conditions (six of 11)
- Difficult VHA hiring process (five of 11)
- Provider salaries are not competitive (five of 11)
- Challenging patient population (three of 11)
- Lack of affordable housing (two of 11)

All interviewees (11 out of 11) noted providing care in **rural settings** is a challenge, giving the following reasons:

- Long travel distance for clients to reach appointments (nine of 11)
- Some veterans prefer a level of geographic isolation (five of 11)

Many interviewees (seven of 11) had administrative and other challenges with **purchased and referred care**, including lack of local providers in the community and lack of local providers willing to contract with VHA (six interviewees).

Many interviewees (seven of 11) identified **missing services** as a challenge. Missing services are those services needed for veterans, per best practices for treatment, that are currently unavailable or not available at the level necessary.

Some interviewees (five of 11) mentioned challenges with **technological limitations**. These challenges included bad or inconsistent connectivity, especially in remote locations, slow response time from the IT department when problems arise, and lack of connectivity or IT support due to weather conditions, specifically in remote areas.

A handful of interviewees (three of 11) listed **social determinants and lack of basic needs** (e.g., housing crises, joblessness, and veterans experiencing homelessness) as challenges to reaching veterans with services.

Results

QUESTIONNAIRE SURVEY

SCOPE:
3,915 veterans across the state completed an electronic survey

In the questionnaire survey, respondents who had served in the U.S. military or met specific qualifications in National Guard service answered questions about their experiences accessing and receiving behavioral health care through the VHA and outside of the VHA system. The survey was completed by 3,915 veterans with representation from all Oregon counties. Rede Group selected noteworthy information and charts to include in this section of the report; a more extensive list of survey tables can be found in Appendix F. The demographic breakdown of respondents by sex, LGBTQI status, age, race/ethnicity, and geographic region is shown in figures 24-28. For the purpose of analysis, Rede Group sorted respondents' counties of residence into three Oregon regions (Eastern, Northern, and Southern), with one category for respondents residing out of state.

Figure 24: Survey participants by sex

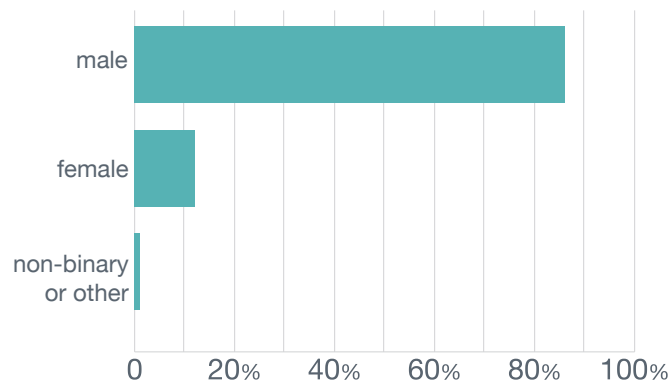
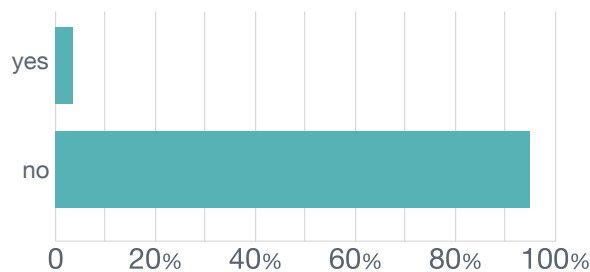


Figure 25: Survey participants by LGBTQI status



Results

QUESTIONNAIRE SURVEY

Figure 26: Survey participants by age

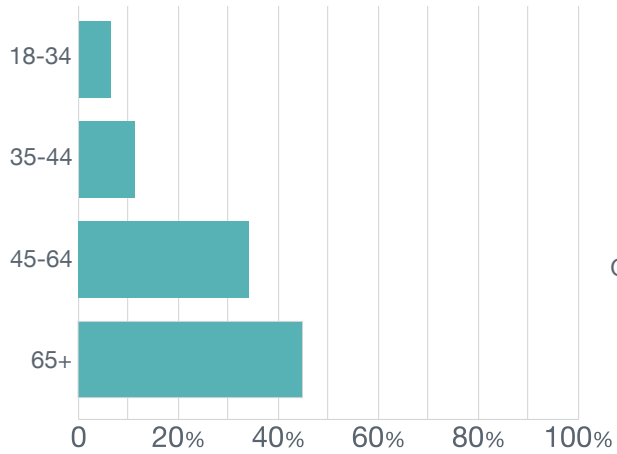


Figure 27: Survey participants by region

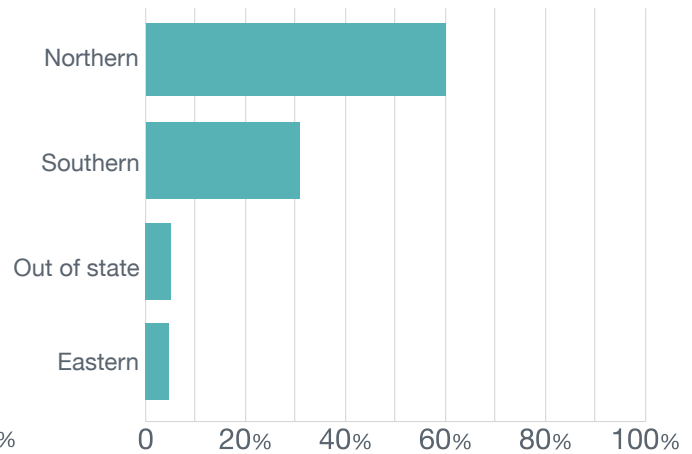
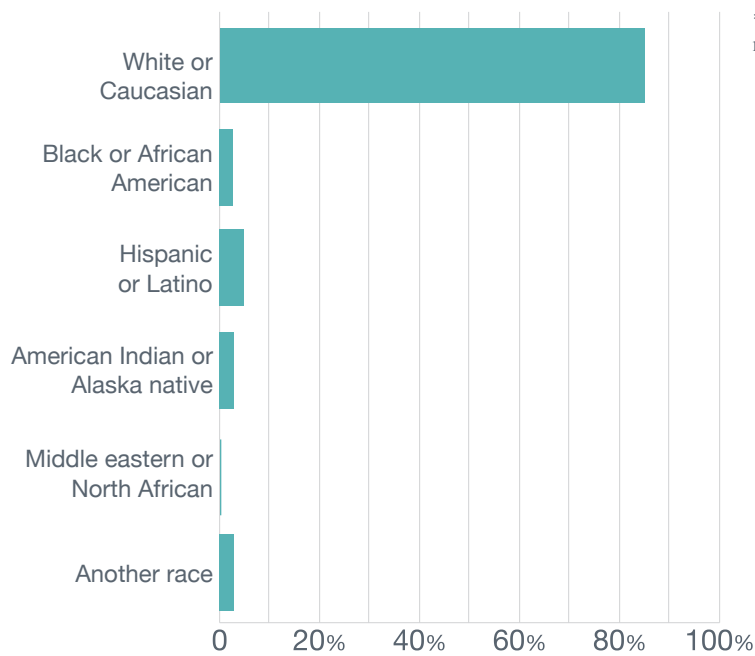


Figure 28: Survey participants by race/ethnicity



*Racial ethnic data is modeled due to small number of responses in the survey

Results

QUESTIONNAIRE SURVEY

VHA/non-VHA services

In order to receive VHA benefits, a veteran must meet certain eligibility requirements (i.e., type of services, discharge status, date of services, length of active duty service). Some of the population surveyed did not meet the eligibility requirements to receive VHA behavioral health services. Of the survey respondents who had received behavioral health care services in the previous two years, 68% had received services through the VHA.

Those who sought services outside of the VHA responded to questions about why they had elected not to utilize the VHA for care. Across all variables analyzed (age, income, education level, and LGBTQI status), participants reported that the most common reasons they went elsewhere for services were that they had private insurance or an HMO, did not like the care they had previously received from the VHA, did not know where to go or who to call, and felt uncomfortable or unsafe going to the VHA. (Please see Figures 11-14 in Appendix F.)

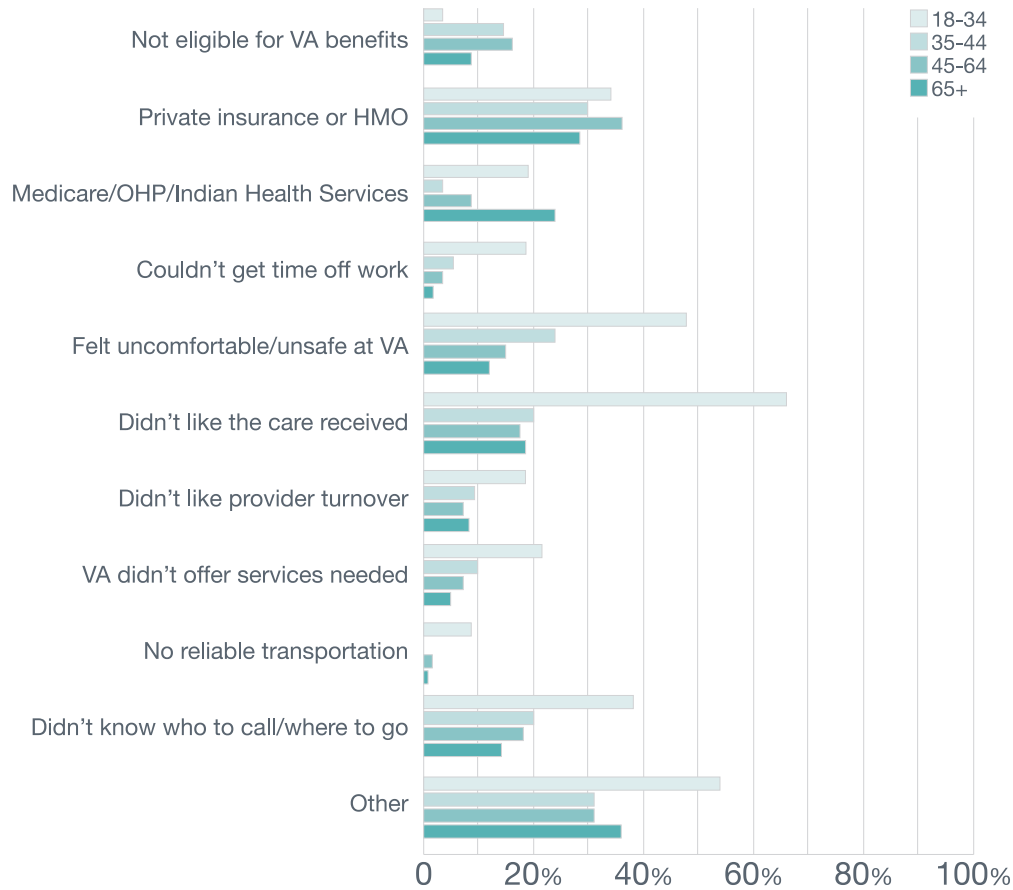
Rede Group conducted an analysis by age for respondents who had not sought services through the VHA in the previous two years (Figure 29). In response to a multiple choice question about why they had not used VHA services, more than 60% of veterans aged 18 to 34 selected “I did not like care I had previously received from VA” and almost half selected “I felt uncomfortable or unsafe going to VA.” Younger age groups responded to the questionnaire at a higher proportion than older age groups, and younger individuals were more likely to select multiple responses than older individuals. This variance suggests that younger veterans may have a different set of needs from older veterans. Comparing responses between age groups must be done cautiously, however. Generational differences in reporting may be responsible for some of the discrepancies in trends, but it is not possible to infer causation from these survey data.

Open-ended responses from veterans who indicated “other” in response to the question, “Why did you not use VA health services?” were uploaded into the qualitative analysis software Dedoose and coded to examine possible themes. Out of 183 responses, approximately 16% reported that there was no local VHA option or the distance to travel for treatment was too far. Approximately 16% also reported that the wait time to get an appointment was too long. Approximately 9% reported that they had already established care with a provider elsewhere, and approximately 8% reported that they were getting care through the VCP or TRICARE. Never hearing back after calling about an appointment, not feeling comfortable at VHA facilities, needing a different type of care than the VHA could provide, and being unaware of VHA benefit eligibility status were each reported by 3% of respondents, respectively.

Results

QUESTIONNAIRE SURVEY

Figure 29: Why did you not use VA services? By age



Results

QUESTIONNAIRE SURVEY

LGBTQI status

Respondents who identified as LGBTQI were more likely to have sought behavioral health care than those who did not identify as LGBTQI (65% vs. 41%, respectively). LGBTQI respondents also reported, at more than twice the rate of non-LGBTQI respondents, not seeking services through the VHA because of feeling uncomfortable or unsafe and not liking the care they had previously received. This result highlights a need to evaluate the specific needs of LGBTQI veterans within the VHA system. LGBTQI veterans were significantly more likely to report not knowing where to go or who to call as a barrier to seeking care, raising the question of how the dissemination of information from the VHA is failing to reach these demographics.

**Figure 30: Over the past two years, have you visited a counselor or other health care provider for mental health concerns?
By LGBTQI status**

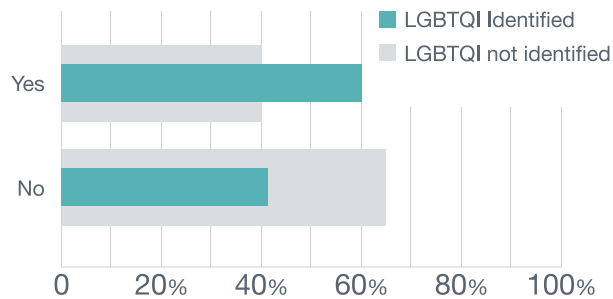
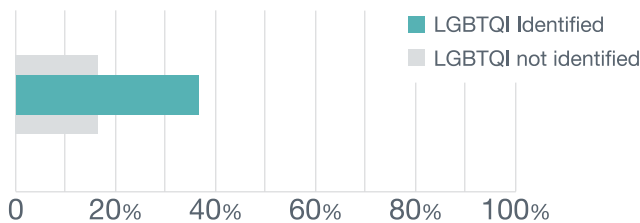


Figure 31: Felt uncomfortable/unsafe at the VA by LGBTQI status



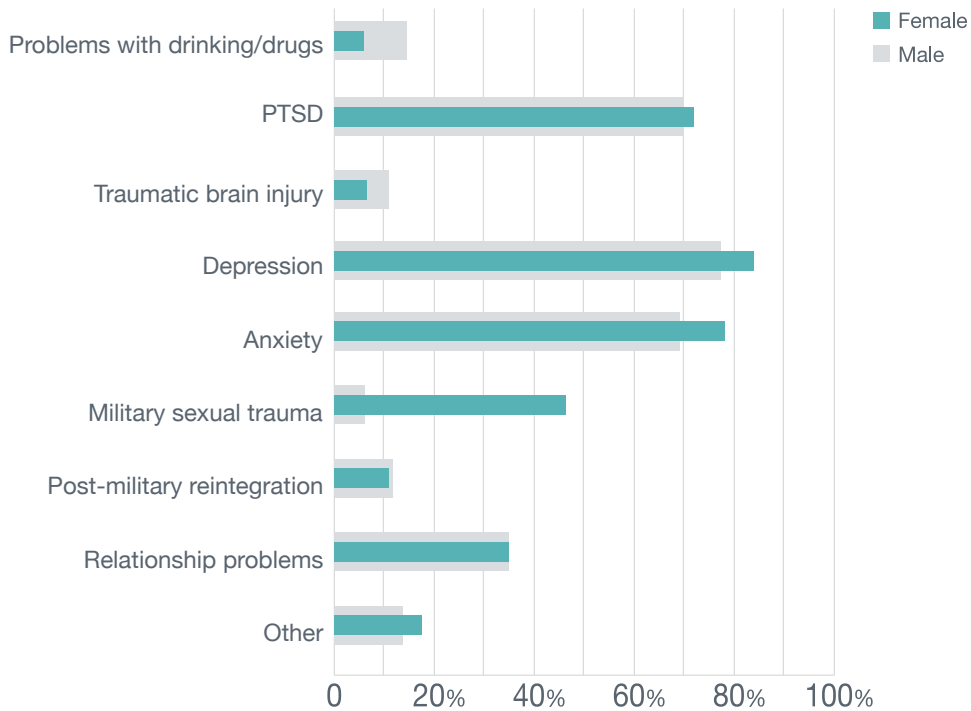
Results

QUESTIONNAIRE SURVEY

Conditions and types of services sought

Respondents who sought services both within or outside the VA system reported those conditions for which they had sought treatment. Across all variables (age, sex, LGBTQI status, income, education level, and region), respondents sought services predominantly for PTSD, anxiety, depression, and relationship problems. (Please see Figures 15-20 for Q9 in Appendix F.) Relationship problems appeared to decrease with age, as did reintegration issues. Female (see Figure 32 below) and LGBTQI veterans were more likely to have sought services for military sexual trauma. (Please see Figures 15 and 20 in Appendix F.)

Figure 32: What conditions have you sought treatment for? By sex

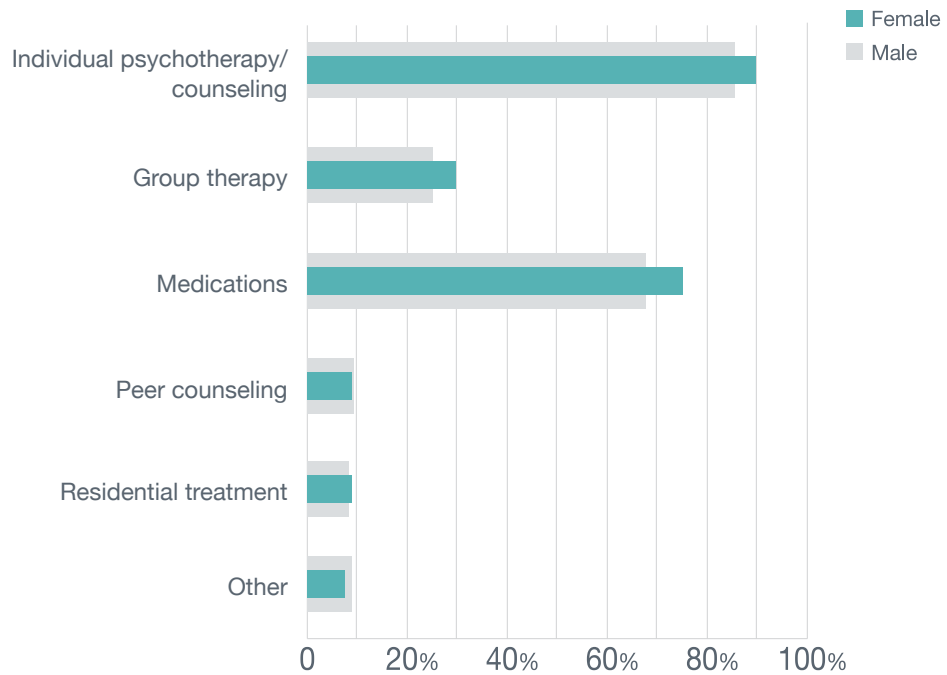


Results

QUESTIONNAIRE SURVEY

The types of services received did not vary dramatically by sex and region, with individual counseling and medication being the most common services received. (Please see Figures 23-24 for Q11 in Appendix F.)

Figure 33: What kind of services have you received? By sex



Results

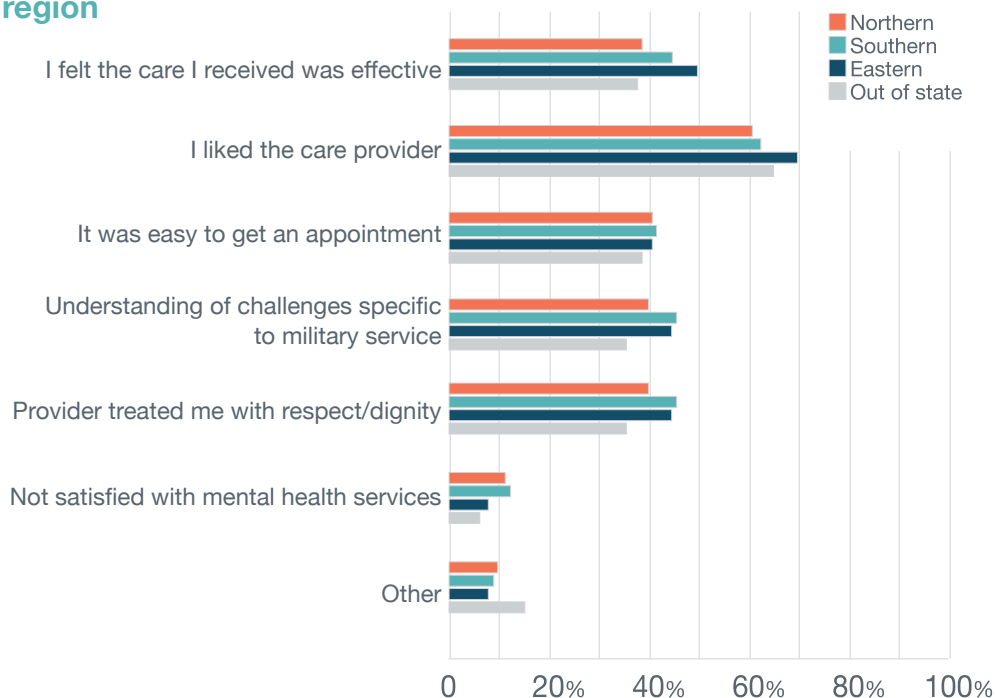
QUESTIONNAIRE SURVEY

Satisfaction

In an analysis of satisfaction, respondents were more likely to respond positively than negatively. (Please see Figures 27-36 for Q13 and Q14 in Appendix F.) Satisfaction ratings were generally high by all variables (sex, region, age, annual income, LGBTQI, and service-seeking status by VHA and non-VHA services), with higher proportions of respondents reporting being very satisfied or satisfied than dissatisfied or very dissatisfied. Respondents' satisfaction with the behavioral health services they received appeared generally positive, with fewer than one-third of respondents across all categories indicating they were dissatisfied or very dissatisfied. Those who sought services through the VA (64%) reported higher levels of satisfaction (very satisfied or satisfied) than those who sought services outside the VA (53%).

For the respondents who indicated satisfaction with the behavioral health care they received, Figure 34 displays, by region, the aspects of care with which they were satisfied. More than half of respondents by all variables indicated they felt respected and were treated with dignity by their provider and liked their provider. More than one-third felt that the care they received was effective, it was easy to get an appointment, and the provider understood their specific needs and challenges.

Figure 34: Drivers of satisfaction among satisfied respondents by region

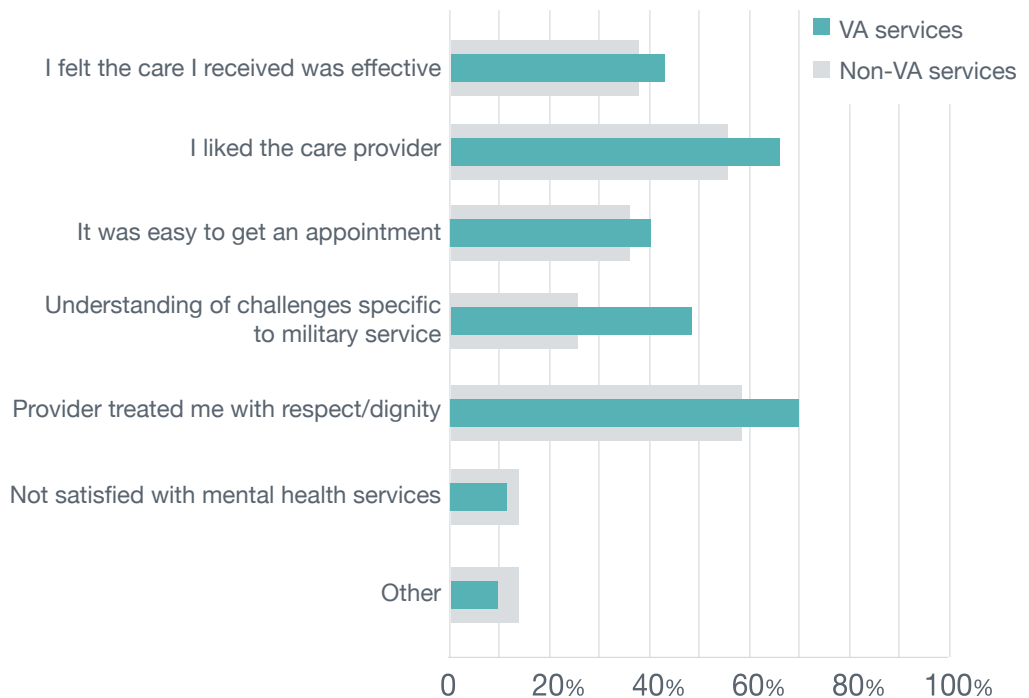


Results

QUESTIONNAIRE SURVEY

Figure 35 shows the drivers of satisfaction by service-seeking status. The highest drivers of satisfaction for those receiving non-VHA care were similar to the highest drivers of satisfaction for those receiving care through the VHA. Those receiving VHA care reported being more satisfied with the ease of getting an appointment to see a provider and with feeling that the provider understood the specific challenges and difficulties associated with military services.

Figure 35: Drivers of satisfaction among satisfied respondents by service-seeking status



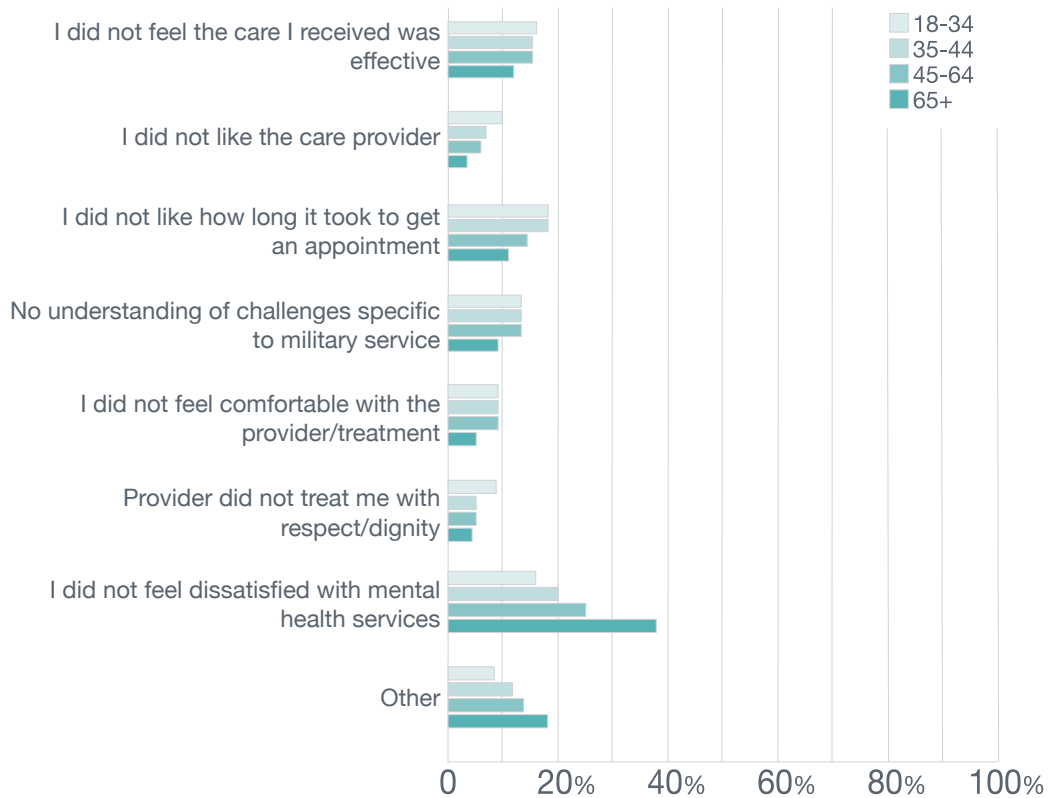
Results

QUESTIONNAIRE SURVEY

Dissatisfaction

Though most respondents reported that they were not dissatisfied with the care they received, respondents who reported dissatisfaction were most likely to identify the source(s) of their dissatisfaction as a perception that care was ineffective and/or as a dislike for how long it took to get an appointment. Dissatisfaction (dissatisfied or very dissatisfied) among those receiving services through the VHA (16%) was slightly lower than among those who sought services outside the VHA (18%). Figure 36 illustrates the differences in satisfaction, by age, with aspects of behavioral health services. The oldest respondents were twice as likely as the younger respondents to report no dissatisfaction with services, with the youngest respondents reporting less satisfaction with efficacy of treatment, wait times, and provider understanding. Again, because a larger proportion of responses comprises younger age groups, it is not possible to infer age-related causation from these data, nor is it possible to infer if these differences are actually related to quality of care, expectation of quality of care, or some other reason.

Figure 36: What aspects of your care have you been dissatisfied with? By age



Results

QUESTIONNAIRE SURVEY

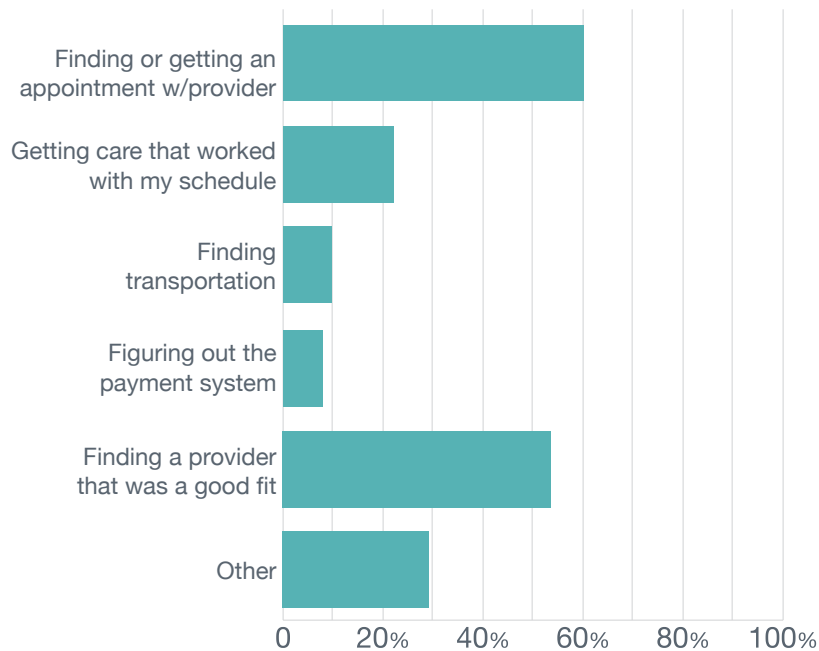
Accessing care

Respondents reported the most common difficulties to accessing behavioral health care to be finding a provider, getting an appointment, and finding a provider that was a good fit (Figure 37). Females were twice as likely as males to report needing services but not receiving them. (Please see Figure 55 for Q19 in Appendix F.) As age increased, respondents were less likely to feel they needed services but did not receive them. (Please see Figure 57 for Q19 in Appendix F.) LGBTQI respondents were twice as likely as those who did not identify as LGBTQI to feel they needed services but did not receive them. (Please see Figure 60 for Q19) in Appendix F.)

Across all variables, respondents who did not receive services reported the most common reasons as feeling uncomfortable or unsafe going for care, not knowing where to go or who to call, trying to get help but getting frustrated and giving up, and not asking for help. (Please see Figures 61-66 for Q20 in Appendix F.)

The majority of respondents by both sex and region attributed their mental health conditions to military service. (Please see Figures 69-70 for Q22 in Appendix F.)

Figure 37: What difficulties have you experienced in getting the care you needed?



Results

QUESTIONNAIRE SURVEY

Limitations

The questionnaire survey used a convenience sample, and, as such, it is limited by selection bias. It is designed to give an overview of what the community is thinking and feeling, and while it covers a wide range of topics and variables, the data are not exhaustive and are not meant to be predictive or imply causality. They are, rather, a description of the information recorded from the survey.

Results

TRIBAL PROVIDER INTERVIEWS

SCOPE:

In-depth structured interviews with Tribal providers from two Tribes; one structured interview with the VA office of Tribal Government Relations

Rede Group conducted individual interviews with members of the Confederated Tribes of the Grand Ronde Community of Oregon and Confederated Tribes of Warm Springs and the Chief of Mental Health and Homeless Operations for VISN 20. Rede Group also conducted an interview with members of the Office of Tribal Government Relations in Washington, D.C., whose role is to implement VA Tribal consultation policy, engage in activities that promote increased access to care and benefits for veterans living in Indian country, and engage in activities that promote economic sustainability for veterans living in Indian country.

Cultural competency

Interviewees from both the Grand Ronde and Warm Springs Tribes emphasized a need for culturally competent, on-reservation, veteran-led behavioral health and peer support services for Tribal veterans. They also identified possible reasons for underutilization of VHA services among Tribal veterans and suggested that Tribal veterans may be reluctant to seek help off-reservation due to historical distrust of government, as well as complicated claims processes. Additionally, Tribal veterans may prefer to remain on reservation for services due to the cultural respect they receive within their communities due to their veteran status.

Interviewees emphasized the importance of family involvement and incorporation of traditional culture in the healing process of veterans on reservations. Interviewees from both Tribes cited a preference for employing traditional means of healing, as well as the importance of being able to speak with someone who understands both Tribal and military culture (e.g., a Tribal veteran talking to another Tribal veteran), as the most important factors in care-seeking behavior among Tribal veterans.

“ Reservations are not prime property because they want them to be out of the way, so most reservations are out of the way from what has become veteran services in Portland and Vancouver. So I’m truly hoping these service officers on reservation will really make a difference for our veterans.”

— Tribal interviewee

“ Native Americans rely a lot on their families. It’s a different culture.”

— Tribal interviewee

Results

TRIBAL PROVIDER INTERVIEWS

Geographic accessibility

The imposed geographic isolation of many reservations can make the idea of accessing services through major VHA hubs, such as those in Portland and Vancouver, challenging and unappealing for Tribal veterans. One interviewee stressed the importance of having a Veteran Service Officer (VSO) directly on the reservation for veterans and their families to access without having to travel extensively.

Geographic isolation, lack of trust in government entities, culturally competent care, and myriad complexities of claims processes and the resulting frustrations were also echoed at the systems level as reasons why Native American veterans may be less likely to access care. All nine (Burns Paiute Tribe, Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians, Confederated Tribes of the Grand Ronde Community of Oregon, Confederated Tribes of Siletz Indians, Confederated Tribes of the Umatilla Indian Reservation, Confederated Tribes of Warm Springs, Coquille Indian Tribe, Cow Creek Band of Umpqua Tribe of Indians, and Klamath Tribes.) of the Tribes within Oregon have either an Indian Health Service unit or a Tribal health program with behavioral health services, but the rurality of much of VISN 20 creates difficulties for Tribal veterans getting to locations where veteran-specific behavioral health care is provided. Some Tribal veterans may, however, prefer the veteran-centric nature of the VHA and prefer to seek care through the VHA for personal reasons.

Veteran identity

While there are cultural competency trainings, summits, and programs available within VISN 20, both Tribal veterans and systems leaders reported the need for providers who are fluent in both veteran and Tribal culture. A Tribal veteran may feel as though their Tribal identity separates them from other veterans and may also feel their veteran status separates them from other Native Americans. These co-existing and sometimes competing identities, experiences, and cultural barriers may compound feelings of isolation among Tribal veterans.

“ [Mental health care for Tribal vets] should include a better understanding of how we lean or why we lean on our culture or our traditions, and then why it’s important to us to incorporate those as part of our healing.”

— Tribal interviewee

Results

NON-VHA PROVIDER INTERVIEWS

SCOPE:

Ten structured interviews with CCO/CMHP providers

Publicly funded non-VHA providers, such as CMHPs and CCOs, play an important role in serving veterans' behavioral health needs. Interviews with a sample of these organizations revealed several themes and narratives surrounding their approach and ability to serve veterans.

Importantly, no systemwide mandate or overarching policy or guidance exists for CMHPs and CCOs around serving veterans.

Veteran identification

Most interviewees (seven out of 10) had mechanisms in place to identify veterans:

- Five out of 10 documented veteran status in an electronic medical record
- Four out of 10 recorded veteran status at intake
- Three out of 10 documented veteran status for billing purposes
- Two out of 10 recorded status due to a MOTS requirement

Despite these documentation procedures, many agencies reported they would not be able to extract data to determine the number of veterans receiving services through their agencies.

PTSD treatment

All agencies interviewed for this study provide important services that could benefit veterans, such as assessment and treatment for PTSD, but none of these services are specific to veterans. In response to an open-ended question about PTSD treatments:

- Four out of 10 offer Eye Movement Desensitization and Reprocessing (EMDR) therapy.
- Three out of 10 offer cognitive processing therapy (CPT)
- Three out of 10 said their contractors provide PTSD treatment, but they were not specific about the type of therapy offered
- Two out of 10 provide PTSD medication management
- Other PTSD assessments/treatments infrequently mentioned included dialectical behavior therapy (DBT), PHQ-9 depression screening, and group and individual counseling

Military-specific provider training

Five out of 10 interviewees have employees who have undergone SBHP training, which is designed to train civilian behavioral health providers in military-specific content.

Results

NON-VHA PROVIDER INTERVIEWS

SBHP training is offered in select states to enhance behavioral health providers' scope of knowledge and skills for treating military service members, veterans, and their families with reintegration- and deployment-related concerns. Oregon is one of nine states that currently offers this training through a three-tiered process and maintains a registry through which trained providers can be located.³³ Searches by region found gaps in the availability of trained providers. For example, a search for providers within 40 miles of Portland found 10 providers, whereas a search for trained providers within 40 miles of Roseburg found zero.

While most interviewees provide services to diagnose and treat sexual trauma, no interviewees had counselors trained to screen and treat patients experiencing PTSD, SUD, major depression, or other mental health challenges as a result of military sexual trauma.

After-hours availability

All interviewees or their contractors offer services outside of normal business hours, defined as 8:00 am to 5:00 pm, Monday through Friday.

- Nine out of 10 agencies offer evening behavioral health counseling appointments
- Four out of 10 mentioned the availability of emergency behavioral health services through a 24/7 crisis team
- Four out of 10 said there is a 24/7 crisis line available
- Three out of 10 offer services on weekends

The ability of veterans to access these “off hours” service offerings, other than the crisis services, is largely dependent on whether or not the veteran meets the requirements of the CMHP funding streams. Not all CMHPs have received Certified Community Behavioral Health Clinic (CCBHC) designation, which requires those facilities to provide services to veterans.

“ They just really should open up their insurance to be able to let veterans get services wherever they are. I don't just mean mental health. I mean physical health, dental health, all that kind of stuff.”

— CMHP interviewee

notes:

33. Star Behavioral Health Providers. Retrieved from <https://starproviders.org/states/oregon>.

Results

NON-VHA PROVIDER INTERVIEWS

Barriers and challenges

In response to a request to identify barriers and challenges to serving veterans, most CCO interviewees reported they had difficulty identifying the barriers because their role is that of an insurance provider or manager of Medicaid funds, rather than a direct service provider.

- Four out of six CMHPs spoke about specific barriers in helping their clients access the VCP
- Four out of 10 interviewees said reimbursement limitations were a barrier. For example, two interviewees cited the inability to get reimbursed by the VHA for providing case management services

Interviewees also listed social and health inequities experienced by some veterans as barriers that can impact their ability to access behavioral health services:

- Three out of 10 said limited housing/homelessness is an issue
- Three out of 10 said transportation or long travel distances for receiving services is a concern
- Two out of 10 said some veterans don't want to go to the VHA or don't feel comfortable going to the VHA in order to receive behavioral health services

In response to an open-ended question about barriers and challenges to serving veterans, CCOs and CMHPs most frequently listed the following:

- Four out of 10 mentioned CCO and CMHP funding/eligibility limitations such as veterans not being eligible for services due to income level; limited funding or resources available to provide veteran services; and not being reimbursed for veterans if they are not Medicaid or Medicare eligible
- Three out of 10 said it is difficult to partner or coordinate services with the VHA
- Three out of 10 indicated there are limited referral resources for veterans

“ I keep hearing all the providers say ‘we do telehealth,’ and it’s becoming really widespread. When you’re limited on resources for our vets, it’s better than nothing, but you lose that one-on-one connection, that personal interaction. A lot of the veterans tell me they don’t like it. You’re also limited on the type of therapy you can do. I don’t know how comfortable I would be receiving EMDR services via telecom.”

—CMHP interviewee

Results

NON-VHA PROVIDER INTERVIEWS

- Two out of 10 said hiring and/or retaining providers who are veterans is difficult
- Two out of 10 said they have difficulty identifying the number of veterans they serve

Referrals and additional resources

In response to an open-ended question about referral resources for veterans, most interviewees were able to list at least a couple of resources to which they refer veterans who are in need of any type of additional social or medical/behavioral health services. However, a couple of interviewees were unable to list even a single referral resource supporting veterans. And some interviewees commented that many of the resources are not necessarily located within their CCO or CMHP service area. The resources most frequently listed were:

- Seven out of 10 interviewees listed VHA facilities (hospitals, CBOCs, or clinics)
- Five out of 10 interviewees were familiar with their local VSO
- Three out of 10 mentioned a local veterans support group
- Three out of 10 were familiar with veterans home/housing resources
- Two out of 10 mentioned one or more non-profit organizations serving veterans
- Two out of 10 listed a local Vet Center
- Other referral resources mentioned included:
 - Federally Qualified Health Centers
 - Crisis centers
 - County mental health services
 - University counseling programs
 - Elks Lodge transportation resources
 - Camp Rilea Armed Forces Training Center

In response to a questions about which additional services or needs veterans have that CCOs and CMHPs wish they could provide, interviewees reported the following:

- Four out of 10 interviewees stated they wished they could be reimbursed to provide a variety of behavioral health services to veterans

“ I wish we could get case management and peer stuff paid for, because they really do need help with housing and our support in an employment program, support in education. I mean, there’s a lot of things that we could do for them, but it just isn’t funded through the VA.”

—CMHP interviewee

Results

NON-VHA PROVIDER INTERVIEWS

- Four out of 10 said housing
- Four out of 10 said peer support
- Two out of 10 said they would like to provide case management to veterans
- Two out of 10 said they would like to have a mental health service provider who is also a veteran on staff
- Two out of 10 said they would like more referral options
- Two out of ten said they saw a need for employment and educational support programs for veterans
- Two out of 10 said they would like to be able to provide veteran-specific trainings for their providers
- Other additional services or needs listed included:
 - More therapists
 - Addiction treatment
 - More providers that offer EMDR
 - More services for older veterans who served prior to 9/11

CCBHC funding

Half of the interviewees (five out of 10) reported that their organization receives additional monies for participating in the CCBHC demonstration project. CCBHCs are designed to provide a comprehensive range of mental health and outpatient SUD services, particularly to vulnerable individuals with the most complex needs. Importantly, CCBHCs must offer services to members of the armed services and veterans, regardless of ability to pay. This ensures veterans who may not qualify for VA services due to discharge status or who may have other reasons for not engaging with federal VA health care will receive services.³⁴

“ It would be amazing if our local CCO could take on the risk and the responsibility for a veteran population by actually serving that population locally through our network. We have such an established local network for total health care, and it could solve the problem of the inadequacies of the VA system and where it’s located. If we could have some sort of local oversight to that benefit and to that delivery system, that would be the best.”

— CCO interviewee

notes:

34. For more information about CCBHC see <https://www.oregon.gov/oha/HSD/BHP/Pages/Community-BH-Clinics.aspx>.

Results

NON-VHA PROVIDER INTERVIEWS

Interviewees were asked to elaborate on what the CCBHC funding enabled them to do. The most common responses to this question were:

- Three out of five organizations hired additional staff
- Three out of five expanded access to services
- Two out of five provided additional staff with SBHP training
- Two out of five were able to reduce wait times for clients to get appointments
- One interviewee opened an additional satellite office
- One interviewee stated that the funding enabled them to improve communication and coordination of services with the VHA

Perhaps one of the most important findings from the non-VHA provider interviews was the almost across-the-board concern that veterans' behavioral health care needs are not being adequately met, sometimes regardless of who the service provider is, and that quality and access to care can look very different depending upon where a veteran lives. Veterans living in a community with a CCBHC, a VHA hospital, or a CBOC are likely to have an easier time accessing quality behavioral health services in comparison to veterans living in communities without these resources.

Despite the hurdles experienced by CMHPs and CCOs in providing behavioral health services to veterans, five out of 10 of the interviewees indicated that they will always strive to provide these services to veterans, regardless of the veteran's ability to pay or whether or not the agency will be reimbursed for the care through an insurance company.

“ Our local VA does not do EMDR or DBT therapy. They only do cognitive behavioral therapy and cognitive processing therapy. So a lot of times, the VA will refer the veterans out. That’s why I’ve gotten a lot of the vets, because of the toolbox I have. The issue is that people think the VA is doing all of these services for our vets. But not all VAs are equal. The services they provide are dependent on their funding streams and also where they are located.”

—CMHP interviewee

Results

FOCUS GROUPS

SCOPE:

Nine focus groups with 63 veteran participants across the state

Veterans in focus groups shared stories and perspectives of their experiences accessing and utilizing behavioral health services through the VHA and outside of the VHA system. Analysis of the focus group transcripts revealed several important themes in the information veterans shared.

Themes

Focus group participants reported a strong desire among veterans to achieve behavioral health wellness. According to the SAMHSA working definition, behavioral health recovery is catalyzed by hope—a holistic, culturally-influenced, peer-supported “process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”³⁵ Veterans interviewed through this study spoke persuasively about their desire to live meaningful lives and to support their communities and their families. Their descriptions of barriers to care or frustrations expressed over the quality of care (either through the VHA or outside of the VHA system) appeared to be fueled by a desire to receive care that would benefit their healing and transformation. In addition, interviewees articulated a desire to address issues in preventing, diagnosing, and treating behavioral health conditions so that future veterans could reap the benefits of an improvement in the health system.

Access issues

- Logistics
- Limited choice of provider
- Discomfort at VHA facilities
- Stigma

Quality of care issues

- Medication
- VHA staff
- Staff turnover
- LGBTQI unique needs
- Peer connections
- Latent trauma

notes:

35.U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2012). SAMHSA’s Working Definition of Recovery: 10 Guiding Principles of Recovery. Retrieved from <https://store.samhsa.gov/system/files/pep12-rec-def.pdf>.

Results

FOCUS GROUPS

Access issues

LOGISTICS

Veterans who had received behavioral health care, at least partially, through the VHA shared experiences with long wait times (many weeks, in some cases) and non-responses when seeking appointments. A lack of appointment times offered outside of work hours presented additional barriers.

Many interviewees reported geographic accessibility and drive time to appointments as a serious concern. Of interest is that this theme was borne out in the Portland area as well as the rural areas of the state. For example, interviewees noted that they must often drive from the greater Portland area to Vancouver for appointments—a commute that for them, in heavy traffic, can take more than an hour. Veterans living outside of the Portland area may be required to travel two to three hours for an appointment. Some focus group participants described the emotional toll of long commutes to appointments to be frustrating, a mental stress, and to exacerbate their PTSD.

LIMITED CHOICE OF PROVIDER

Struggling to find and develop a relationship with a behavioral health care provider surfaced as a strong theme in focus groups. Focus group participants expressed feelings of demoralization at their lack of choice in selecting a behavioral health care provider. Interviewees acknowledged the critical nature of the therapeutic relationship and the key role that trust plays in that relationship. However, when they were assigned a therapist with whom they had difficulty forming therapeutic connection, they felt they had no recourse because no other providers were available within the system. Several potentially important subthemes emerged from discussions about provider choice. First, combat veterans expressed difficulty forming connections with a therapist who had no combat experience or who demonstrated limited knowledge of the nature of war. This subtheme was particularly relevant for Vietnam War veterans, both male and female. Second, many interviewees identified a systemwide “one size fits all” approach as problematic and damaging to effective treatment. Interviewees felt the VHA was routing them through a progression of modalities and expressed doubts as to whether the steps in the progression (such as being required to take a mindfulness class prior to receiving individual counseling) were based on best practices for achieving wellness, or, rather, were cost saving measures. Finally, interviewees who had undergone counseling via video were very uncomfortable and dissatisfied with that service.

Results

FOCUS GROUPS

DISCOMFORT AT VHA FACILITIES

Some interviewees expressed feeling uncomfortable at VHA facilities as another barrier to accessing care. This theme was particularly true for female veterans with military sexual trauma, some who expressed discomfort or fear when waiting for appointments in facilities that were crowded with male veterans.

STIGMA

When talking about access to care, some interviewees pointed to cultural stigma around behavioral health issues as a barrier to seeking treatment (e.g., causing a delay in care-seeking or the decision not to seek care at all). Interviewees described stigma around behavioral health issues as being equated to a character flaw or personal weakness accompanied by a sense of shame around not being mentally or emotionally strong enough to cope. In addition, interviewees with military sexual trauma spoke about the stigma associated with being a victim of sexual violence and bearing the weight of that “label.”

The very act of acknowledging a behavioral health concern can be counterintuitive for military personnel who demonstrate and rely upon uncharacteristic strength throughout their military careers

Quality of Care Issues

MEDICATION

A belief veterans were being overmedicated for behavioral health conditions surfaced as a theme in focus groups among both men and women and across age groups. Some veterans expressed frustration over a “requirement” that they take medications as a prerequisite for receiving other therapies. Veterans who reported a preference for not taking medications, for example, perceived this requirement, as they understood it, as a reason to delay care-seeking or not to seek care at all.

“ I’m a Marine—I’m the helper, I’m the solver, I’m the fixer. I can’t have anything wrong with me. I know it came out of the culture I was in, and has helped me in some ways, but it’s really screwed me up in other ways because I’ve had problems for years and never addressed them.”

— Focus group participant

Results

FOCUS GROUPS

VHA STAFF

Many interviewees had experienced interactions with providers who seemed indifferent or less-than-engaged. This theme was stronger for women, who also noted that they had encountered minimizing or, in some cases, judgmental statements from providers. Interviewees in the LGBTQI focus group reported encounters with VHA staff who they described as discourteous or “rude,” a theme that only surfaced in this focus group. At the same time, some (albeit fewer) focus group participants identified VHA staff who treated them with respect, dignity, and determination to meet their needs. Focus group participants applauded these instances, reporting the ways in which such treatment could positively impact their ability to develop trust in the system and achieve their wellness goals.

VET CENTERS

Focus groups in Portland, Eugene, and Bend reported the important role of Vet Centers. Interviewees spoke about positive experiences with Vet Center counselors and programs and noted that some of the weaknesses in VHA facilities were instead met by Vet Centers.

STAFF TURNOVER

Across all groups, staff turnover in VHA facilities was a strong theme that greatly affected the quality of care. Participants described a revolving door of psychiatrists, therapists, and counselors and spoke despairingly of the difficulties presented by this rotation, such as an inability to build trust, extensive wait times for a new therapist, and interruptions in progress toward their goals. While this theme was stronger for men, it was definitely shared by women and LGBTQI veterans. Several women described experiences of being re-traumatized by the necessity of “constantly” having to reconvey traumatic events.

LGBTQI UNIQUE NEEDS

LGBTQI veterans described a system that was not situated to meet their unique needs. According to focus group participants, they have regularly encountered therapists and other providers who have no background, training, or experience with LGBTQI issues.

“ It’s too easy to be generalized [as LGBTQI]. None of us likes to be generalized. We have specific issues, and we want somebody that knows what we’re going through and can help us with them.”

— Focus group participant

Results

FOCUS GROUPS

PEER CONNECTIONS

Among the strongest themes across all focus groups was veterans' desire to connect with other veterans as a way to further their goals toward behavioral health wellness. Interviewees spoke to the healing power of connecting with other individuals, either in a provider or peer relationship, who had experienced military life, combat, or reintegration into civilian life. Many interviewees spoke to the expeditious building of trusting relationships that is possible when working with other veterans.

LATENT TRAUMA

During the course of the focus groups, several older interviewees described having recently (within the previous two years) personally acknowledged trauma associated with incidents from past decades that fall within the spectrum of military sexual trauma. These interviewees described situations where the effects of the traumatic incidents were not addressed, diagnosed, or treated at the time they occurred (during the 1970s, 1980s, and early 1990s), but, instead, the interviewees were honorably discharged to return to civilian life. They described a deep sense of shame over being discharged, and, given the cultural context at the time, they chose secrecy over disclosure about the trauma. Interviewees described the compounded

“ I have had therapy for almost 30 years through the VA and that wouldn't happen on the outside. I wouldn't be able to afford it if I wasn't a veteran.”

—Focus group participant

“ I'm just now learning to tell the truth and not try to tell a story to cover up. I'm doing it for other women, including my daughter-in-law, who just got out of the Army from Afghanistan and was raped. Didn't want to tell anyone.”

—Focus group participant

Results

FOCUS GROUPS

effects of the trauma and the secrecy (for decades, in some cases) as truly difficult. Because the cultural climate around sexual trauma has changed in the past two decades and continues to transform misconceptions of the causes of sexual harassment, aggression, and violence, more individuals may, in the future, acknowledge and seek treatment for military sexual trauma.

From the focus group interviews, veterans expressed a strong desire to achieve behavioral health wellness, to support their communities and families, and to improve behavioral health conditions for future veterans.

Interviewees noted that standing in their way of making progress were problems with access to services (e.g., long wait times to get an appointment, lack of after-hours or weekend appointments, long travel times to appointments, and lack of transportation). Additional barriers to progress identified by interviewees included a lack of choice of behavioral health providers; discomfort at VHA facilities; stigma around behavioral health problems; overreliance on medication; and indifferent staff, staff turnover, and a system that does not accommodate particular needs (e.g., those of LGBTQI veterans). Some interviewees also reported that the effects of latent trauma impacted their ability to access behavioral health services.

“ To try and send us out on the civilian side would be fine if, nationwide, doctors would be trained. No matter what kind of doctor you are, you’re going to deal with ex-military people.”

—Focus group participant

“ I started going to some groups, and you know, kinda found a little bit of my voice. Found out who maybe I was, who I wasn’t, and I’m very thankful for the opportunities that I have had.”

—Focus group participant

Results

FOCUS GROUPS

Interviewees also noted the importance and value of connecting with other veterans and of forming a therapeutic relationship with a behavioral health provider with whom they can relate.

“ I’m grateful that I had resources. I’ve done the MST group, the cognitive behavior therapy, and I’m working on DBT now. I absolutely can say that the VA saved my butt.”

—Focus group participant

“ I went 35 years with just being hard-headed. It’s sad that I had to go through 35 years. I can’t get them back. We got a lot of young guys doing their part. I’d like to see them taken care of and not go through what I went through.”

—Focus group participant

“ I was in the Navy, ship and aircraft repair in the late eighties and early nineties. I have PTSD, trauma, and sexual trauma. I don’t feel like they really know what to do with me...or us.”

—Focus group participant

A portrait of an older man with a blue tint, looking slightly to the right. He has a serious expression and is wearing a dark blue shirt. A small red horizontal line is positioned to the left of the word 'RECOMMENDATIONS'.

RECOMMENDATIONS

Recommendations

In consultation with OHA, the Rede Group developed a comprehensive set of recommendations from the findings of this report that can be implemented within the next one to five years to create measurable and achievable improvements in behavioral health care for Oregon veterans.

Veterans' role in designing systems improvements

FINDINGS

- Veterans exhibit a strong desire to achieve behavioral health and wellness and are likely to attribute at least some of their behavioral health conditions to military service. While many veterans express satisfaction with the care they have received, the efforts of some are stymied by issues with access to and quality of behavioral health care services provided to them, including: logistics, limited provider choice, discomfort at VHA facilities, stigma, medication, indifferent or less-than-engaged VHA staff, VHA staff turnover, unique needs of veteran subgroups, peer connections, and latent trauma related to military experiences (e.g. military sexual trauma, TBI)
- Veterans express a **strong** desire to improve behavioral health conditions for future veterans
- **Meaningful** engagement of individuals and communities experiencing health and wellness concerns builds trust and results in better solutions¹

RECOMMENDATIONS

1. Engaging individuals in finding solutions for their own health needs increases the credibility of results and improves the quality and patient-centered focus of care. Due to the unique experiences and behavioral health needs of veterans, OHA seeks to prioritize their input into the findings and recommendations of this report as an essential component of the implementation process. By October 2019, OHA should present this report to veterans at 15-25 small, community-based meetings convened in locations throughout Oregon. The purpose of these meetings should be:
 - To share report findings with veterans and their families to seek feedback
 - To provide a forum for local-level problem solving with key stakeholders, in addition to veterans, who support veterans services including: county veterans service offices, local VHA providers, Tribal health offices, county mental health authorities, CCOs, local mental health authorities, local public health authorities, and local housing authorities and experts
 - Special care must be taken to organize and structure meetings that are accessible to all veterans and designed to meet the special needs of women, LGBTQI, and Tribal veterans and veterans with military sexual trauma

notes:

1. Marson, Cicely, et al. (2016). "Community Participation for Transformative Action on Women's, Children's, and Adolescents' Health." Bulletin of the World Health Organization. 94(5). Retrieved from: <https://www.who.int/bulletin/volumes/94/5/15-168492/en/>
2. DeSalvo KB, et al (2017). Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century. Preventing Chronic Disease, 14:170017. Retrieved from https://www.cdc.gov/pcd/issues/2017/17_0017.htm

Recommendations

2. Expanding on its initiative to support veteran suicide prevention at the county level, by June 2020, OHA should consider a mechanism to fund additional innovative, cross-sector, community-level projects that are designed to bridge gaps in services found in this report. This pioneering initiative will engage community groups, caregivers, and local providers and put Oregon at the forefront of utilizing the current nationwide Public Health 3.0 framework² that emphasizes cross-sectoral collaboration to address social determinants—education, environment, housing, transportation, economic development, access to healthy foods—to improve veterans’ health outcomes and influence their ability to lead happy, healthy lives. OHA funding opportunities should be structured to fund start-up costs that support communities in evaluating and self-sustaining effective programs into the future

One example of a similar program is the California Department of Veterans Affairs Mental Health Grant Program for Counties that has provided funding to counties for local programs such as a live public television call-in program for veterans, free monthly legal clinics, and case management support (housing, benefits, employment) and peer mentorship for veterans pending, participating in, or exiting veteran treatment court

3. Because OHA and ODVA understand the critical role that representation of veteran subgroups in oversight, leadership, and evaluation of their initiatives plays in improving behavioral health care access for all veterans, by June 2020, the agencies should identify or establish a statewide veterans’ behavioral health commission which is chaired by a veteran and whose membership comprises at least 75% veterans:
 - 50% of whom live in rural or frontier counties in Oregon
 - 50% of whom are women
 - At least one of whom is a Tribal veteran
 - At least one of whom identifies as LGBTQI
 - At least 50% of whom have experienced a behavioral health condition or diagnosis

The commission should be tasked with:

- Reviewing this and other reports regarding veterans’ behavioral health to provide additional insights and guidance regarding implementing recommendations
- Providing ongoing consultation to the legislative and executive branches regarding veterans’ behavioral health issues
- Providing, at least biennially, an issue brief and recommendations regarding VHA services in Oregon to Oregon’s federal congressional delegation

Recommendations

Consistent and sustainable coordinated access

FINDINGS

- Oregon currently does not have an adequate number of providers to support the behavioral health needs of the state's veterans. The majority of the state—all but Clackamas, Washington, Yamhill, and most of Lane counties—is federally designated as a Mental Health Care Professional Shortage Area (HPSA).³ While there is no official federal HPSA designation type for veteran populations, this systemic provider shortage impacts veterans' ability to access quality behavioral health care. According to results of the questionnaire survey, more than half of Oregon veterans have difficulty finding a behavioral health provider who is a good fit. Interviews with VHA and non-VHA providers indicate insufficient numbers of sufficiently trained providers to support the behavioral health needs of veterans across the state. Additionally, veterans with mental health diagnoses are more likely to utilize non-mental health medical services, such as the emergency department. For example, veterans with a PTSD diagnosis are 55% more likely than those with no mental health diagnosis to utilize emergency services, putting stress on a system that lacks capacity and training to support their specific needs
- All of the VHA providers interviewed for this report identified recruitment and retention of qualified staff as a challenge, citing the following reasons:
 - Difficulty drawing and keeping staff in rural areas
 - Difficult VHA hiring process
 - Non-competitive salaries
 - Challenging patient population
 - Lack of affordable housing
- Challenges with recruitment and retention of VHA providers impacts both patients and staff, especially in rural areas. Veterans report that provider turnover makes development of safe therapeutic relationships difficult and can contribute to retraumatization for some veterans. Current understaffing of VHA facilities creates poor working conditions for existing staff
- The logistics of accessing services can be difficult and time-consuming for veterans. Many report experiences with long wait times to secure appointments, long commutes, and lack of transportation as barriers. For example, results of the questionnaire survey show that 60% of veterans identify finding or getting an appointment with a behavioral health care provider as a barrier to accessing care. Services are more accessible for those who qualify for (honorably discharged combat veterans or those with a diagnosis of military sexual trauma) and live within proximity to Vet Centers

notes:

3. Oregon Health Authority (2016). Map of Mental Health Care Professional Shortage Area by Designations by Type. Retrieved from <https://www.oregon.gov/oha/HPA/HP-PCO/Documents/2016-MH-HPSA-Map.pdf>

Recommendations

- Veterans who receive care through the VHA report slightly higher levels of satisfaction with services than those who receive care through other means, but veterans are also nearly as likely as not to report poor interactions with VHA staff
- Some veterans' trust in VHA behavioral health services has been undermined by a perception of a one-size-fits-all approach with an overreliance on pharmacological therapies and frustration that an inability to choose their own providers impacts their ability to build therapeutic relationships

RECOMMENDATIONS

4. Building on its robust collaborative relationship with the Portland VA Health Care System, OHA should continue to develop strong relationships with regional VA providers throughout VISN 20
5. OHA, ODVA, and Portland VA Health Care System are engaged in a bold, often logistically challenging movement to improve behavioral health care for veterans. However, in some cases, these agencies need not come together to reinvent the wheel but instead to adapt an existing blueprint for the specific needs of the veterans they collectively serve. The weeks and months following discharge from the military are a critical time for veterans, and thus, these agencies should collaborate to develop a comprehensive state- and federally-funded program to address veterans' needs through transition back to civilian life. Program plans should include a scalable pilot initiative with built-in process and outcome evaluation metrics. The goals of the program should include:
 - Develop systems to:
 - Identify individuals returning from active military duty to civilian life in Oregon
 - Offer those individuals behavioral health screening services upon their return to Oregon (as agencies with statewide jurisdiction, either OHA or ODVA must lead this activity, managing data on individual veterans)
 - Coordinate and deliver clinical services to veterans and their families using VHA services for those who qualify for them and Oregon's CCOs for those who qualify for Medicaid. To achieve this goal, OHA and ODVA must recognize that CCOs may need training and additional capacity to meet veterans' behavioral health needs, including:
 - Screening, diagnostics, and treatment for military sexual trauma
 - Treatment for military PTSD
 - Screening, diagnostics, and treatment for TBI and related disorders
 - Military cultural sensitivity training

Recommendations

- Train behavioral health providers with an emphasis on increasing the number and competency levels of those treating returning veterans
- Identify and conduct outreach to service members, veterans, friends and family, community members, and any professionals serving military populations
- Promote care-seeking by disseminating information about behavioral health services and recruiting veterans and their families into trainings and clinical services
- Support behavioral health safety nets for veterans, including CMHPs, through a reliable referral network, recognizing that CMHPs would need additional training and capacity to meet the unique needs of veterans including but not limited to: training in military culture, military sexual trauma, and PTSD medication management; systems in place to identify and track veteran clients; and additional funding or resources to serve veterans
- Link county and Tribal VSOs with local primary care providers to provide veterans who are seeking physical health care with additional access to education about availability of behavioral health services

One example of a similar program is the Welcome Back Veterans initiative—a national effort which funded Centers of Excellence at academic medical facilities to expand access and improve the quality of community-based mental health care for veterans and their families.

6. OHA, ODVA, and the VA Health Care Systems in Oregon should build on current successes in collaborative work to further increase state and federal agency coordination across behavioral health systems by emphasizing cross-agency and cross-sector strategies that will:
 - Ensure sufficient, and sufficiently trained, providers are accessible to veterans and that veterans have adequate opportunity to choose a provider
 - Ensure a timely, efficient, and effective referral process for veterans seeking behavioral health services
 - Emphasize and prioritize development of systems for emergency departments to coordinate veterans' behavioral health care and to facilitate linking veterans with the VHA

Outreach to improve access

FINDINGS

- Around half of male veterans and 40% of female veterans surveyed who felt they have needed but did not receive behavioral health services reported it was because they did not ask for help. One-third of veterans who felt they needed

Recommendations

but did not receive services reported it was because they felt uncomfortable or unsafe going for care, and one-quarter reported trying to get help but getting frustrated and giving up

Stigma around mental health and substance use is a major barrier to seeking behavioral health care for veterans. Stigma is embedded in military culture and communities-at-large and can be targeted at specific subgroups of veterans whose access to services may already be impacted by fear or discomfort in seeking services (e.g., women veterans, LGBTQI veterans)

RECOMMENDATIONS

7. OHA, ODVA, and the VA Health Care Systems in Oregon should collaborate to develop a cohesive, well-researched, and targeted education and outreach effort to destigmatize behavioral health issues and treatment using market tested, culturally-specific messages promoting care-seeking and demonstrating that Oregon is making veterans' behavioral health care a priority. While the use of a multimedia campaign shows promise, these efforts should be undertaken in conjunction with some combination of the above recommendations, as well as resources such as the VA's 24-hour telephone helpline. Minimally, the outreach effort should include:
 - Provider education focused on destigmatization of mental health diagnosis and treatment for primary care and behavioral health care providers
 - Mass communication with formative research testing conducted by a qualified contractor that includes rural, women, Tribal, African-American, LGBTQI, Latinx, and younger veteran subpopulations in all research and communications objectives
 - Programs highlighting and directing veterans to existing services
 - Outreach to community groups to stimulate conversation about efforts to destigmatize behavioral health issues at the local level

As a component of this effort, OHA and ODVA should collaborate on a one-stop website that provides veterans and their families with basic navigational support. Mass communications and other outreach efforts should universally direct interested parties to the website. OHA should rigorously evaluate the impacts of outreach and mass communications, including examination of:

- Reach to target audiences, including caregivers and community groups
- Website traffic
- Social media engagement
- Recall

Recommendations

Quality of care

FINDINGS

- Both veterans and providers identify peer relationships as an essential aspect of behavioral health services. Veterans report that peer relationships fast-track the therapeutic trust-building process. Veterans also report positive experiences with Vet Centers
- CCOs and CMHPs provide important services that could benefit veterans, such as assessment and treatment for PTSD, but none of these services are specific to veterans
- All CCOs and CMHPs interviewed described concerns about the level and quality of care available to veterans

RECOMMENDATIONS

8. Building on success with its existing framework for facilitating veteran-to-veteran behavioral health support in partnership with ODVA, OHA should continue to develop and fund quality peer support models with an emphasis on peer-led support groups and peer-to-peer “navigation support” for behavioral health care systems and services in all regions of the state. In addition, with resources, OHA should prioritize expanding culturally competent peer support for specific populations, including: rural Tribal, LGBTQI, combat, female, and aged-34-and-under veterans. Peer support programs supported by OHA should be rigorously evaluated, using relevant and reliable indicators that are co-developed with veterans. Evaluation results should be shared with veterans groups and used for quality improvement
9. As noted elsewhere, OHA should work with CCOs and CMHPs to collect veteran status data in Electronic Health Records. In addition, OHA should encourage and support CCOs in developing quality improvement strategies to improve access and behavioral health services for veterans

Cultural competency

FINDINGS

- Tribal veterans are impacted by historical distrust of government entities, imposed geographic isolation, and complex claims processes. Tribal representatives report a need for cultural competency in services, with an emphasis on a preference for traditional healing modalities and peer support as the most important factors in care-seeking behavior for Tribal veterans

Recommendations

- Variances exist in the specific needs and expectations of subgroups of veterans (e.g., age, gender, LGBTQI identity, etc.) that impact how those veterans seek care. For example, LGBTQI veterans report at more than twice the proportion of non-LGBTQI veterans not seeking care through the VHA because of feeling uncomfortable or unsafe and not liking the care they received. Tribal representatives report that Tribal combat veterans benefit the most from peer or provider relationships with other Tribal combat veterans
- Some women veterans report that they are met with bias affecting their care when interfacing with VA Health Care facilities, including assumptions that they are not veterans (and are present on behalf of a family member) or that they did not serve in combat roles and, therefore, do not require the same level of care

RECOMMENDATIONS

10. The VHA and Vet Centers should promulgate plans to build capacity for cultural competency practices with measurable objectives that address the unique needs of groups of veterans, including, but not limited to, LGBTQI, African-American, and Tribal veterans, and veterans with military sexual trauma. Specifically:
 - Establish expectations for treatment of women in VA Health Care facilities that presumes equality with male veterans
 - Evaluate the discrete needs of LGBTQI, Tribal, and African-American veterans
 - Perform a critical analysis of provider trainings (such as Do Ask, Do Tell) currently promulgated by the VHA to improve services and environments for specific populations to ensure alignment with Oregon's commitment to health equity
 - Contract with one or more of Oregon's Regional Health Equity Coalitions to support cultural competency and develop approaches to addressing systemic, institutional racism, classism, sexism, and homophobia

Provider outreach

FINDINGS

- The availability of publicly-funded non-VHA providers who are trained in the knowledge and skills to screen for and/or treat concerns specific to veterans and their families is limited, particularly in rural areas

Recommendations

RECOMMENDATIONS

11. Collaborating to increase the number of non-VHA providers with training in military or veterans' behavioral health issues will allow OHA and ODVA to enhance veterans' access to providers with the skills to identify them and their needs and to provide military trauma informed services. The roll out of an effort to improve the availability of trained providers should include a pilot program to prioritize emergency departments and CCO providers with plans for statewide scalability
12. OHA should conduct a review of evidence-based programs, such as the Star Behavioral Health Providers training, to offer providers a menu of programs that meet their needs and provide them with the skills and tools to meet the unique needs of veterans, including, at a minimum, providing culturally relevant care to individuals with military PTSD, TBI, and military sexual trauma. OHA should also establish objective metrics for increasing the number of trained providers and evaluating progress toward meeting objectives

Data and research

FINDINGS

- Some veterans' behavioral health outcomes, when compared to those of non-veterans, are counterintuitive when considered in light of differences (or lack thereof) in behavioral health characteristics between the two groups. For example:
 - Veterans are more likely to have health insurance and to use health care services than non-veterans
 - Veterans are less likely than non-veterans to report they have been told they have depression but more likely to die by suicide
 - Veterans and non-veterans have similar tobacco and alcohol use, but veterans are more likely to die in opioid-affiliated occurrences
- Publicly funded non-VHA providers do not have comprehensive systems in place to identify veterans. For example, according to OHA⁴, a veteran status identifier is not included in the Medicaid enrollment data. Some data are collected for public databases, such as the MOTs. However, OHA lacks the ability to access the aggregated data in a meaningful way. This significant gap in access to quality data about veterans' behavioral health impacts the state's ability to evaluate improvements in behavioral health systems
- More research into behavioral health conditions and treatments for veterans with OTH discharge status is necessary in order to adequately serve this group. However, without adequate data to identify these veterans and their care-seeking trends, it will be difficult to assess and address their specific needs

notes:

4. Brennan, G. and C Coon. (2018, October 23). Personal interview.

Recommendations

VHA providers report administrative and other challenges with the purchased and referred care systems. Providers at individual VHA facilities also report they are unable to provide some services that are considered essential to best practices for veterans' behavioral health care

RECOMMENDATIONS

13. OHA should further investigate age-specific trends in substance use and other suicide and opioid mortality risk factors, specifically in veterans aged 34 and younger, with the understanding that epidemiological data about this age group, such as information about health care and behavioral risk factors, will be difficult (and possibly costly) to obtain. In addition, OHA should continue to monitor suicide rates for men aged 75 and older. Relevant findings should be applied to efforts outlined in the “Special Considerations: Suicide” section of these recommendations
14. The state has an important and necessary responsibility to collect the data that allows its veterans to receive the highest quality, most appropriate care for their behavioral health needs. Thus, OHA should establish data systems to routinely gather health status, behavioral health, and health care information about Oregon's veterans, with particular attention paid to those at greater risk due to social determinants of health. Specifically:
 - Require all CCOs to document the veteran status of all patients aged 18 and over
 - Require all county health departments and county mental health departments that provide direct service to document the veteran status of all patients aged 18 and older
 - Ensure that barriers to gathering client data, such as fear of refusal of service, are systematically addressed
 - Encourage adoption of a standard for routinely collecting patients' veteran status across the entire behavioral health care system
 - Include veteran status variable in state-level Medicaid datasets and the APAC Databases
 - Address barriers within OHA to timely access of data from OHA's data systems
 - Ensure that OHA has the ability to fully utilize data from the NSDUH by one or both of the following actions:
 - Develop staff capacity within OHA to analyze and report NSDUH data
 - Develop contracts with non-government agencies that can perform as designate agents with the Federal Statistics Regional Data Center

Recommendations

As the aforementioned data systems are developed and operationalized, and until data are available from them, develop a long term (five-year) agreement with a contractor to routinely collect data about behavioral health risk factors, access, and quality of care, including an annual Oregon veterans behavioral health questionnaire survey, using available technology. Utilize information from data collection efforts to track trends and identify needs for systems improvements

15. The VA should establish a federally mandated method for monitoring the effects of changes in purchased and referred care such as the VCP. Areas of inquiry should include an analysis of whether or not administrative issues present a barrier to non-VHA providers who may otherwise be qualified or interested in serving veterans. Identified barriers should be addressed to ensure that community-level providers are available to veterans

Special considerations: Suicide

FINDINGS:

- Veterans are at greater risk of suicide mortality than the general population
- Veterans aged 18-34 are at the highest risk for suicide in Oregon and are more vulnerable the more recently they have been discharged from service. Evidence suggests veterans with social ties are less likely to commit suicide
- Though veterans aged 75 and older are no longer at the highest risk for suicide, the behavioral health of this older population remains an important consideration; the majority of veterans are aged 65 and older, meaning that this age group represents a larger number of veterans potentially at risk

RECOMMENDATIONS:

16. Starting with the current culturally appropriate, evidence-based suicide prevention trainings already in development, OHA and ODVA should continue efforts to improve and coordinate suicide prevention programs specific to the veteran population pursuant to current strategic initiative articulated in:
 - VA's National Strategy for Preventing Veteran Suicide
 - Oregon Public Health State Health Improvement Plan
17. Recognizing the critical role of innovation in problem solving and systems change, OHA, ODVA and VA Health Care Systems in Oregon are encouraged to seek out and embrace promising innovative practices. Innovation in approach can create low cost, high impact holistic solutions that optimally serve veterans and create new multi-sector, public-private allies in prioritizing their well-being. OHA and ODVA could, for example, collaborate to develop artist-in-residence

Recommendations

programs with the intention of decreasing suicide risk by exploring creative solutions to welcome returning veterans home and assist their transition back into their communities. Potential funding mechanisms include private donations, state or city endowments, or a matching program from multiple sources. OHA and ODVA could engage organizations such as the Regional Arts and Culture Council (RACC) and the Oregon Arts Commission as partners and advisors and may seek to pilot such an initiative within an existing framework such as the RACC Public Art Residencies Intersections Program.

Many national and local precedents exist for partnering artists interested in socially engaged practices with service-based or municipal organizations to approach pressing issues with a new perspective. An example of a similar program is the New York City Public Artists-in-Residence program, which has facilitated partnerships between artists and the Department of Veterans Services to spur conversation about violence, trauma, and survival among veterans and non-veterans through performance and to foster community among women and LGBTQI veterans through local conferences, potluck dinners, and classes

Special considerations: Military sexual trauma

FINDINGS

Veterans' capacity for care-seeking is impacted by both a military culture of behavioral health stigma and the effects of trauma. In older female veterans especially, the effects of long-held trauma and related secrecy are compounded. Female veterans with military sexual trauma report discomfort or fear at VHA facilities, and providers report a need for more community-based, gender-specific care options, especially for treating veterans experiencing military sexual trauma. Both male and female veterans experience military sexual trauma, however, a high percentage (at least 50%) of female veterans in Oregon have experienced military sexual trauma. There are no inpatient military sexual trauma treatment programs within the state, and female veterans report in greater proportion than male veterans feeling that they have needed behavioral health services and did not receive them. Results of focus groups with women veterans suggest they may be more likely to seek treatment for latent military sexual trauma given the current social climate, which encourages sharing stories of sexual assault. Oregon should ensure system-wide capacity for an increase in individuals seeking treatment for military sexual trauma

Recommendations

RECOMMENDATIONS

- 18.** OHA, ODVA, and the VA Health Care Systems in Oregon should improve access to treatment for military sexual trauma, including:
- The VHA and Vet Centers should configure clinical spaces and intake processes that are comfortable for individuals with military sexual trauma
 - OHA should develop programs to increase the number of providers throughout Oregon who are specially trained to identify and treat military sexual trauma, including ensuring the availability of female providers with military sexual trauma identification and treatment training at all CCOs and Title X of the Public Health Service Act providers
 - The VHA, OHA, and ODVA should collaborate to increase availability and accessibility to appropriate inpatient treatment for women with military sexual trauma who require more intensive support, including conducting a cost analysis study for establishing an inpatient option in Oregon for women or that provides separate programs for men and women and adheres to VA guidelines for separate sleeping areas

Special considerations: Housing

FINDINGS

- Homelessness and housing insecurity are serious concerns in Oregon's veteran population. More than 1,300 veterans are estimated to be homeless in Oregon on any given night, with many more at risk of homelessness due to poverty, lack of support networks, and poor living conditions⁵
- Key informants from the VHA, CMHPs, and CCOs interviewed for this report identified housing insecurity and homelessness as a serious challenge in providing care to veterans
- The stability, quality, safety, and affordability of housing affects health outcomes at the individual and population levels

RECOMMENDATIONS

- 19.** Like all social determinants of health, housing must be a consideration in efforts to improve behavioral health outcomes. ODVA, OHA, and the VA Health Care Systems in Oregon all support or provide resources and information for veterans experiencing homelessness; in addition, OHA should continue efforts (building on current work with CCOs) to prevent housing insecurity and homelessness, systemically

notes:

5. Oregon Department of Veterans' Affairs. Retrieved from: <https://www.oregon.gov/odva/Resources/Pages/Homeless-Veterans.aspx>



APPENDIX



Appendix

- A.** Behavioral Risk Factor Surveillance System Tables
- B.** VHA Providers Interviewed
- C.** VHA Provider Interview Guide
- D.** Questionnaire Survey Instrument
- E.** Questionnaire Survey Logic Pattern
- F.** Questionnaire Survey Charts
- G.** Non-VHA Providers Interviewed
- H.** Non-VHA Provider Interview Guide
- I.** List of Tribal Interviews
- J.** Tribal Interview Guide
- K.** Overview of Focus Group Participants
- L.** Focus Group Interview Guide
- M.** Literature Review
- N.** Death Certificate and Vital Statistics Suicide and Opioid Data Tables

APPENDIX A

Behavioral Risk Factor Surveillance System (2016) Tables

Note: Veteran status from the question: Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit?

Table 1. Oregon BRFSS (2016)
Gender by Veteran Status

Gender	Veteran Status	
	Yes (N = 1,220)	No (N = 7,374)
Male	91.9	42.8
Female	8.1	57.2

Note: Numbers in the table represent the percentage of respondents
Note: p < 0.001

Table 2. Oregon BRFSS (2016)
Marital Status by Veteran Status

Marital Status	Veteran Status	
	Yes (N = 1,213)	No (N = 7,282)
Married	60.1	50.9
Divorced	19.1	12.3
Widowed	8.7	6.3
Separated	1.2	2.0
Never married	8.9	22.3
Member of an unmarried couple	1.8	5.4
Member of Registered Domestic Partnership	0.3	0.8

Note: Numbers in the table represent the percentage of respondents
Note: p < 0.001

Table 3. Oregon BRFSS (2016)
Employment Status by Veteran Status

Employment Status	Veteran Status	
	Yes (N = 1,209)	No (N = 7,284)
Employed for wages	33.6	47.7
Self-employed	5.9	9.5
Out of work for 1 year or more	2.4	2.3
Out of work for less than one year	1.6	3.4
Homemaker	0.8	7.2
Student	1.7	6.2
Retired	48.1	17.5
Unable to work	5.9	6.2

Note: Numbers in the table represent the percentage of respondents
Note: p < 0.001

Table 5. Oregon BRFSS (2016)
Age by Veteran Status

	Veteran Status	
	Yes (N = 1,204)	No (N = 7,251)
Age (average)	60.6	46.5

Note: p < 0.001

Table 6. Oregon BRFSS (2016)
Have any Kind of Health Insurance by Veteran Status

Have Health Insurance	Veteran Status	
	Yes (N = 1,214)	No (N = 7,337)
Yes	96.6	90.0
No	3.4	10.0

Note: Numbers in the table represent the percentage of respondents

Note: p < 0.001

Table 7. Oregon BRFSS (2016)
Past 12 Months Did Not See Provider due to Cost by Veteran Status

Did Not See Provider	Veteran Status	
	Yes (N = 1,214)	No (N = 7,349)
Yes	5.4	12.2
No	94.6	87.8

Note: Numbers in the table represent the percentage of respondents

Note: p < 0.001

Table 10. Oregon BRFSS (2016)
Smoking Status (Now) by Veteran Status

Smoking Status (Now)	Veteran Status	
	Yes (N = 694)	No (N = 2,766)
Every day	22.4	29.0
Some days	7.0	10.8
Not at all	70.6	60.2

Note: Numbers in the table represent the percentage of respondents

Note: p < 0.001

Table 11. Oregon BRFSS (2016)
Smokeless Tobacco Status (Now) by Veteran Status

Smokeless Tobacco Status (Now)	Veteran Status	
	Yes (N = 1,157)	No (N = 6,869)
Every day	2.3	2.3
Some days	2.7	1.8
Not at all	95.0	95.9

Note: Use of chewing tobacco, snuff, or snuss

Note: Numbers in the table represent the percentage of respondents

Note: p = 0.249

Table 12. Oregon BRFSS (2016)
Alcohol Use in Past 30 Days by Veteran Status

Alcohol Use in Past 30 Days	Veteran Status	
	Yes (N = 1,112)	No (N = 6,667)
Yes	60.4	60.2
No	39.6	39.8

Note: At least one drink of alcohol in the past 30 days

Note: Numbers in the table represent the percentage of respondents

Note: p = 0.900

Table 13. Oregon BRFSS (2016)
Heavy Drinking by Veteran Status

Heavy Drinking	Veteran Status	
	Yes (N = 1,106)	No (N = 6,585)
No	93.8	92.2
Yes	6.2	0.8

Note: Adult men having more than two drinks per day and adult women having more than one drink per day

Note: Numbers in the table represent the percentage of respondents

Note: p = 0.095

Table 14. Oregon BRFSS (2016)
Binge Drinking by Veteran Status

Binge Drinking	Veteran Status	
	Yes (N = 1,107)	No (N = 6,622)
No	87.9	82.7
Yes	12.1	17.3

Note: Males having five or more drinks on one occasion and females having four or more drinks on one occasion

Note: Numbers in the table represent the percentage of respondents

Note: p < 0.001

Table 17. Oregon BRFSS (2016)
Depression by Veteran Status

Depression	Veteran Status	
	Yes (N = 1,213)	No (N = 7,336)
Yes	18.1	25.4
No	81.9	74.6

Note: Ever told have a depressive disorder including depression, major depression, dysthymia, or minor depression

Note: Numbers in the table represent the percentage of respondents

Note: $p < 0.001$

Table 19. Oregon BRFSS (2016)
Physical Health by Veteran Status

Days During Past 30 Days Physical Health Was Not Good	Veteran Status	
	Yes (N = 1,183)	No (N = 7,167)
Days (average)	5.4	4.0

Note: Thinking about physical health, which includes physical illness and injury, how many days during the past 30 days physical health was not good

Note: $p < 0.001$

Table 20. Oregon BRFSS (2016)
Mental Health by Veteran Status

Days During Past 30 Days Mental Health Was Not Good	Veteran Status	
	Yes (N = 1,193)	No (N = 7,240)
Days (average)	3.3	4.5

Note: Thinking about mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days mental health was not good

Note: $p < 0.001$

Table 21. Oregon BRFSS (2016)
Physical or Mental Health Kept From Doing Usual Activities by Veteran Status

Days During Past 30 Days Kept From Doing Usual Activities	Veteran Status	
	Yes (N = 589)	No (N = 4,265)
Days (average)	6.7	4.7

Note: During the past 30 days, for about how many days poor physical or mental health keep from doing your usual activities, such as self-care, work, or recreation

Note: $p < 0.001$

APPENDIX B
VHA Providers Interviewed

VHA Facility Interviewed	Catchment Area	VHA Facilities Discussed in the Interview
Portland VA Health Care System	Portland	<ol style="list-style-type: none"> 1. Portland VA Health Care System 2. Bend CBOC 3. Fairview CBOC 4. Hillsboro CBOC 5. Lincoln City Clinic 6. Loren R. Kaufman VA clinic (The Dalles) 7. North Coast CBOC 8. Salem CBOC 9. West Linn CBOC 10. Newport Clinic
Salem CBOC	Portland	<ol style="list-style-type: none"> 1. Salem CBOC
Portland Vet Center	Portland	<ol style="list-style-type: none"> 1. Portland Vet Center
Central Oregon Vet Center	Portland	<ol style="list-style-type: none"> 1. Central Oregon Vet Center
Roseburg VA Medical Center	Roseburg	<ol style="list-style-type: none"> 1. Roseburg VA Medical Center 2. Brookings CBOC 3. Eugene Healthcare Center 4. North Bend CBOC
Brooking CBOC	Roseburg	<ol style="list-style-type: none"> 1. Brookings CBOC
North Bend CBOC	Roseburg	<ol style="list-style-type: none"> 1. North Bend CBOC
Eugene Vet Center	Roseburg	<ol style="list-style-type: none"> 1. Eugene Vet Center
Jonathan M. Wainwright Memorial VA Medical Center	Walla Walla	<ol style="list-style-type: none"> 1. Walla Walla VA Medical Center 2. La Grande CBOC 3. Morrow County VA Telehealth Clinic 4. Wallowa County Telehealth Clinic
White City VA Medical Center/VA Southern Oregon Rehabilitation Center	White City	<ol style="list-style-type: none"> 1. White City VA Medical Center 2. Grants Pass CBOC 3. Klamath Falls CBOC
Grants Pass Vet Center	White City	<ol style="list-style-type: none"> 1. Grants Pass Vet Center

APPENDIX C

VHA Provider Interview Guide

Veterans Behavioral Health Services Improvement Project

Veterans Health Administration Facility:

Survey Participants:

- 1.
- 2.
- 3.

Introduction:

The Rede Group, at the request of the Oregon Health Authority and the Oregon Department of Veterans' Affairs, is conducting a statewide study regarding the delivery and use of, and barriers and access to, behavioral health service for veterans. Research indicates that veterans often struggle with issues pertaining to mental health, substance abuse, and other behavioral health challenges. This survey is a part of a project to understand strengths and weaknesses in access to behavioral health services offered to Oregon vets, and make recommendations to improve access and reduce barriers among veterans accessing services. The Rede Group will be asking questions regarding services your health facility provides for specific behavioral health services that are outlined in the VHA Uniform Mental Health Services in VA Medical Centers and Clinics Handbook.

This interview will take no more than 60 minutes. We will be taking notes and recording the interview so that we can analyze the information in our report to OHA and ODVA. The recording will not be shared with anyone outside of the Rede Group and will only be used as a reference to verifying information in our notes and for accuracy of reporting. The final report will be made available to you. Your comments today will not be attributed to you in the report, nor will they be shared with the Oregon Department of Veterans' Affairs. We will not attribute any information to you in the report, and will only include your name as a person interviewed if we receive your permission to do so. Do you mind if we record the interview?

Because we have 60 minutes to cover a wide range of available services, there may be times when I ask that we move onto another question and I may interrupt you to do so. Please know that this is not intended to be rude, but rather to ensure that we cover all questions in the survey.

Do you have any questions before we begin?

In this interview we would like to gather as much information as we can about behavioral health services provided at the _____ facility.

The following questions are about the behavioral health services your health facility provides. I will first ask a few open-ended questions about challenges and weaknesses in service delivery. Then I'll move on to asking questions about providing a particular behavioral health service, and then I will ask a series of more specific questions about those services. Let's go ahead and get started.

Survey Questions:

1. What do you feel your greatest weaknesses are in terms of being able to provide quality behavioral health care to veterans in your community?
2. What are the most challenging aspects of providing care?
3. Are there services that you wish you were able to provide but currently don't or aren't able to?
4. Is there any other information you feel it would be useful for us to have in terms of where and why gaps in services exist?

Now I'll ask questions regarding the specific behavioral health services offered at facilities in the _____ CBOC / Clinic / Vet Center.

5. (For CBOCs) Does this facility qualify as a very large, large, mid-size or small CBOC?
 1. Very large (more than 10,000 unique veterans each year)
 2. Large (5000-10,000 veterans)
 3. Mid-size (1500-5000 veterans)
 4. Small (fewer than 1500 veterans)

(1) How many unique veterans does this facility serve per year?

5a. Does the _____ facility provide services for substance use disorders (SUD)?

Yes No Unsure

(1) **If no**, what is your referral process if a patient comes in needing these services?

5b. Does the _____ facility provide pharmacotherapy/medication for SUD?

Yes No Unsure

(1) **If no**, what is your referral process if a patient requires these services?

5c. Does the _____ facility provide individualized counseling services for SUD?

Yes No Unsure

(1) **If yes**, is gender-specific counseling available (e.g. female counselors for female clients)?

(a) **If no**, what is your referral process if a patient comes in needing to see a counselor of the same gender?

(2) **If yes**, how many individual sessions are clients allocated?

(3) **If no**, what is your referral process if a patient requires these services?

5d. Does the _____ facility provide group counseling services for SUD?

Yes No Unsure

(1) **If yes**, is gender-specific group counseling available (e.g. women only group counseling)?

(2) **If yes**, how many group sessions are clients allocated?

(3) **If no**, what is your referral process if a patient requires these services?

5e. What is your referral process if a patient needs either short- or long-term inpatient residential treatment for SUD?

(1) Where are the closest residential treatment facilities?

5f. Does the _____ facility provide services for opioid withdrawal, stabilization, and treatment?

Yes No Unsure

(1) **If no**, what is your referral process if a patient comes in needing these services?

5g. Do you screen patients for tobacco use?

Yes No Unsure

(1) **If yes**, how often (e.g., at initial intake, annually, at every visit, etc.)

5h. Does your facility offer nicotine addiction treatment?

Yes No Unsure

(1) **If yes**, with or without counseling?

5g. Are there any additional services offered to patients who are identified as having SUDs?

6. Does the _____ facility provide assessment, treatment, and services for post-traumatic stress disorder (PTSD)?

Yes No Unsure

(1) **If no**, what is your referral process if a patient requires these services?

6a. Does the _____ facility provide pharmacotherapy/medication for PTSD?

Yes No Unsure

(1) **If no**, what is your referral process if a patient comes in needing these services?

6b. Does the _____ facility provide individualized counseling services for PTSD?

Yes No Unsure

(1) **If yes**, is gender-specific counseling available (e.g. female counselors for female clients)?

(a) **If no**, what is your referral process if a patient comes in needing to see a counselor of the same gender?

(2) **If no**, what is your referral process if a patient requires these services?

(3) Have your counselors been trained specifically on the understanding, treatment, and management of patients who are experiencing PTSD?

6c. Does the _____ facility provide group counseling services for PTSD?

Yes No Unsure

(1) **If yes**, is gender-specific group counseling available (e.g. women-only group counseling)?

(a) **If no**, what is your referral process if a patient need gender-specific group counseling?

(2) **If no**, what is your referral process if a patient requires these services?

6d. What is your referral process if a patient needs either short- or long-term inpatient residential treatment for PTSD?

(1) Where are the closest residential treatment facilities?

7. Does the _____ facility provide diagnosis, assessment, and evaluation of Traumatic Brain Injury (TBI) and co-occurring conditions?

Yes No Unsure

(1) **If no**, what is your referral process if a patient requires these services?

8. Does the _____ facility provide services for suicide assessment, intervention, and management?

Yes No Unsure

(1) **If no**, what is your referral process if a patient requires these services?

8a. Does the _____ facility provide pharmacotherapy/medication for patients at risk for suicide (antidepressants, antipsychotics, etc.)?

Yes No Unsure

(1) **If no**, what is your referral process if a patient requires these services?

8b. Does the _____ facility provide psychotherapy and counseling services for patients at risk for suicide?

Yes No Unsure

(1) **If no**, what is your referral process if a patient requires these services?

8c. Does the _____ facility provide follow-up services for patients at risk for suicide, including phone contact, case management, and/or home visits?

Yes No Unsure

(1) **If no**, what is your referral process if a patient requires these services?

8d. Do counselors receive ongoing suicide assessment, prevention, and intervention training and educational opportunities? Are these trainings mandatory for counselors?

(1) **If yes**, can you describe what trainings are available and how often?

8e. Assuming secured, inpatient care isn't available in-house, what is your referral process for veterans who require hospital admissions for a mental disorder or an acute psychiatric crises?

8f. Does the _____ facility have agreements with appropriate agencies or hospitals to allow them to arrange for involuntary hospitalization where appropriate?

Yes No Unsure

8g. Does the _____ facility have procedures in place to facilitate access to national suicide prevention hotlines when appropriate?

Yes No Unsure

8h. How are services provided on evenings, weekends, or outside of normal business hours?

(1) Do you have procedures in place for responding to mental health emergencies when they occur during times of operation?

9. Have counselors at the _____ facility been trained to screen and treat patients who are experiencing PTSD, SUD, major depression, or other mental health challenges as a result of Military Sexual Trauma (MST)? What is the training process?

Yes No Unsure

(1) **If yes**, can you please describe the protocol for screening, advising, and assisting with behavioral health issues arising from or related to MST?

(2) **If yes**, are gender-specific services available (e.g. female counselors for female clients, or male counselors for male clients)?

(a) **If no**, what is your referral process if a patient comes in needing to see a counselor of the same gender?

(3) **If no**, what is your referral process if a patient requires these services?

9a. Do counselors receive ongoing training and educational opportunities for screening, treatment, and management of co-occurring mental health issues related to MST? Is ongoing MST training mandatory for mental health providers?

(1) **If yes**, can you describe what trainings are available and how often?

9b. What is your referral process if a patient needs either short- or long-term inpatient residential programs with specialized MST treatment to assist Veterans with recovery from MST?

(1) Where are the closest residential treatment facilities?

9c. Does the _____ facility have specialized outpatient mental health services focusing specifically on sexual trauma?

Yes No Unsure

(1) **If no**, what is your referral process if a patient requires these services?

9d. Does the _____ facility have specially trained sexual trauma counselors?

Yes No Unsure

9e. Does the _____ facility have a designated contact person for MST-related issues?

Yes No Unsure

10. Does the _____ facility provide services for depression?

Yes No Unsure

(1) **If no**, what is your referral process if a patient requires these services?

10a. Does the _____ facility provide pharmacotherapy/medication for depression?

Yes No Unsure

(1) **If no**, what is your referral process if a patient requires these services?

10b. Does the _____ facility provide individualized counseling services for depression?

Yes No Unsure

(1) **If yes**, is gender-specific counseling available (e.g. female counselors for female clients)?

(a) **If no**, what is your referral process if a patient comes in needing to see a counselor of the same gender?

(2) **If yes**, how many individual sessions are clients allocated?

(3) **If no**, what is your referral process if a patient requires these services?

10c. Does the _____ facility provide group counseling services for depression?

Yes No Unsure

(1) **If yes**, is gender-specific group counseling available (e.g. women only group counseling)?

(a) **If no**, what is your referral process if a patient comes in needs gender-specific group counseling?

(2) **If yes**, how many group sessions are clients allocated? What is the frequency of meetings?

(3) **If no**, what is your referral process if a patient requires these services?

(Readjustment Counseling Services questions, for Vet Centers)

11. Does the facility provide readjustment counseling and outreach services to all Veterans and their families?

Yes No Unsure

(1) **If no**, are services offered only to combat veterans?

11a. Does the facility provide individualized readjustment counseling services (RCS) for Vets and their families?

Yes No Unsure

(1) **If yes**, is gender-specific counseling available (e.g. female counselors for female clients)?

(2) **If no**, what is your referral process if a patient needs to see a counselor of the same gender?

(3) **If yes**, how many individual sessions are clients allocated?

(4) **If no**, what is your referral process if a patient requires these services?

11b. Does the facility provide group military readjustment counseling services for Vets and their families?

Yes No Unsure

(1) **If yes**, is gender-specific group counseling available (e.g. women only group counseling)?

(a) **If no**, what is your referral process if a patient needs gender-specific group counseling?

(2) **If yes**, how many group sessions are clients allocated?

(3) **If no**, what is your referral process if a patient requires these services?

11c. Does the facility provide bereavement counseling for families who experience an active duty death?

Yes No Unsure

12. How does this facility provide or facilitate opportunities for family involvement, education, consultation in veterans' care?

13. Please describe any difficulties you've had in hiring and/or retaining qualified, trained, competent behavioral health providers.

13a. Do all staff who are not veterans receive training about military and veterans' culture?

14. We recognize that local and regional issues may affect the provision and implementation of certain behavioral health services. Please describe any challenges your facility/facilities has had with the following:

- a. Space limitations within VA facilities
- b. Lack of availability in certain regions of mental health clinicians who could be recruited to the VA
- c. Difficulties in meeting information technology needs
- d. Distances for patient travel
- e. Limitations in the availability of community-based providers who could provide services

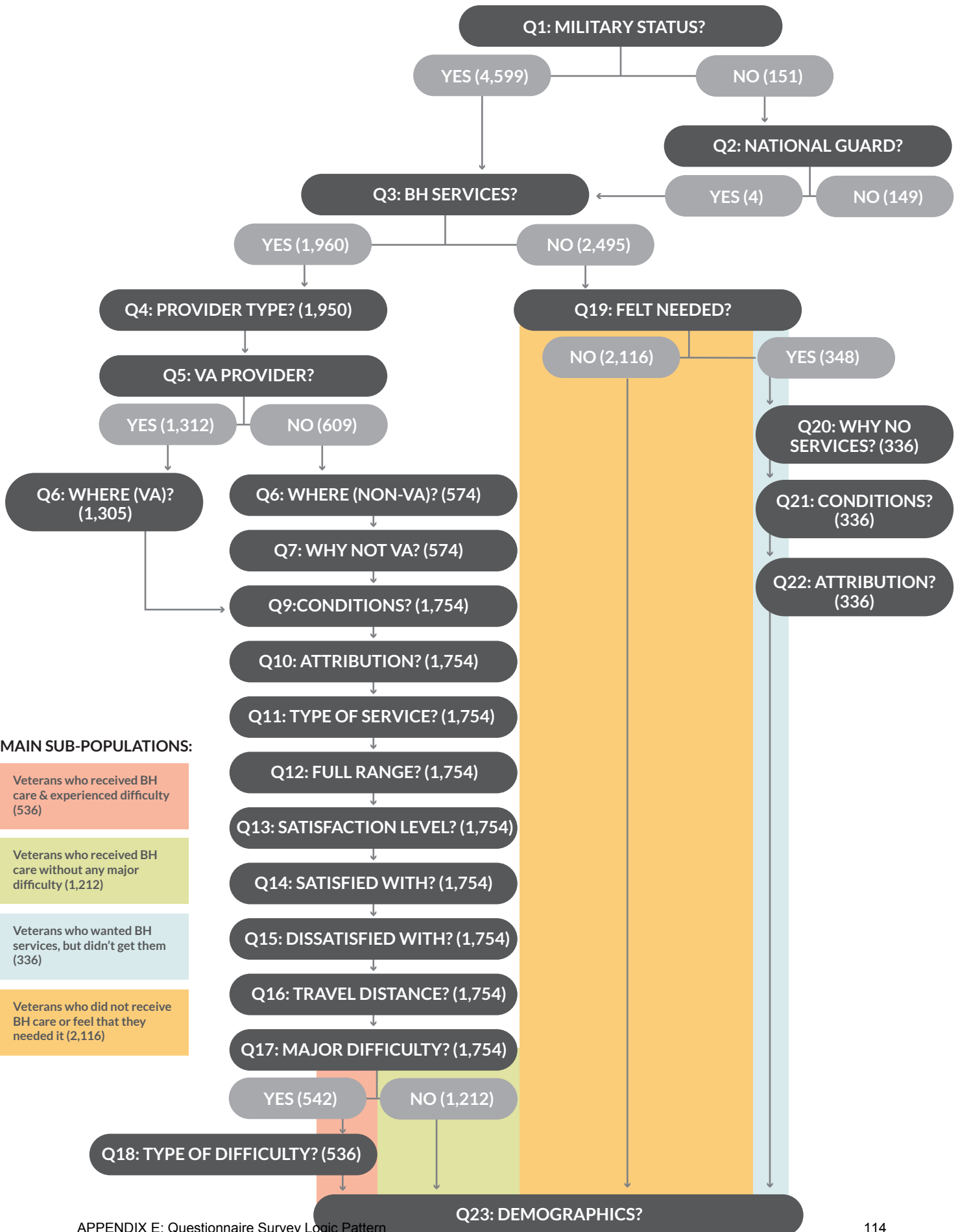
- f. The time that may be required to develop contacts or other arrangements with local provider organizations

15. Is there anything else you would like us to know about the behavioral health services provided at this facility?

Closing:

Thank you so much for your time and attention today. If you have any questions or want to follow-up on anything we talked about today please call or email me.

APPENDIX E QUESTIONNAIRE SURVEY LOGIC PATTERN



APPENDIX F Questionnaire Survey Charts

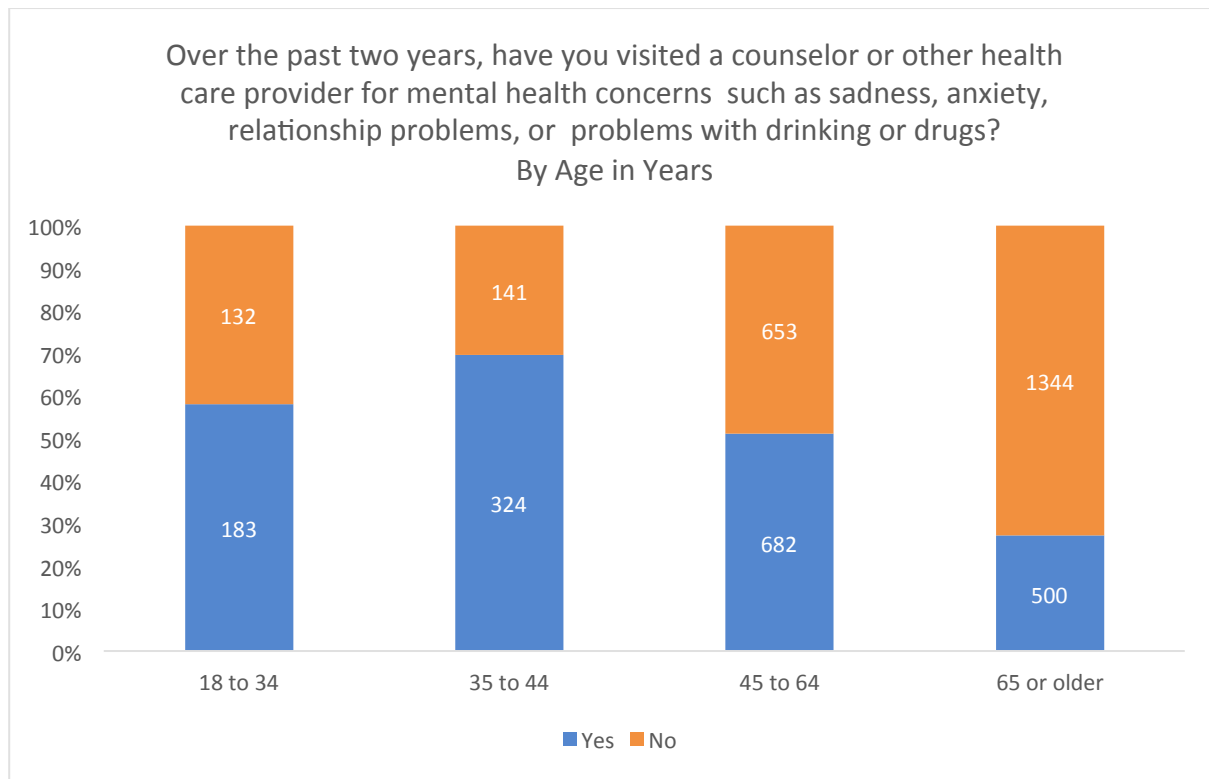
Veterans Questionnaire Survey Charts

Question 3: **Over the past two years, have you visited a counselor or other health care provider for mental health concerns such as sadness, anxiety, relationship problems, or problems with drinking or drugs?**

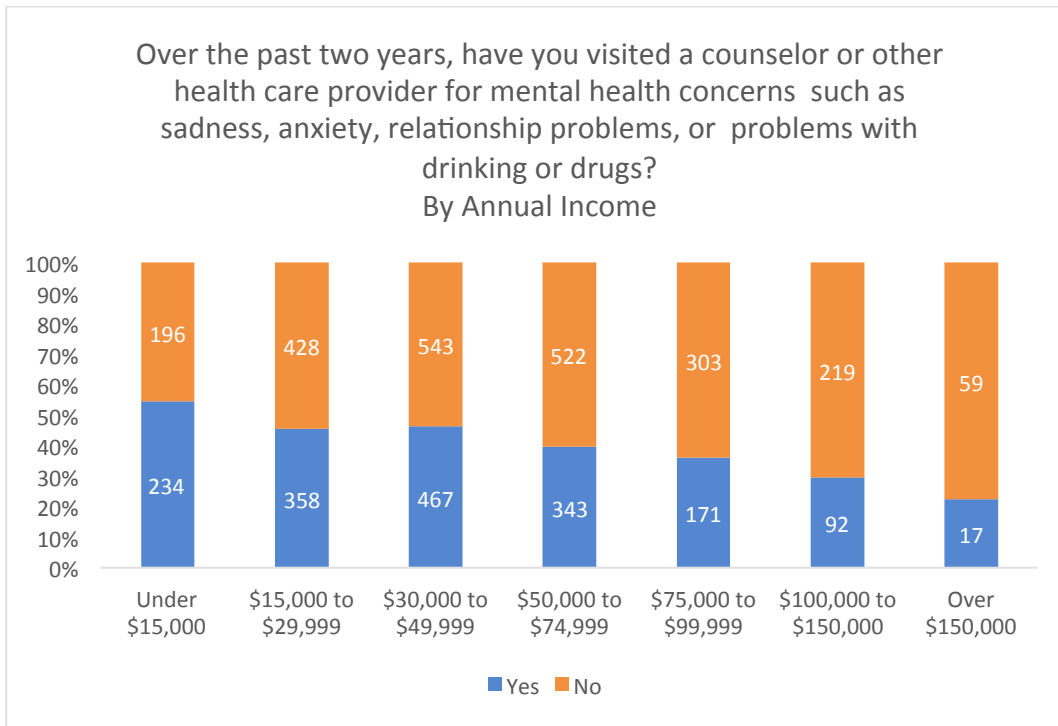
N = 4455

Respondents must have: served in the US Military or National Guard.

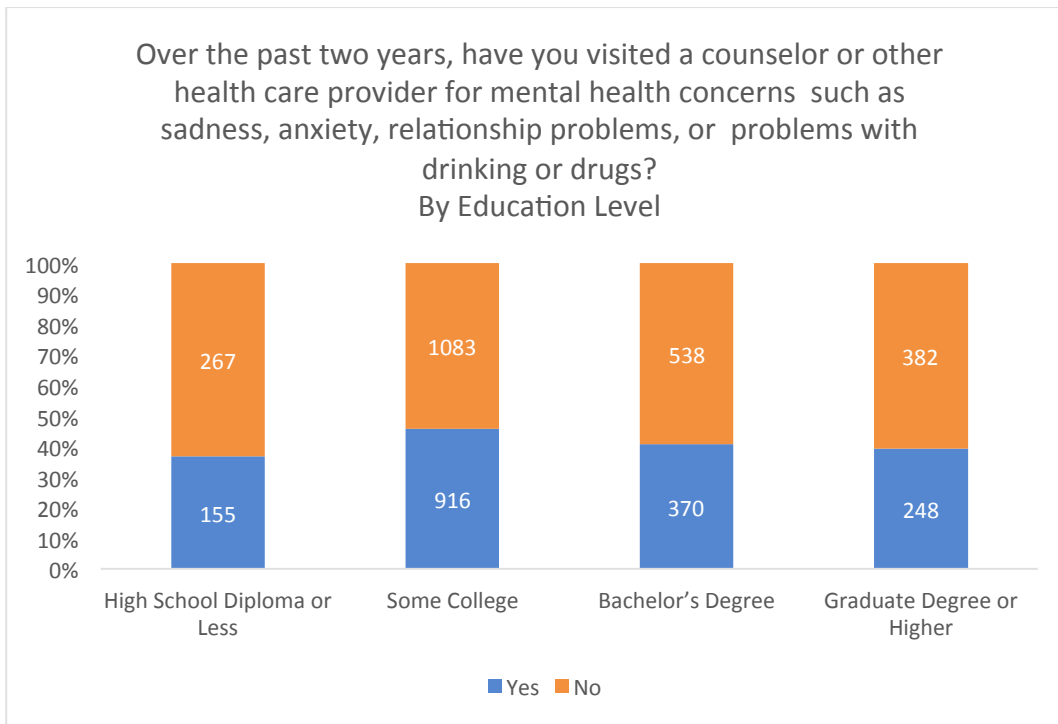
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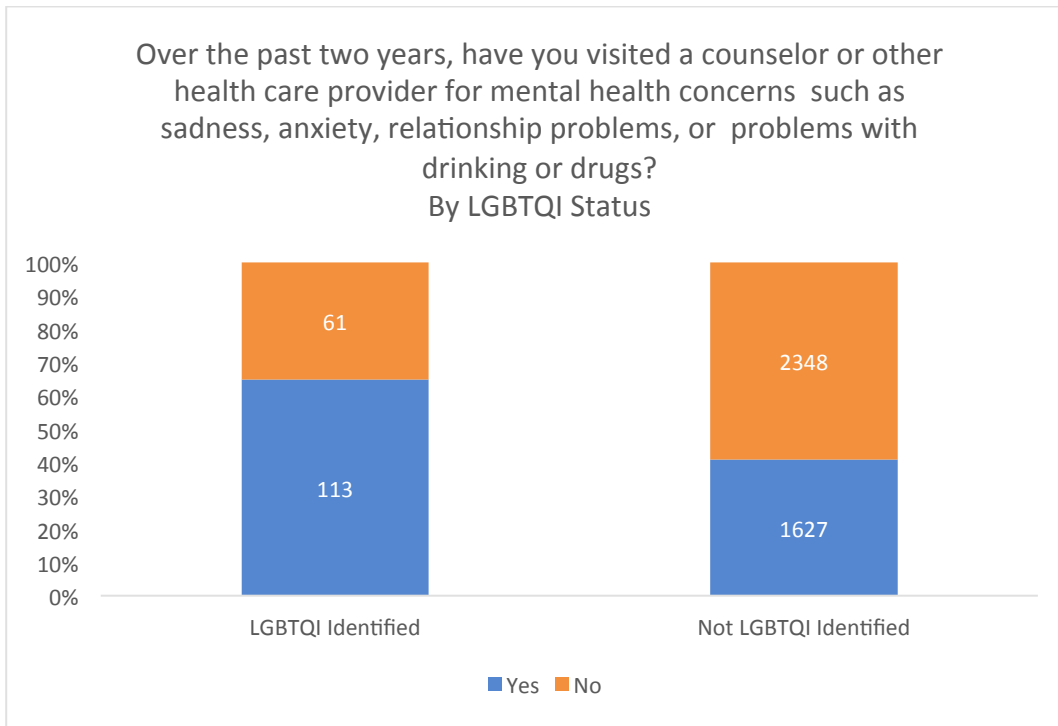
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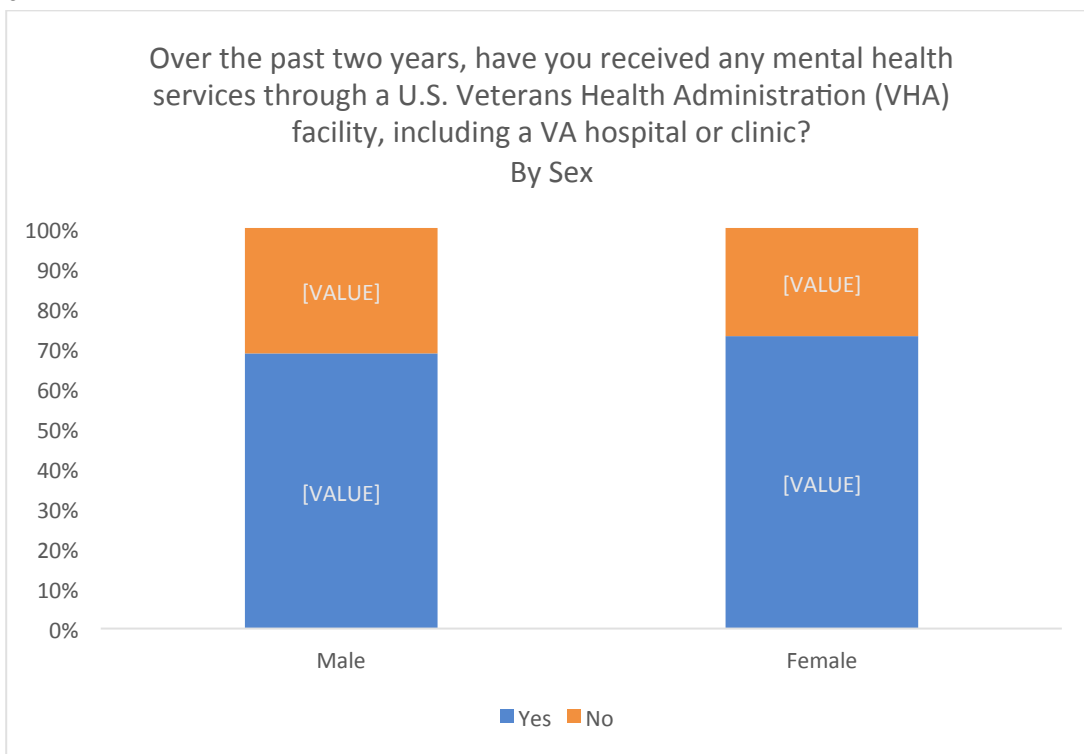


Question 5: Over the past two years, have you received any mental health services through a US Veterans Health Administration (VHA) facility, including a VA hospital or clinic?

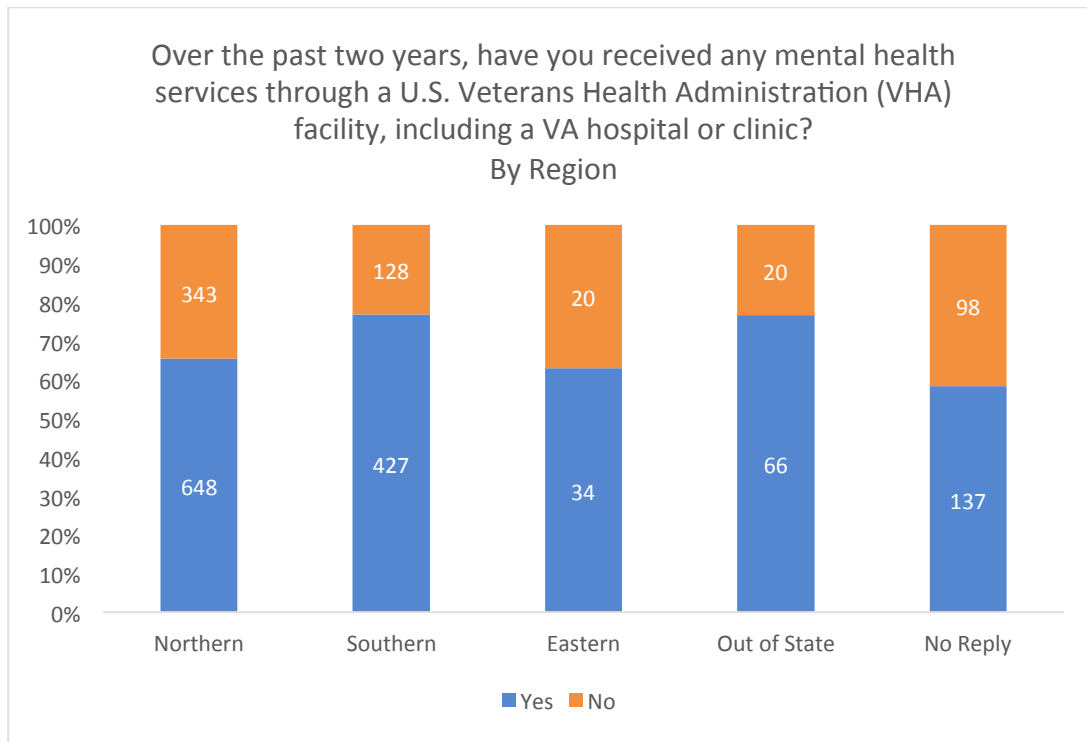
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Respondents must have: served in the US Military or National Guard, and sought mental health services in the last two years either within or outside the VA.

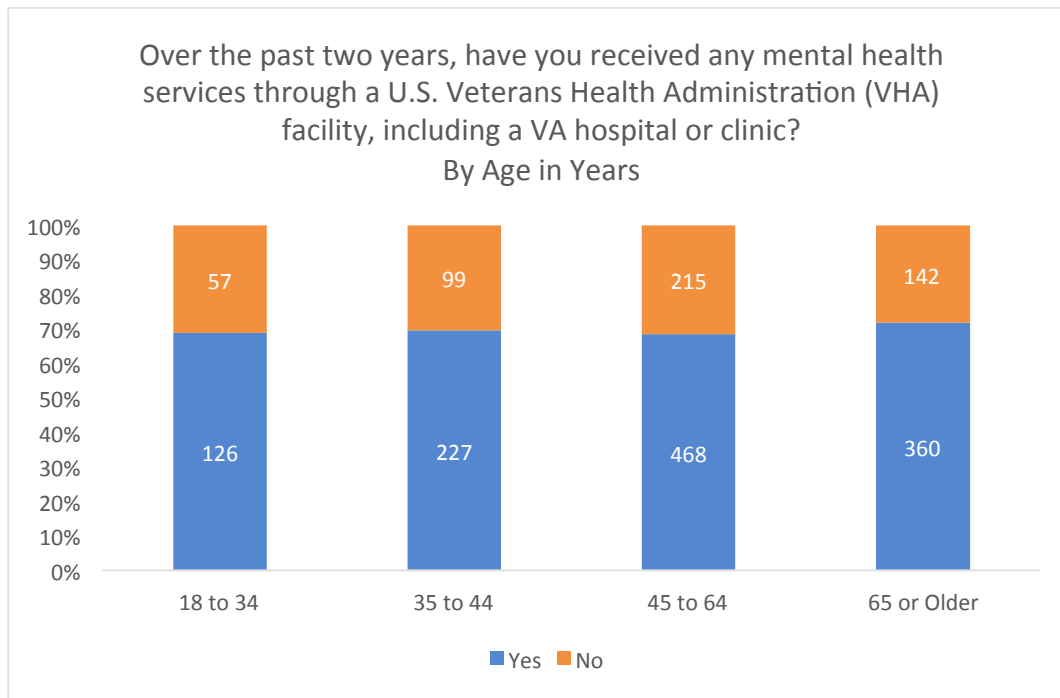
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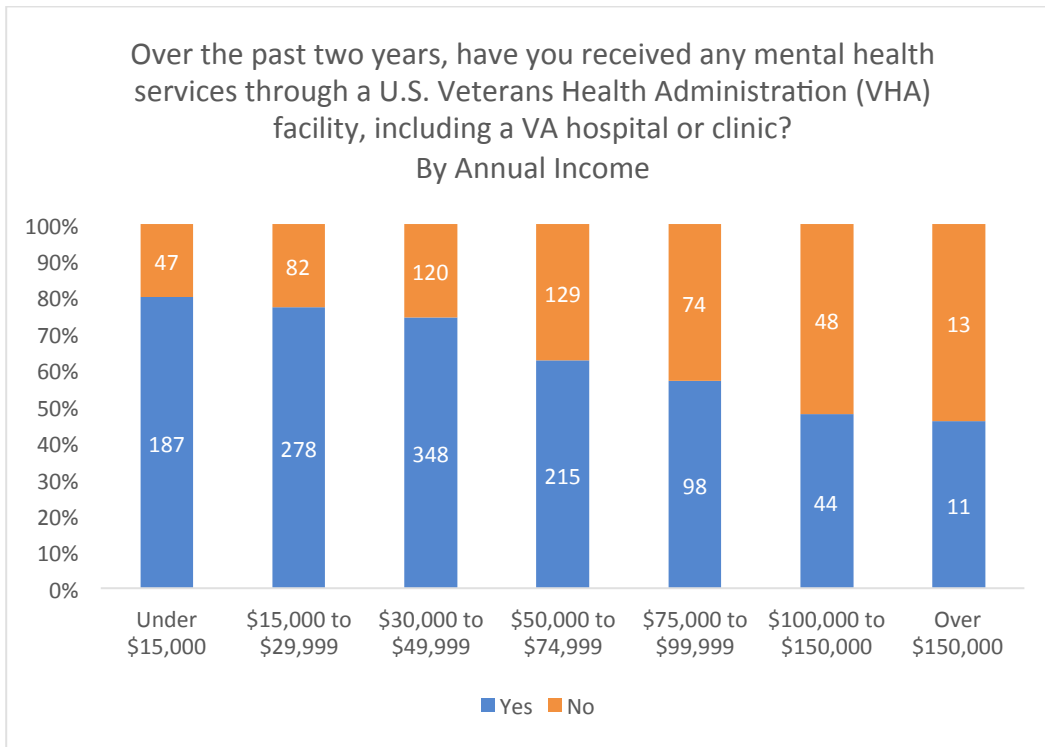
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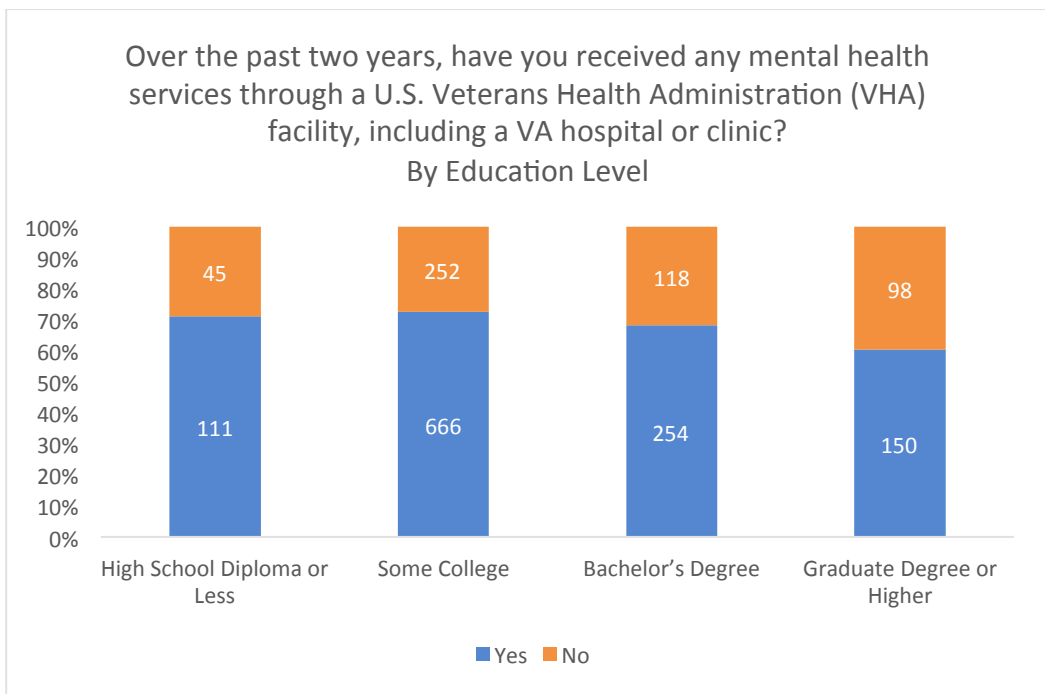
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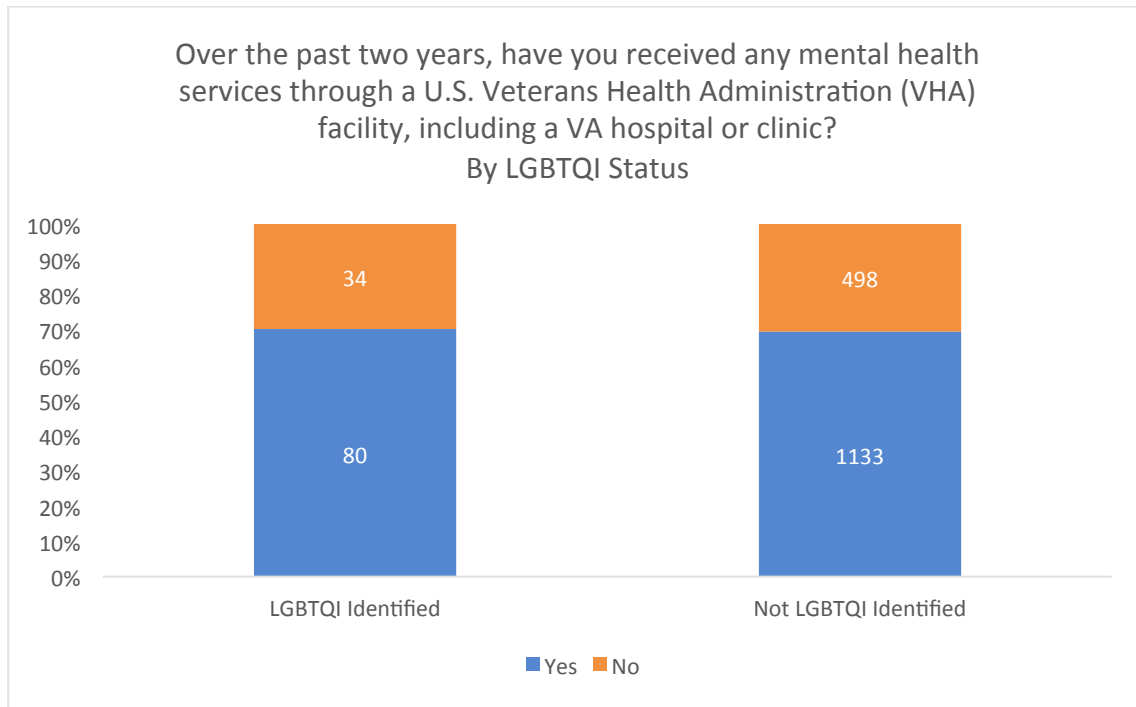
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9.



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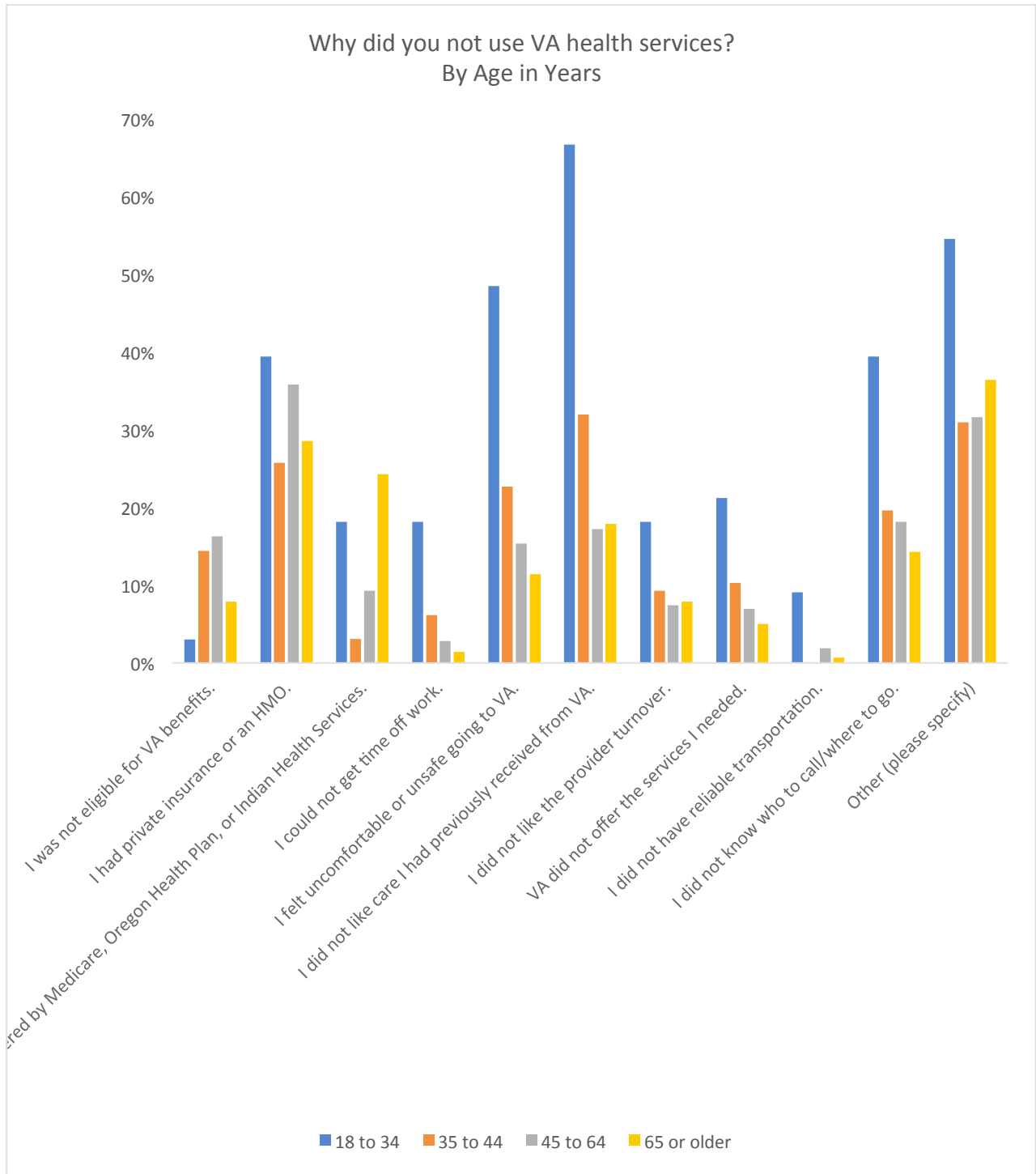


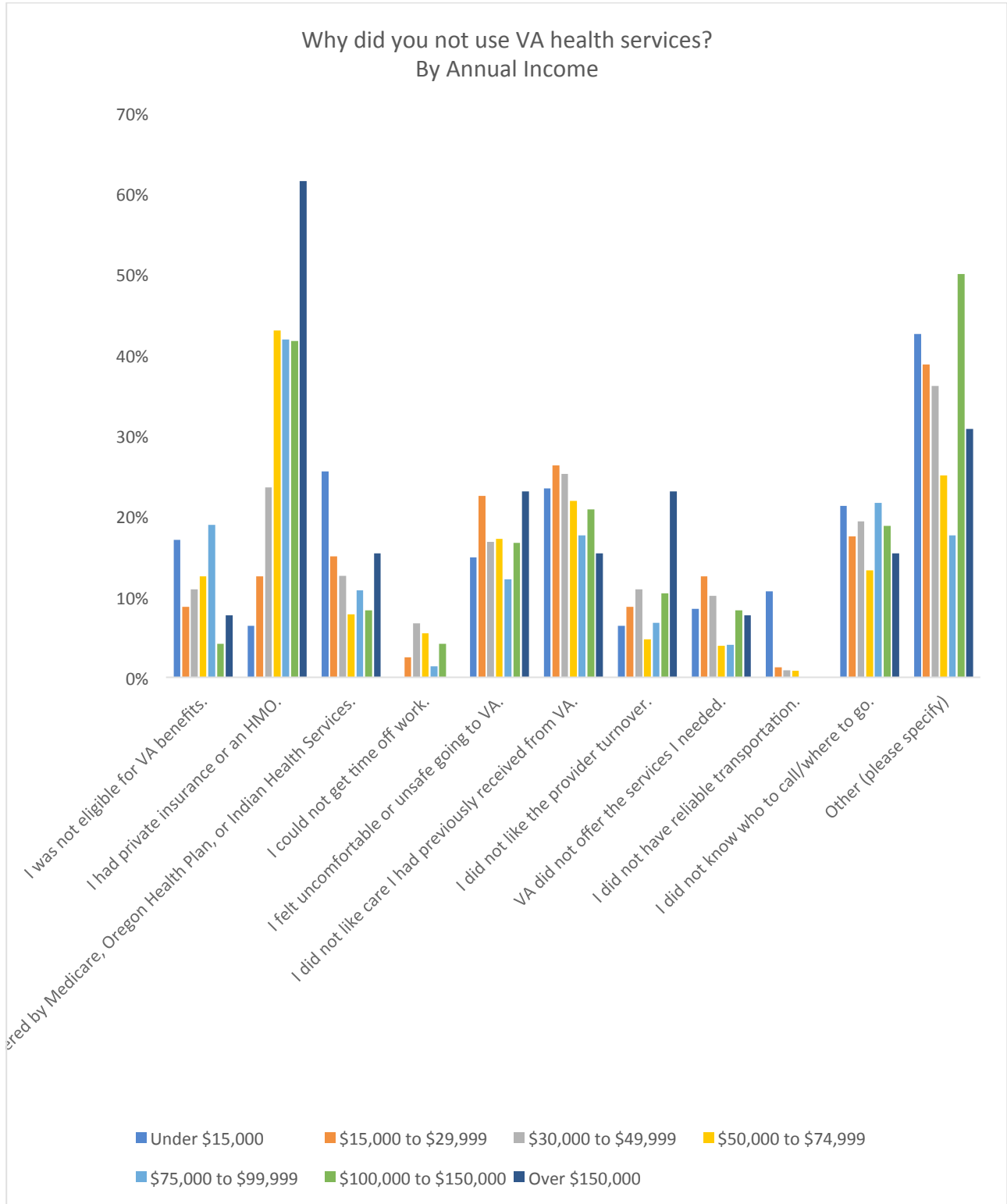
Question 7: Why did you not use VA health services? (Please select all that apply.)

N = 574

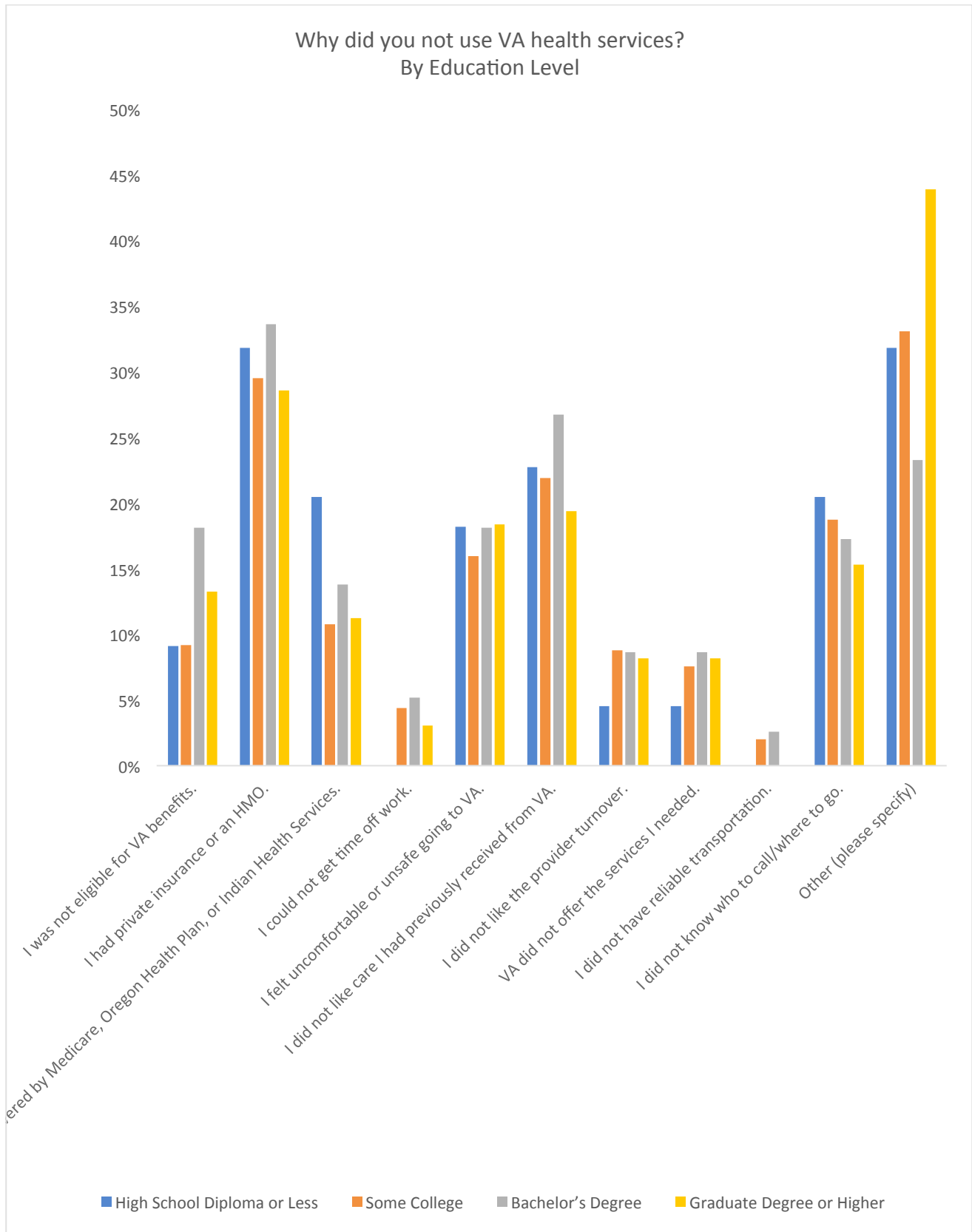
Respondents must have: served in the US Military or National Guard, and specifically sought mental health services in the last two years outside of the VA.

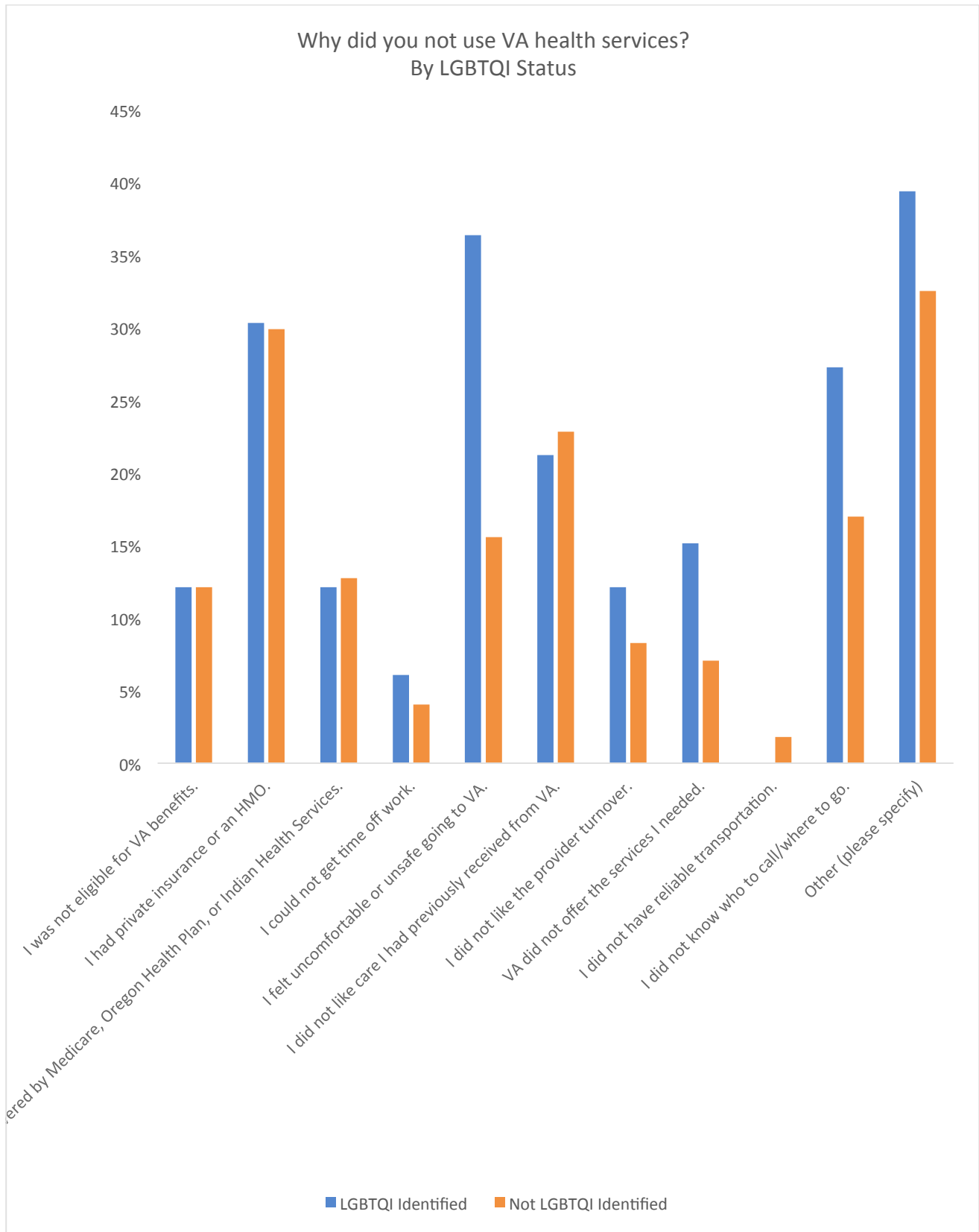
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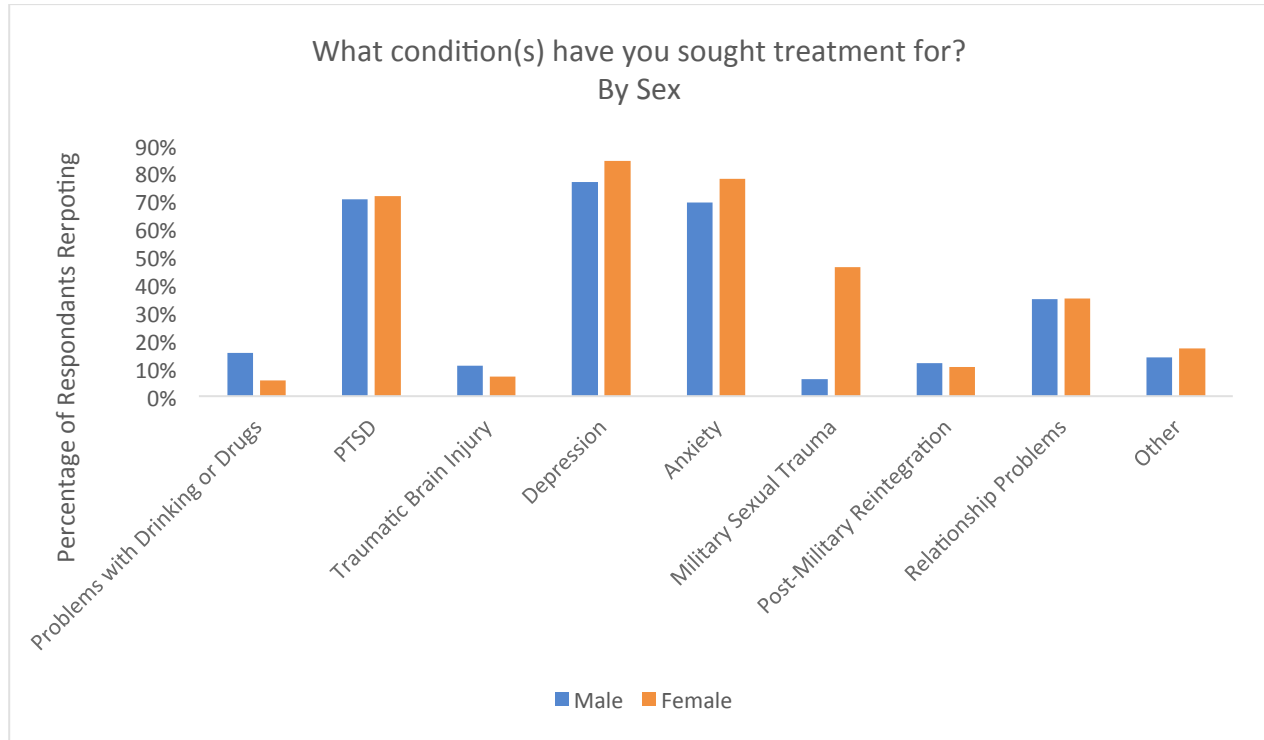


Question 9: What condition(s) have you sought treatment for? (Please select all that apply)

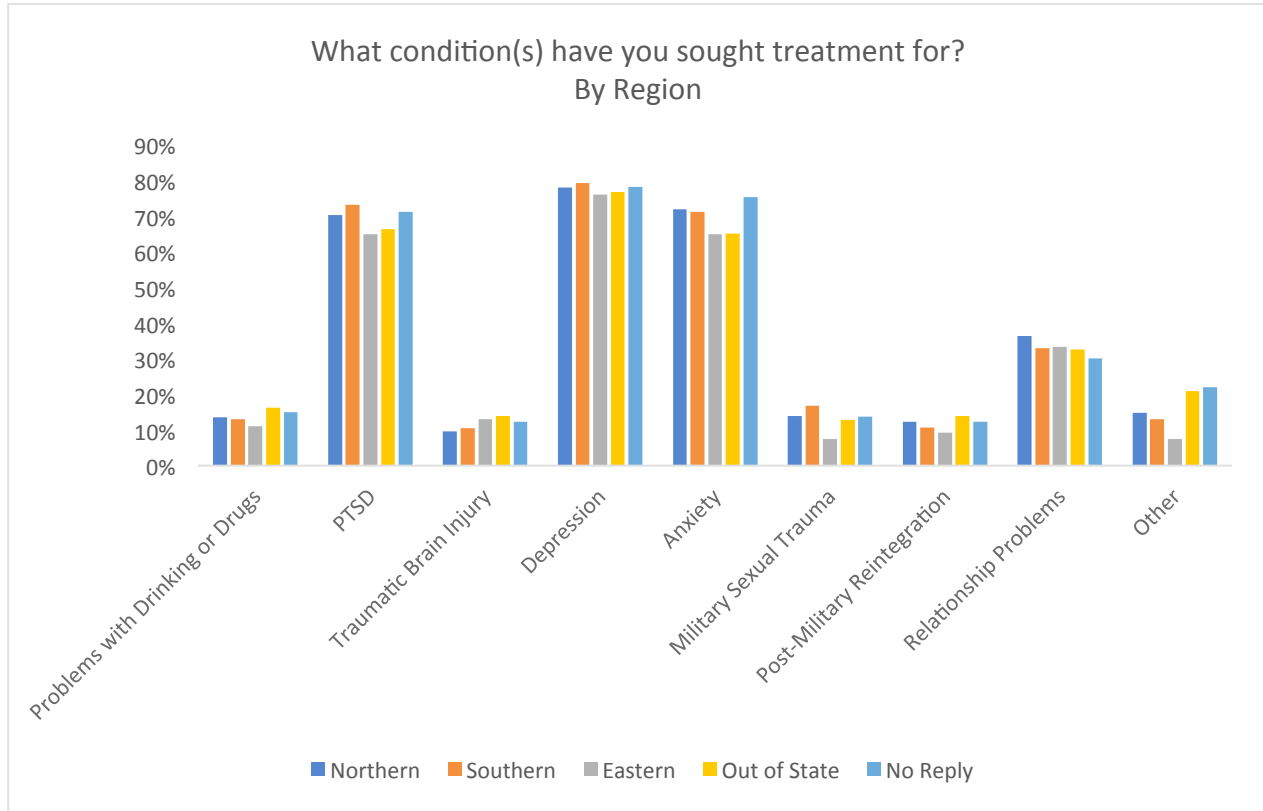
N = 1754

Respondents must have: served in the US Military or National Guard, and sought mental health services in the last two years either within or outside the VA.

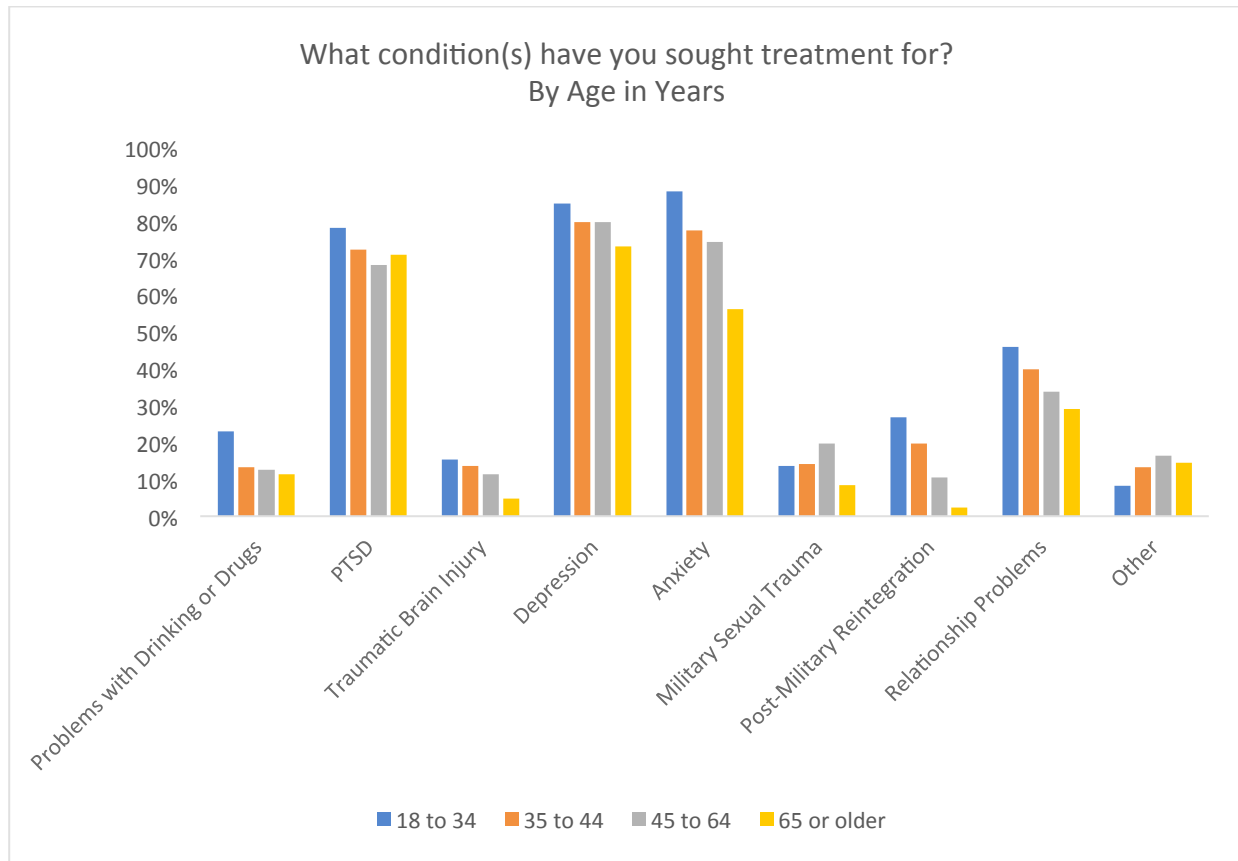
15.



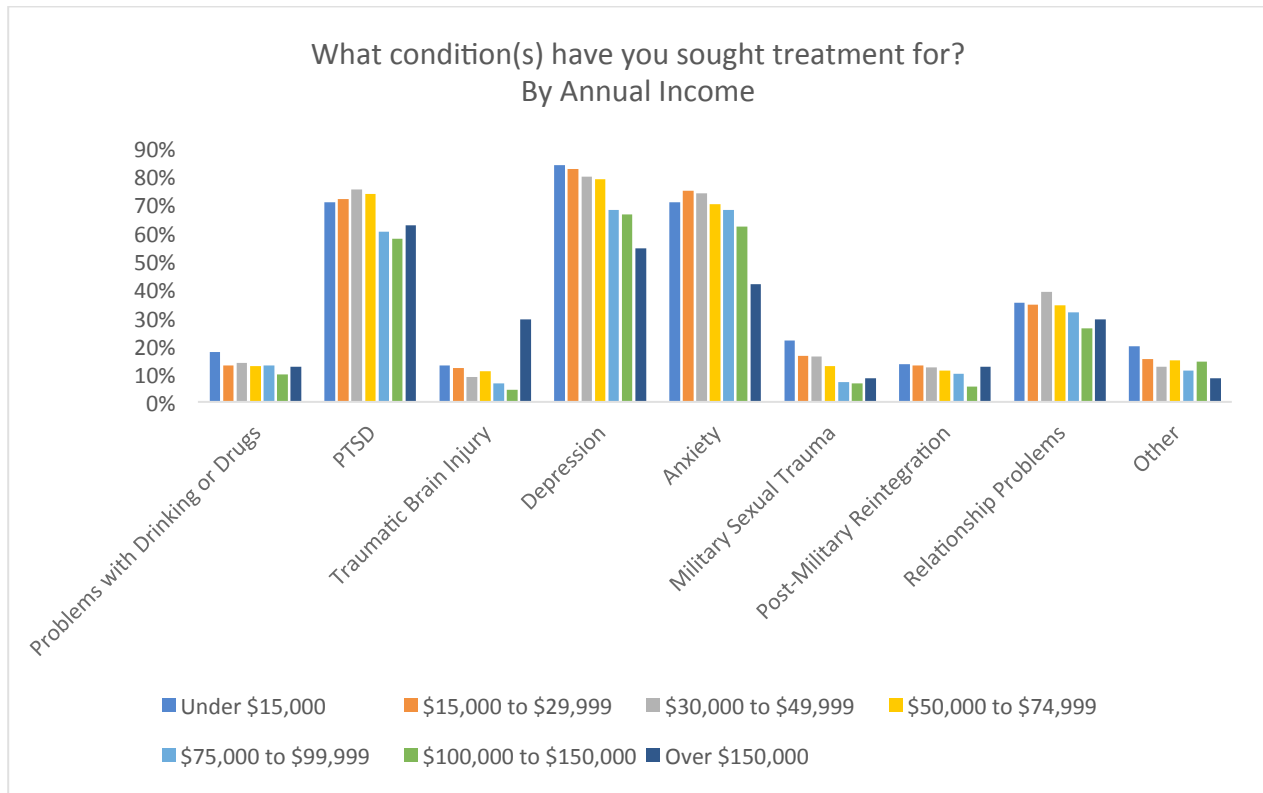
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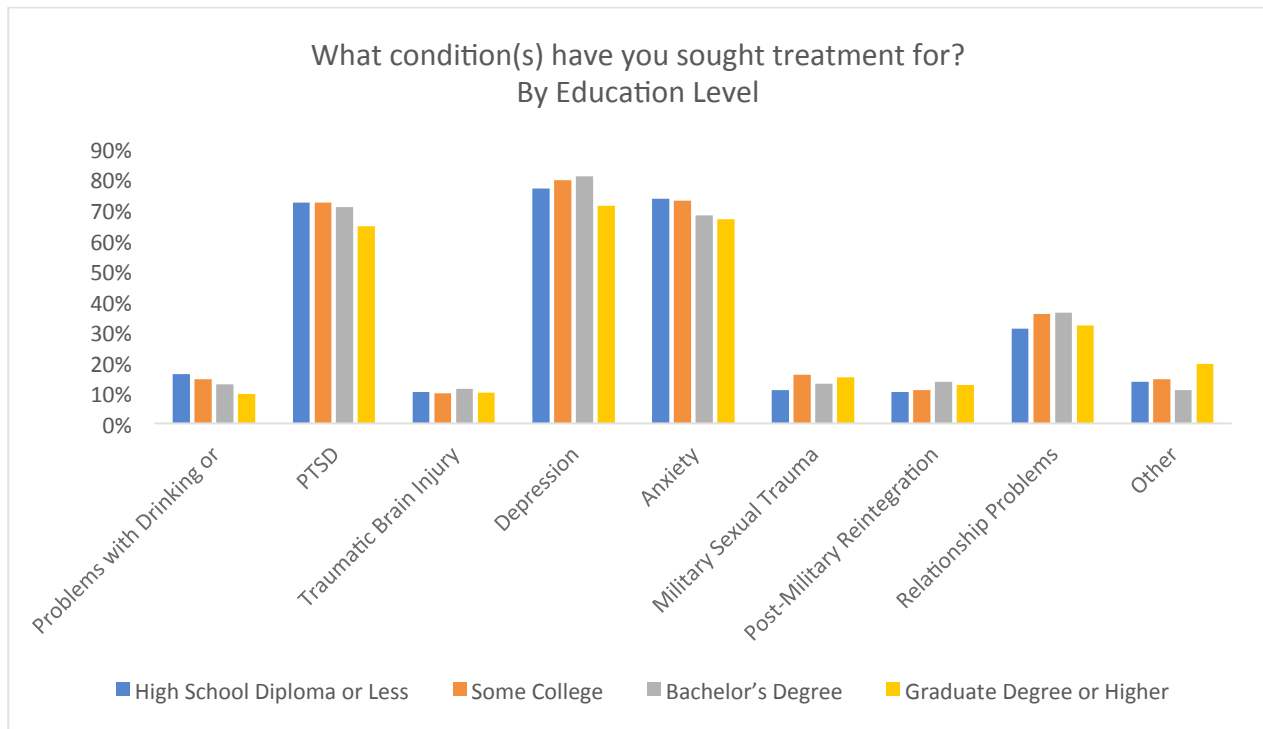
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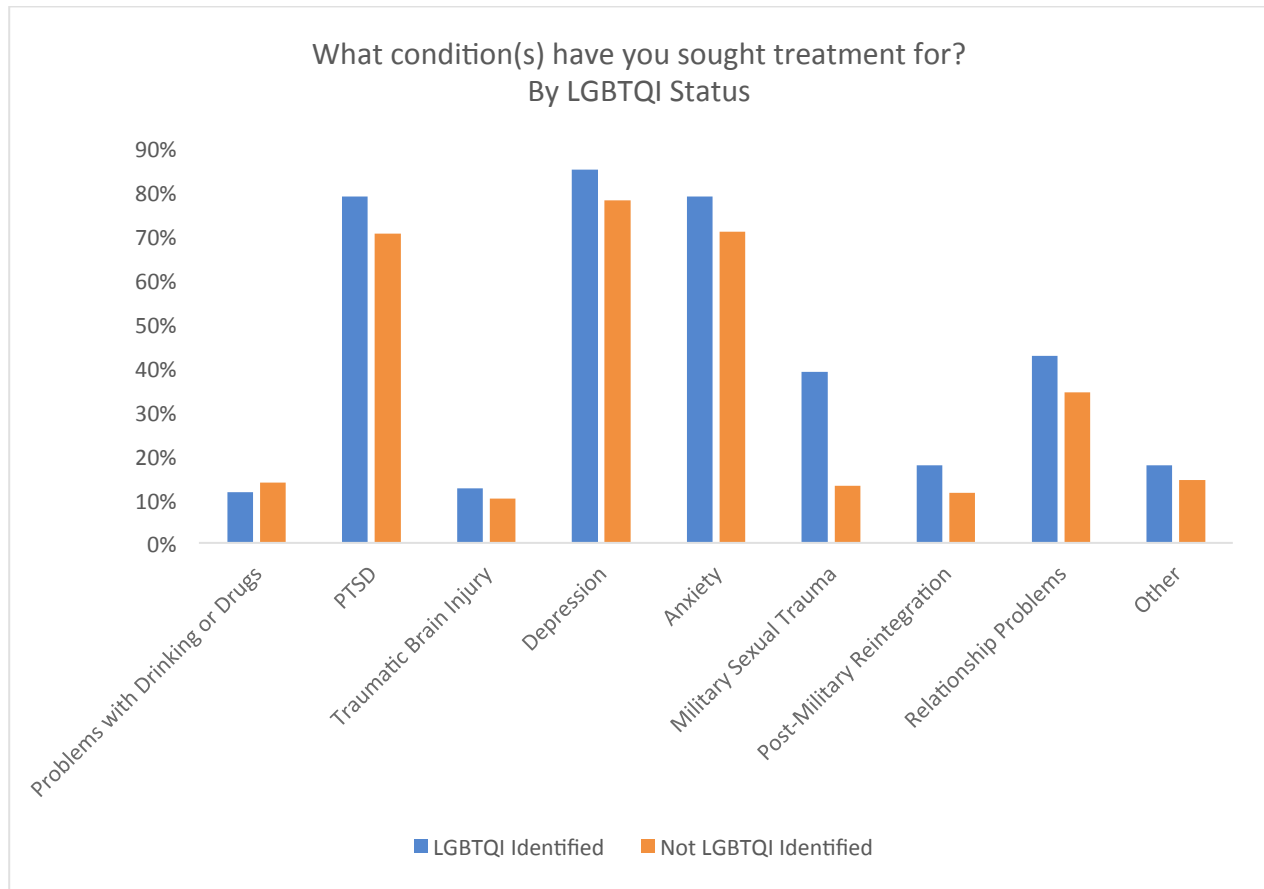
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19.



20.

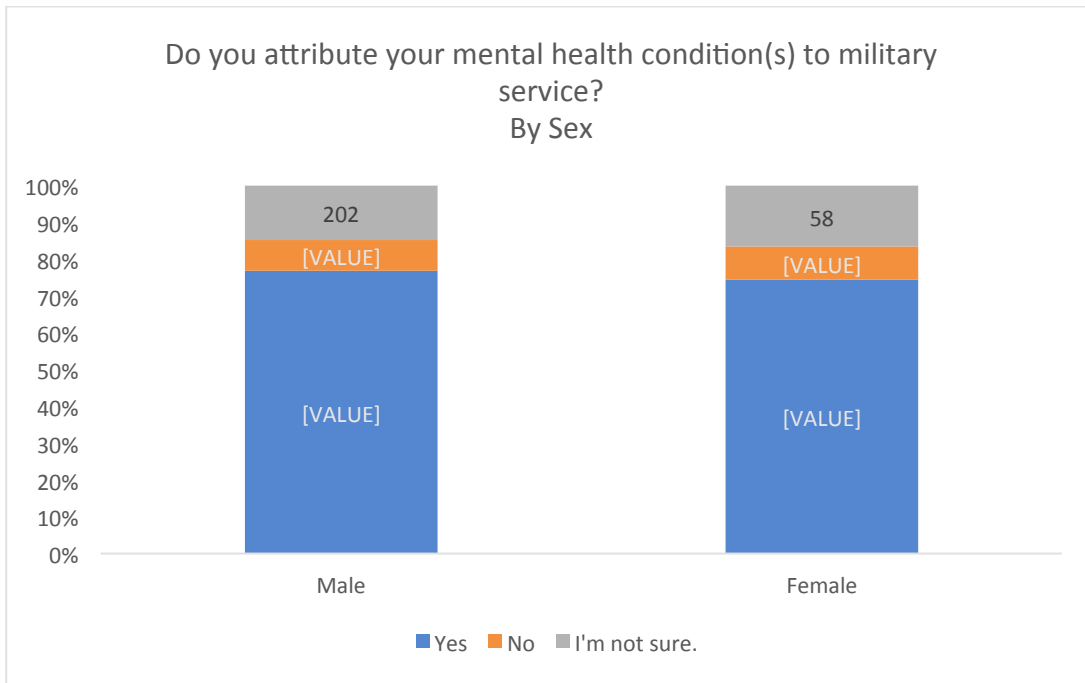


Question 10: Do you attribute your mental health condition(s) to military service?

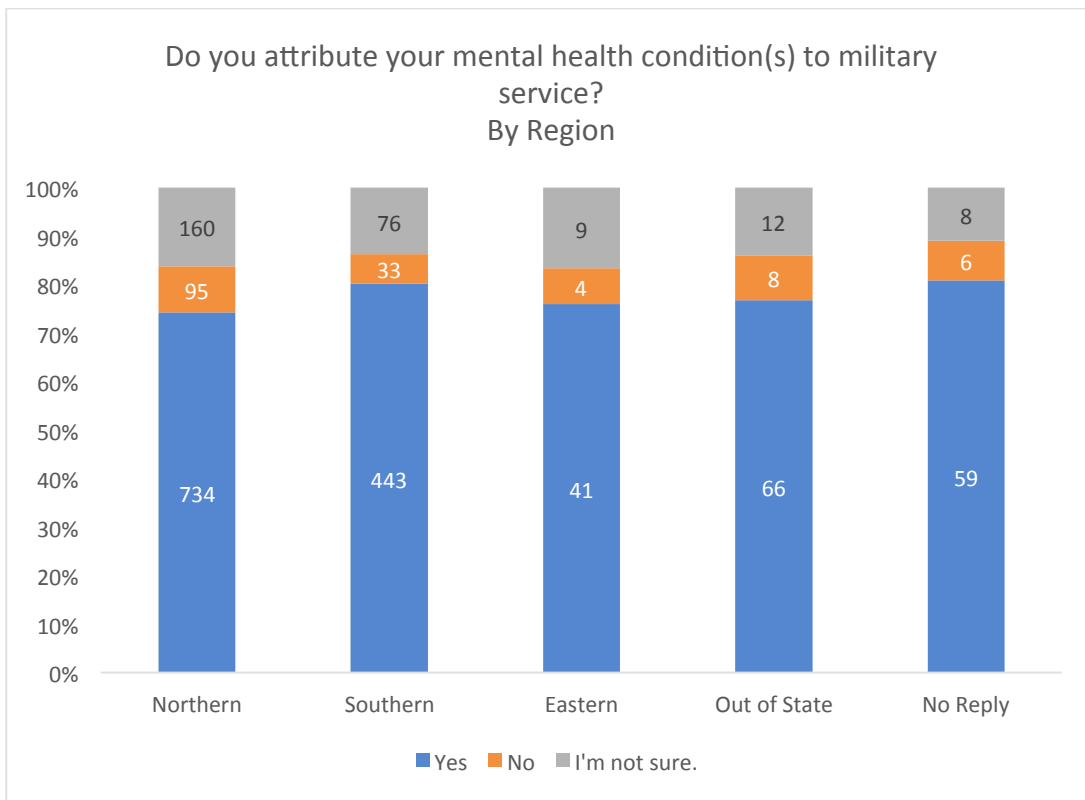
N = 1754

Respondents must have: served in the US Military or National Guard, and sought mental health services in the last two years either within or outside the VA.

21.



22.

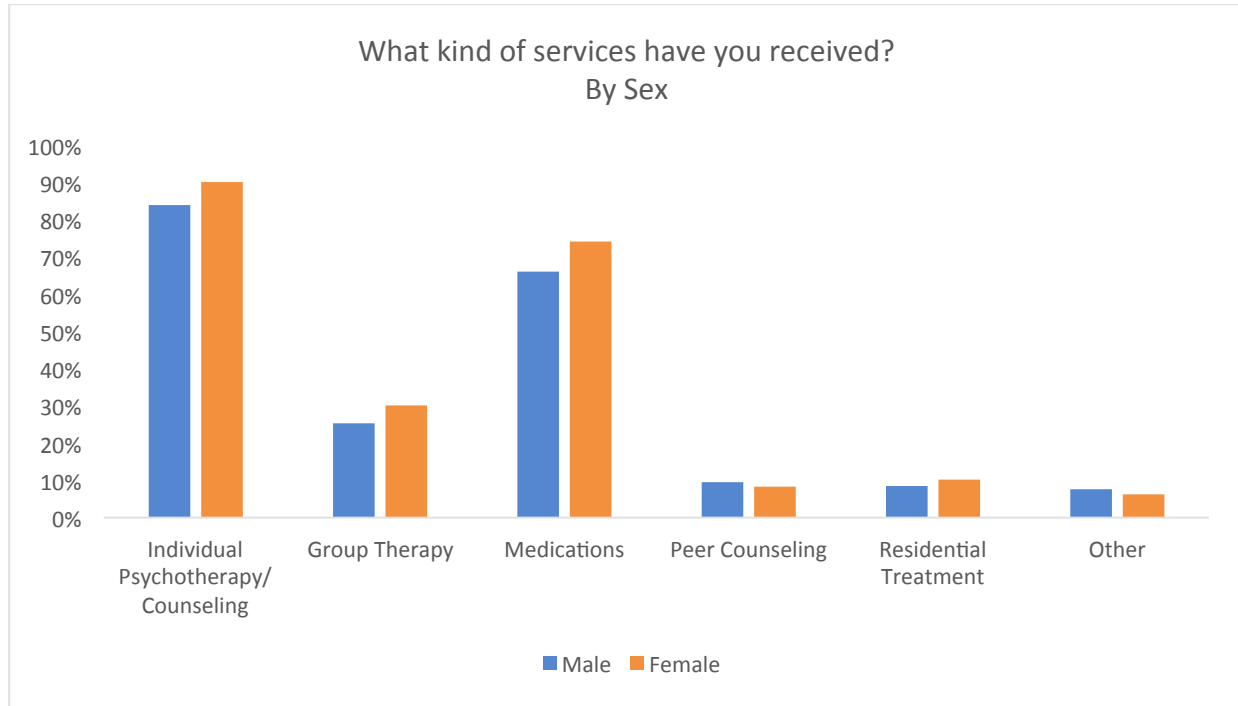


Question 11: What kind of services have you received? (Please select all that apply)

N = 1754

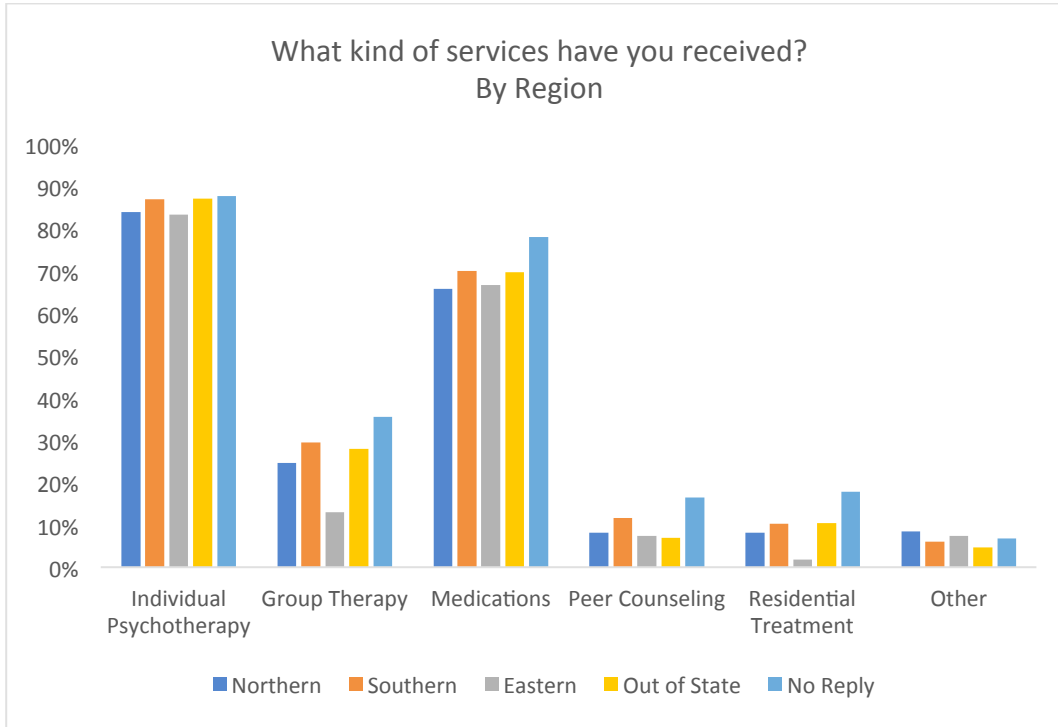
Respondents must have: served in the US Military or National Guard, and sought mental health services in the last two years either within or outside the VA.

23.



	Individual Psychotherapy/ Counseling	Group Therapy	Medications	Peer Counseling	Residential Treatment	Other
Male	1143	344	899	129	115	104
Female	316	106	260	29	36	22

24.

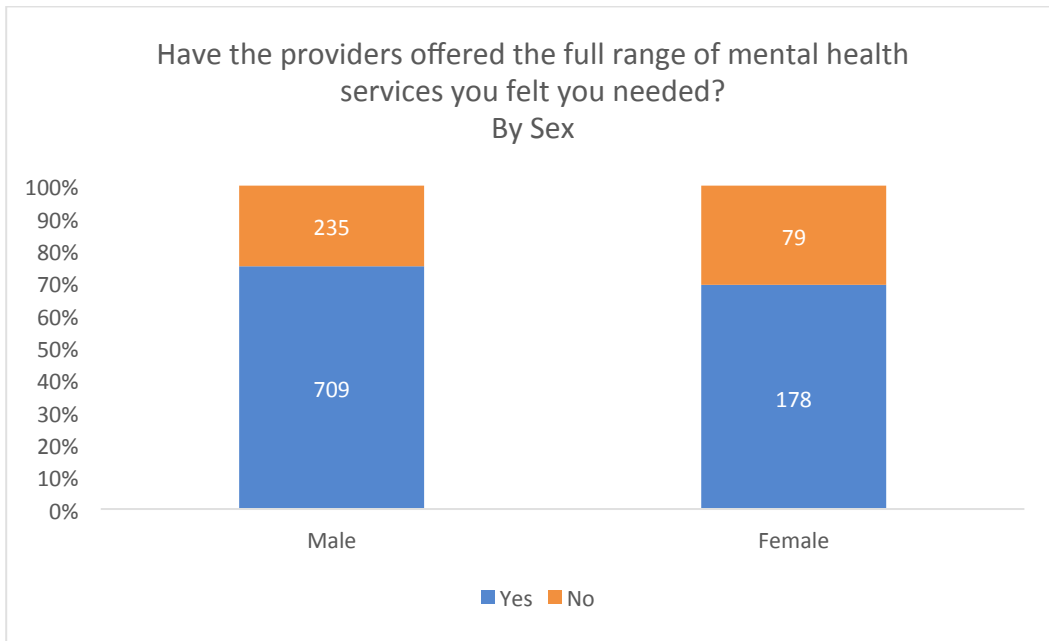


Question 12: Have the providers offered the full range of mental health services you felt you needed?

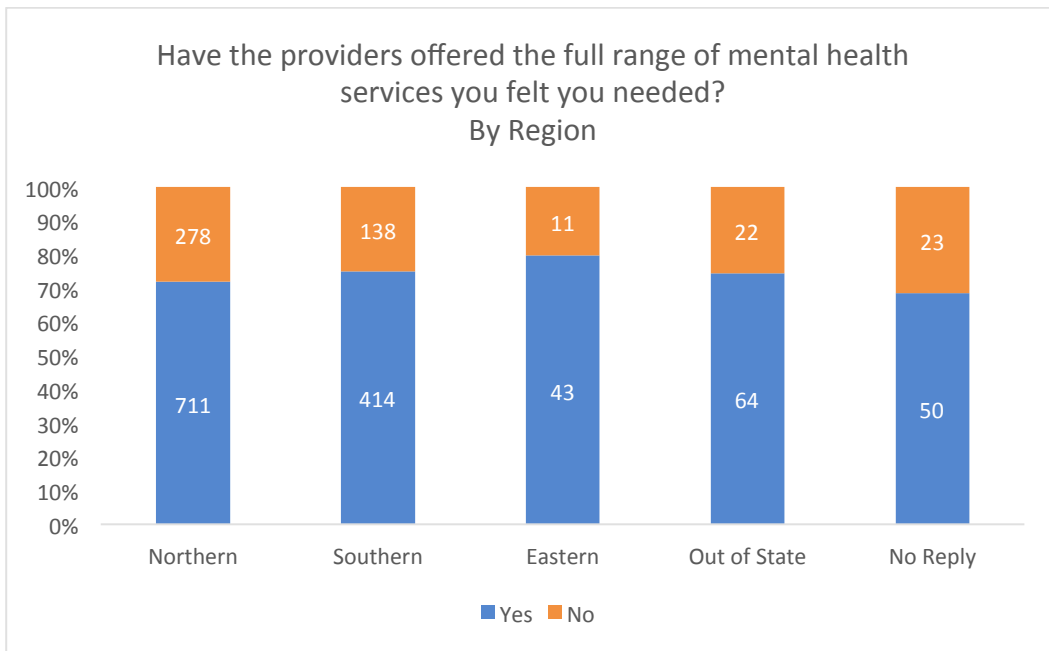
N = 1754

Respondents must have: served in the US Military or National Guard, and sought mental health services in the last two years either within or outside the VA.

25.



26.

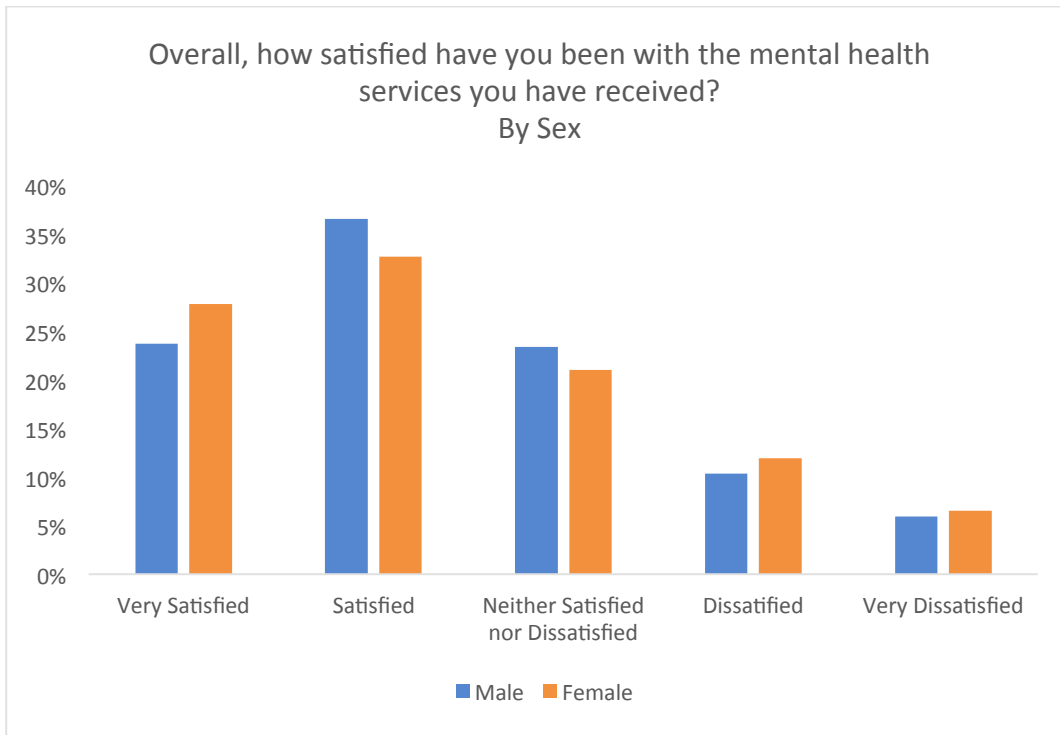


Question 13: Overall, how satisfied have you been with the mental health services you have received?

N = 1754

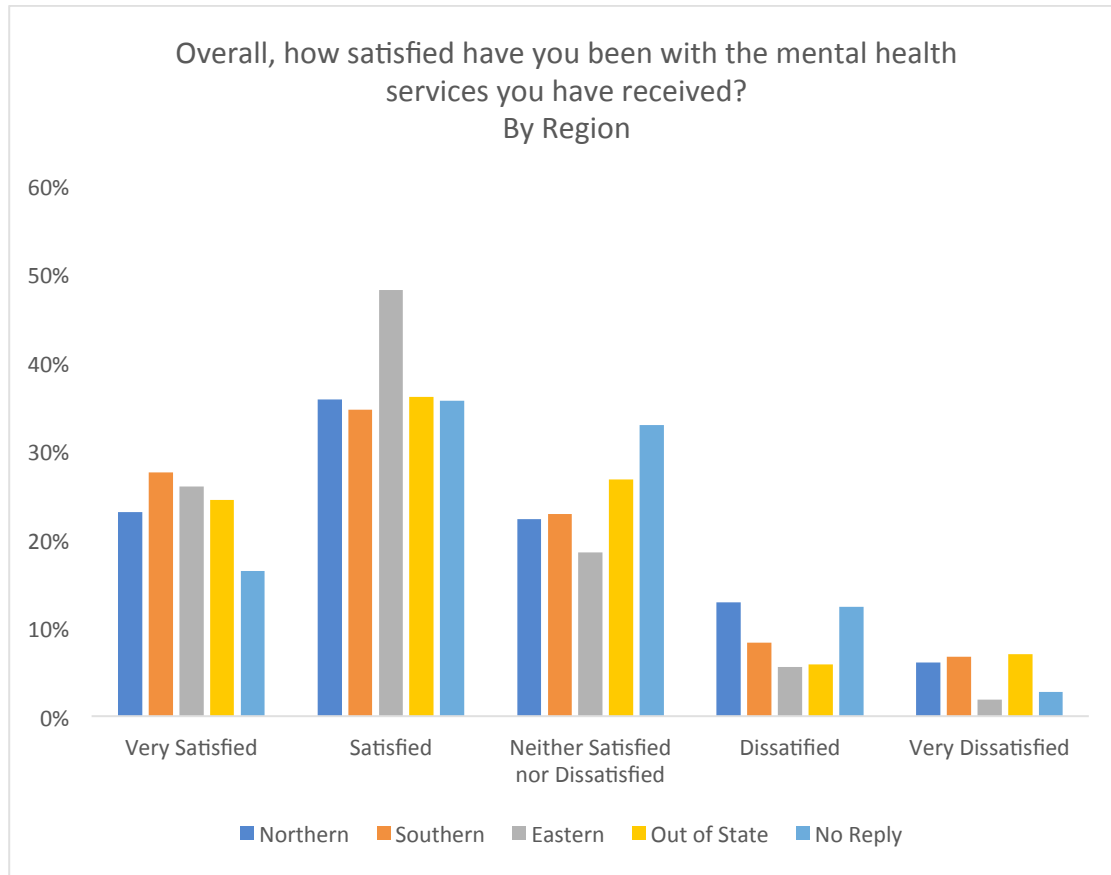
Respondents must have: served in the US Military or National Guard, and sought mental health services in the last two years either within or outside the VA.

27.



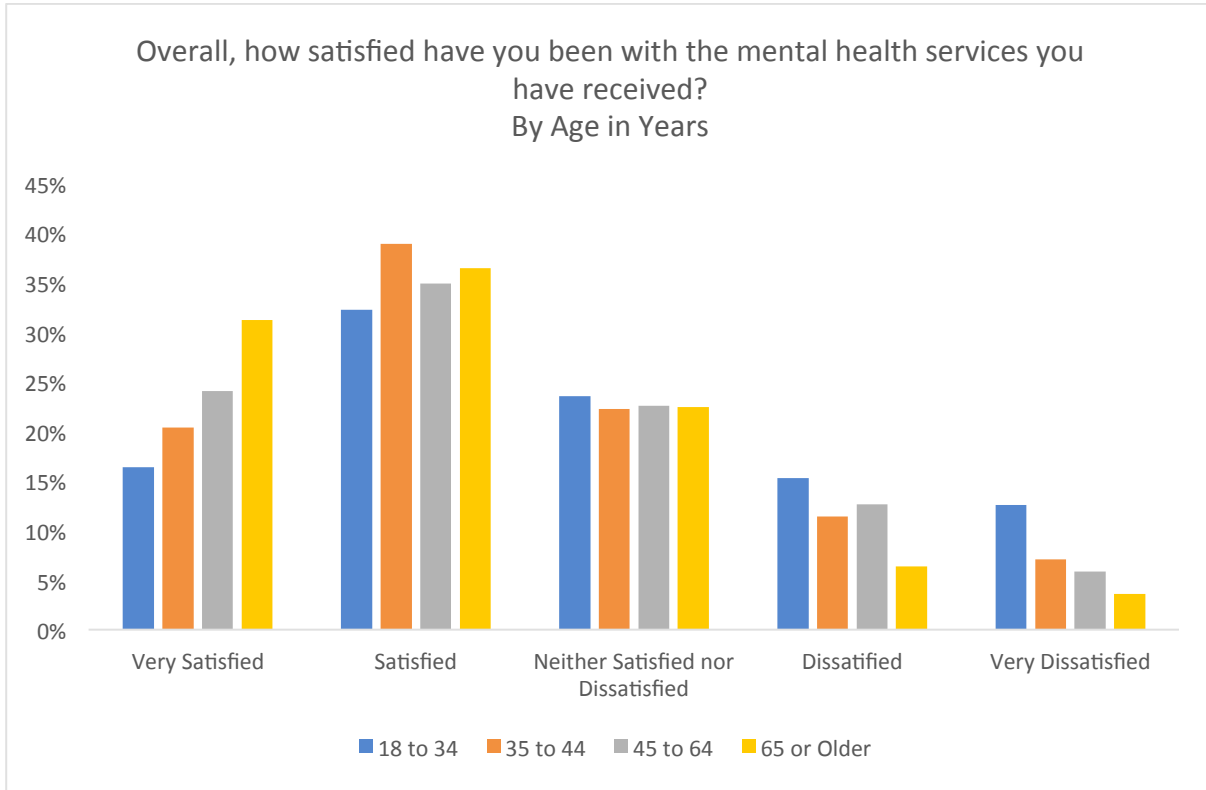
	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied	Total
Male	325	501	321	142	81	1370
Female	98	115	74	42	23	352

28.

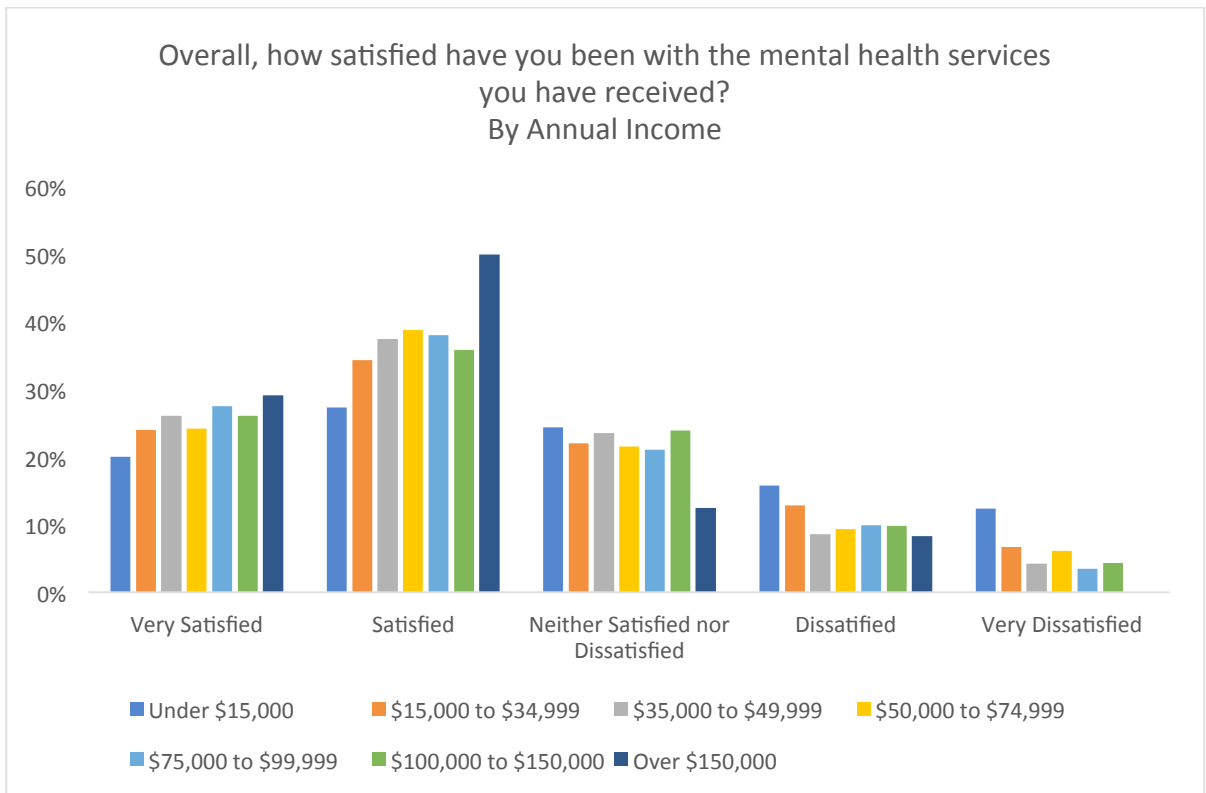


	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied	Total
Northern	228	354	220	127	60	989
Southern	152	191	126	46	37	552
Eastern	14	26	10	3	1	54
Out of State	21	31	23	5	6	86
No Reply	12	26	24	9	2	73

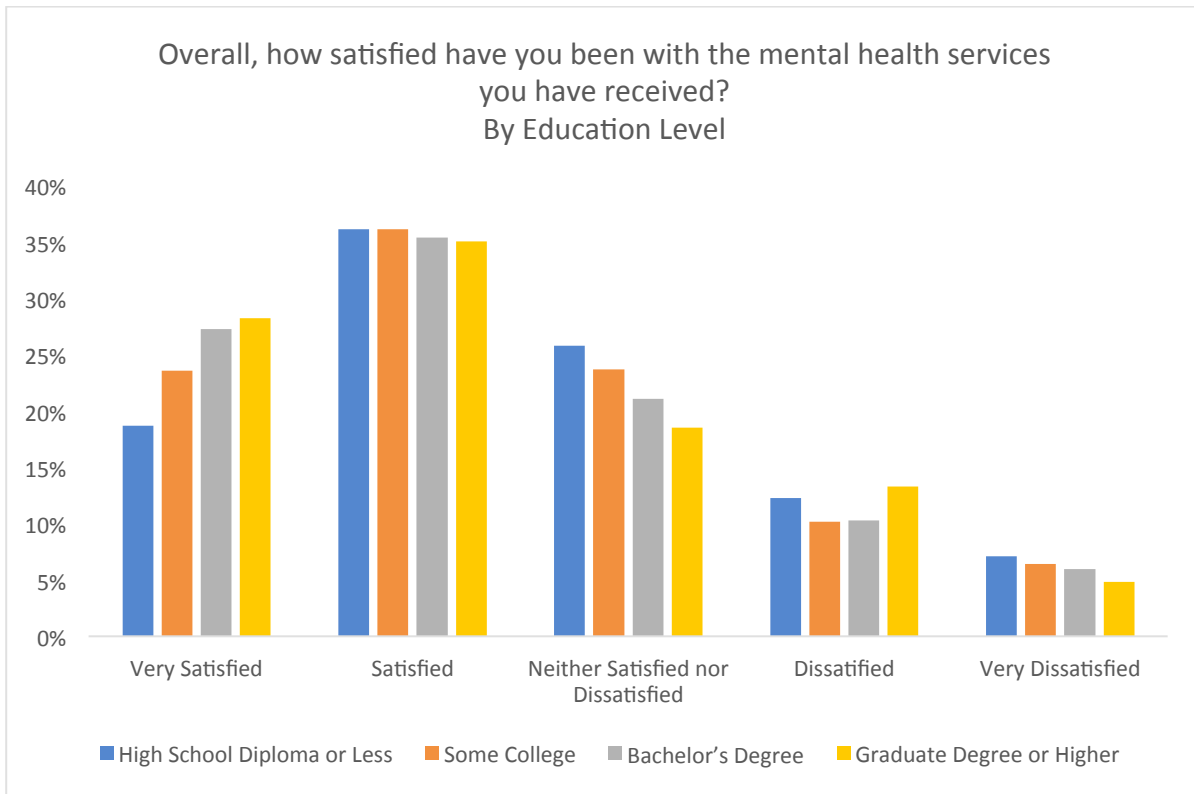
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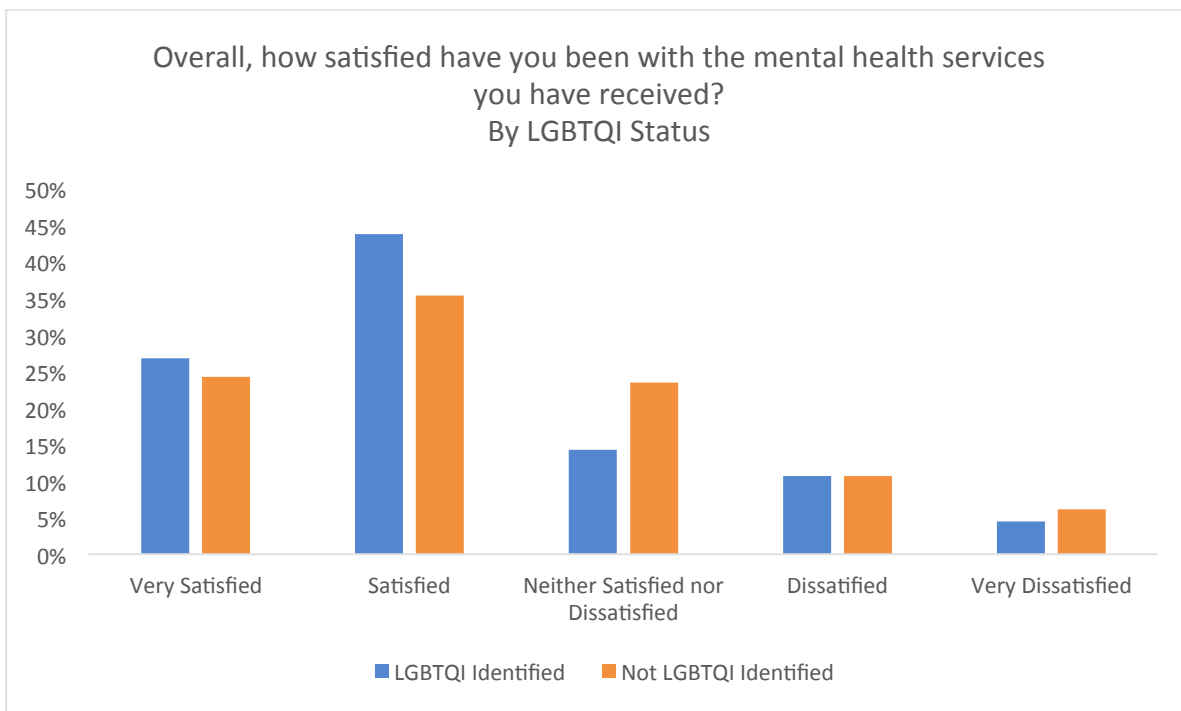
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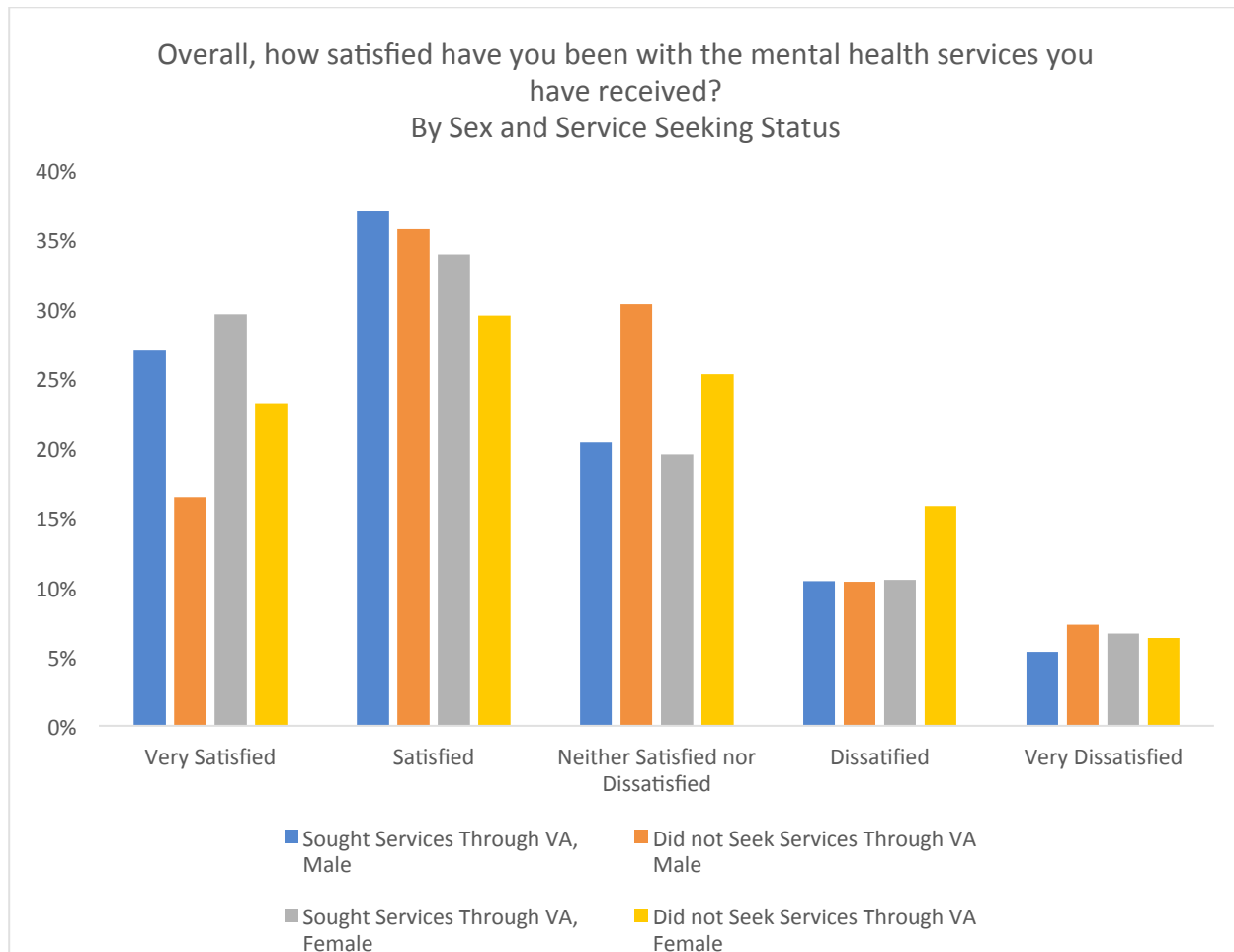
31.



32.



33.

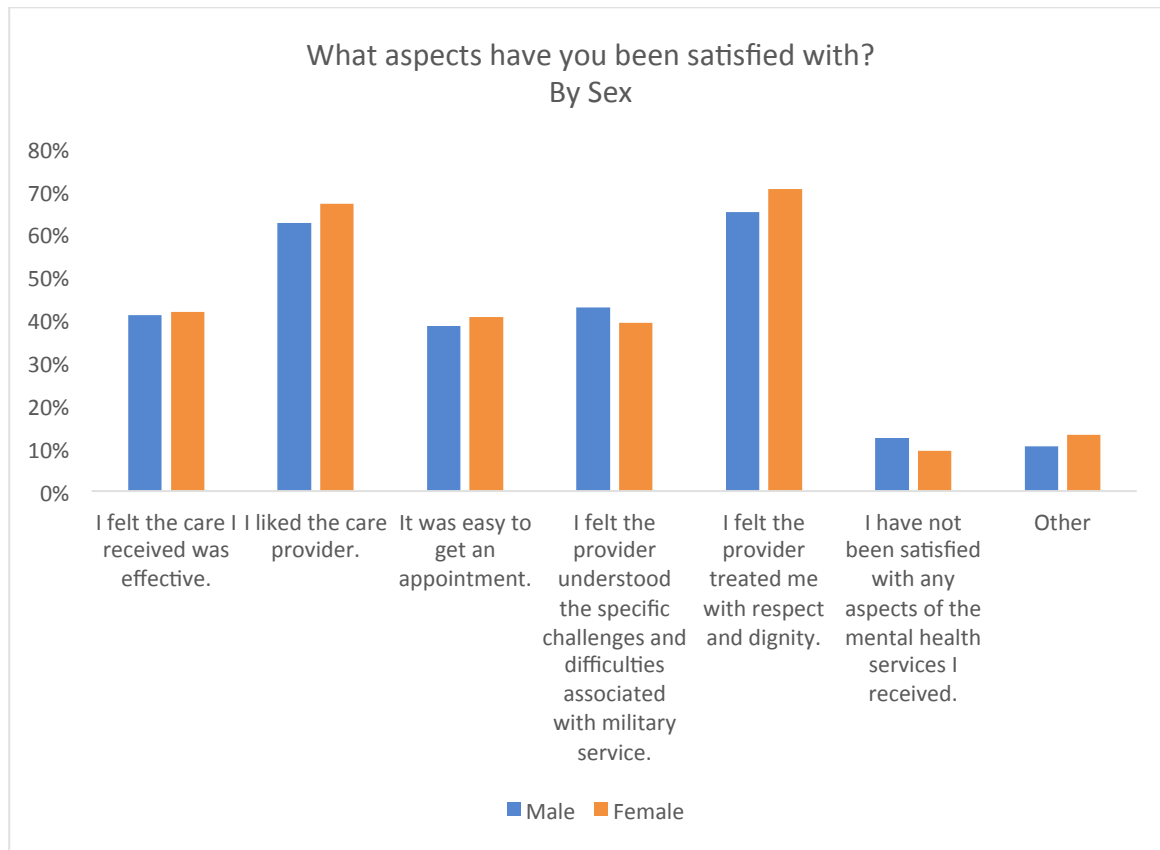


Question 14: What aspects have you been satisfied with?

N = 1754

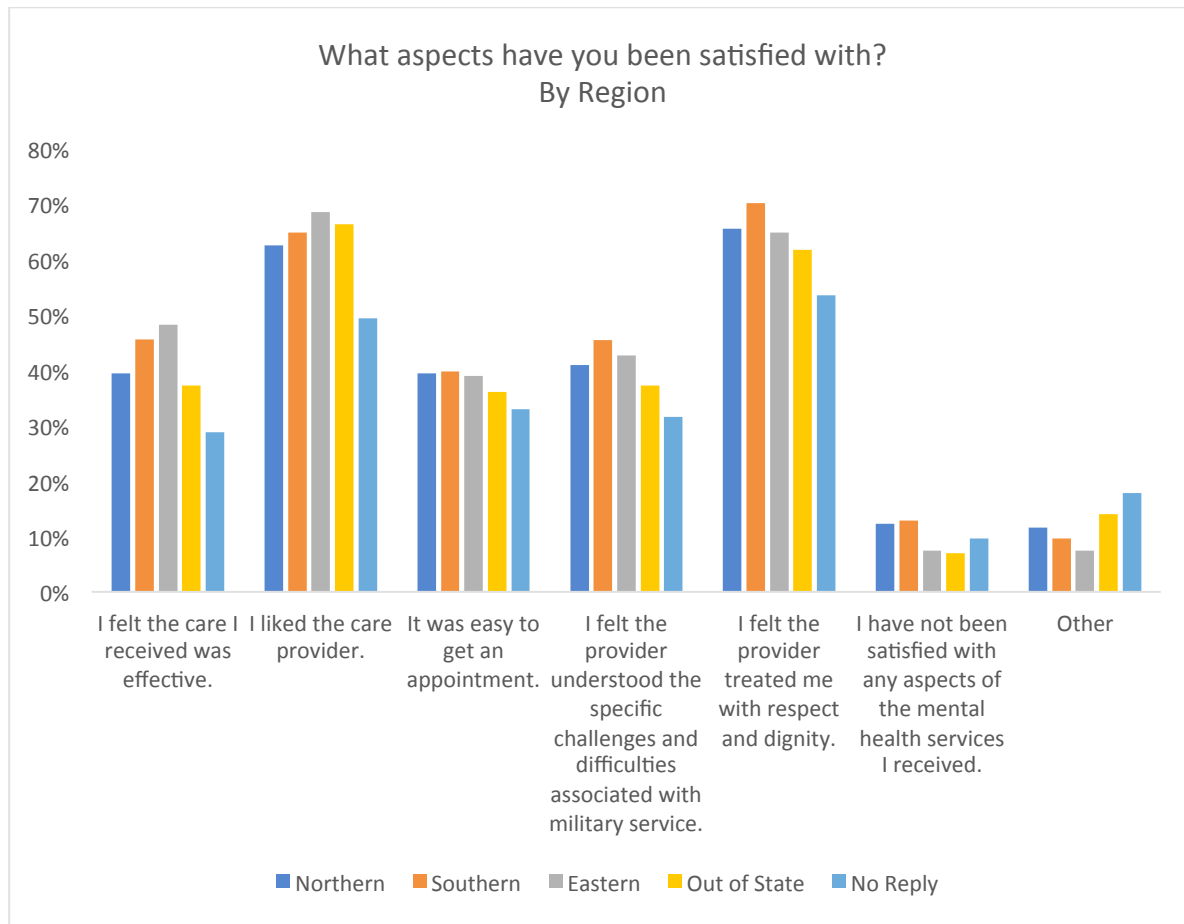
Respondents must have: served in the US Military or National Guard, and sought mental health services in the last two years either within or outside the VA.

34.



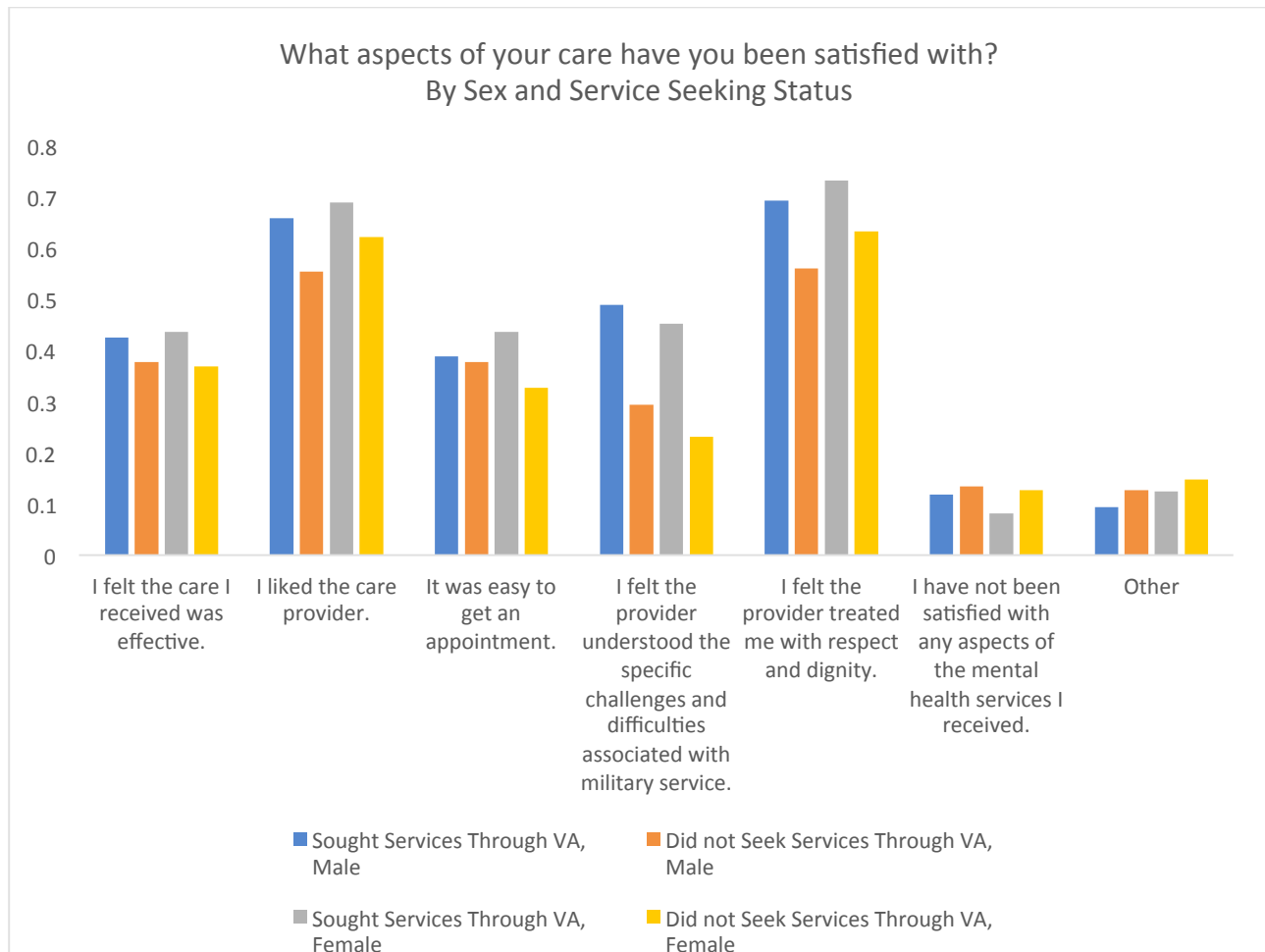
	I felt the care I received was effective.	I liked the care provider.	It was easy to get an appointment.	I felt the provider understood the specific challenges and difficulties associated with military service.	I felt the provider treated me with respect and dignity.	I have not been satisfied with any aspects of the mental health services I received.	Other	Total
Male	561	855	526	586	891	169	142	1368
Female	147	236	143	138	248	33	46	352

35.



	I felt the care I received was effective.	I liked the care provider.	It was easy to get an appointment.	I felt the provider understood the specific challenges and difficulties associated with military service.	I felt the provider treated me with respect and dignity.	I have not been satisfied with any aspects of the mental health services I received.	Other	Total
Northern	389	617	389	404	647	121	114	988
Southern	251	357	219	250	386	71	53	551
Eastern	26	37	21	23	35	4	4	54
Out of State	32	57	31	32	53	6	12	86
No Reply	21	36	24	23	39	7	13	73

36.

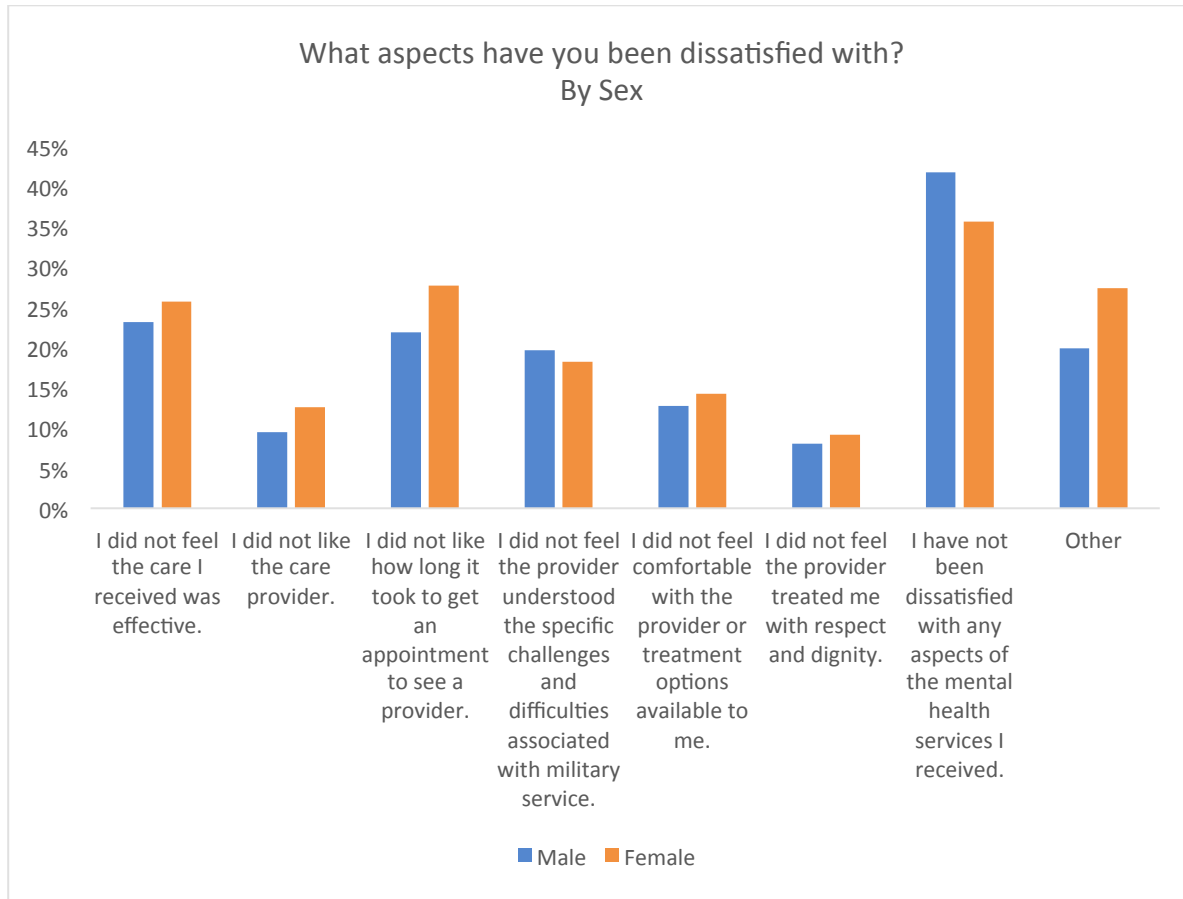


Question 15: What aspects have you been dissatisfied with? (Please select all that apply)

N = 1754

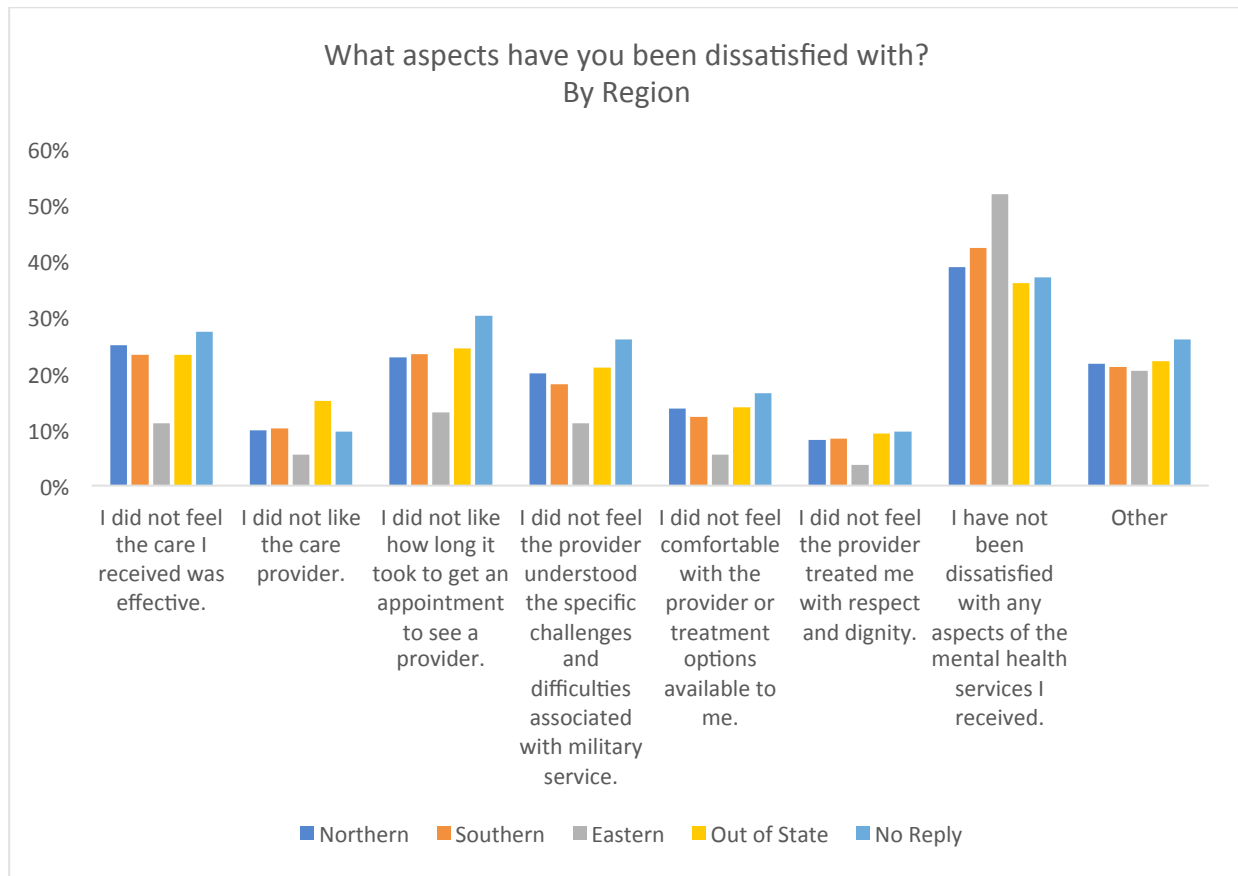
Respondents must have: served in the US Military or National Guard, and sought mental health services in the last two years either within or outside the VA.

37.



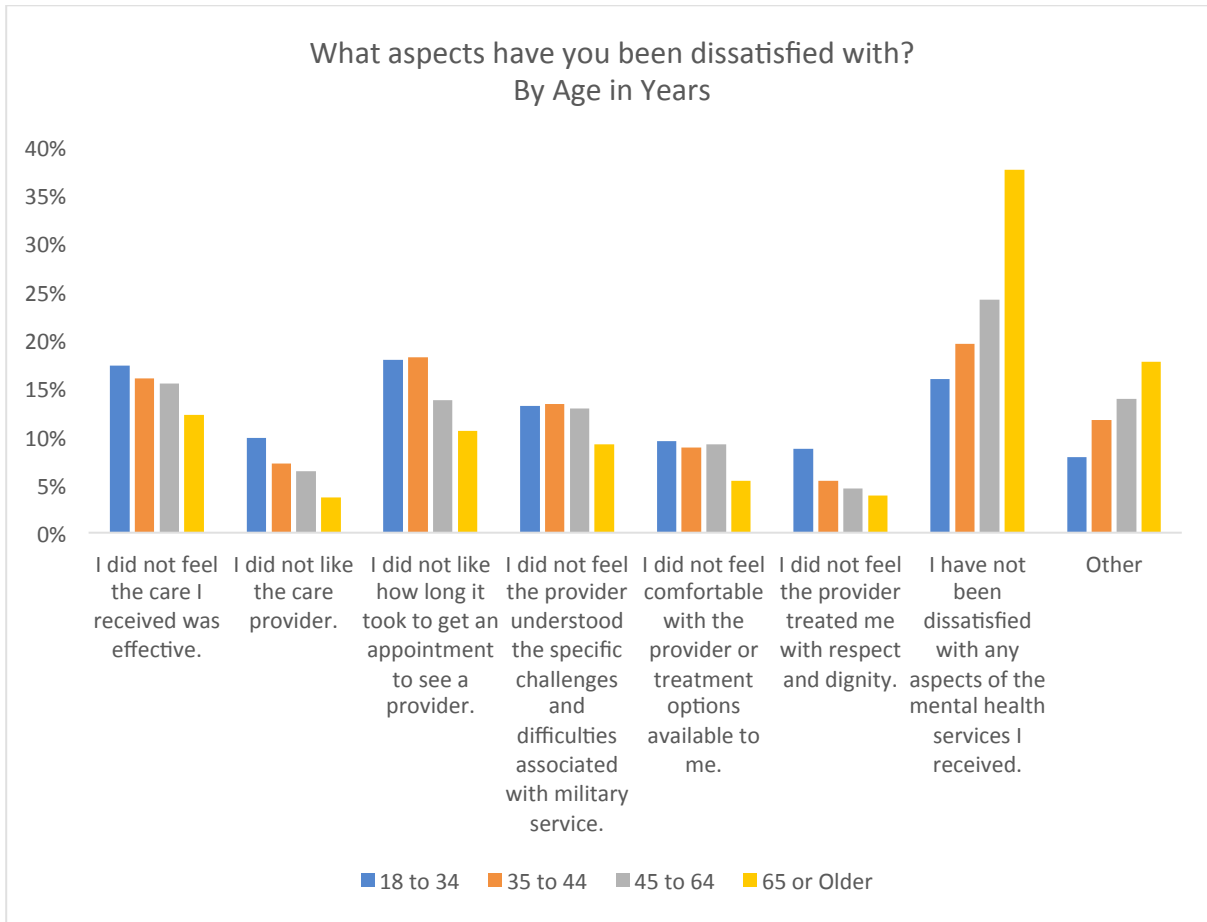
	I did not feel the care I received was effective.	I did not like the care provider.	I did not like how long it took to get an appointment to see a provider.	I did not feel the provider understood the specific challenges and difficulties associated with military service.	I did not feel comfortable with the provider or treatment options available to me.	I did not feel the provider treated me with respect and dignity.	I have not been dissatisfied with any aspects of the mental health services I received.	Other	Total
Male	316	129	298	268	173	109	569	271	1364
Female	90	44	97	64	50	32	125	96	351

38.

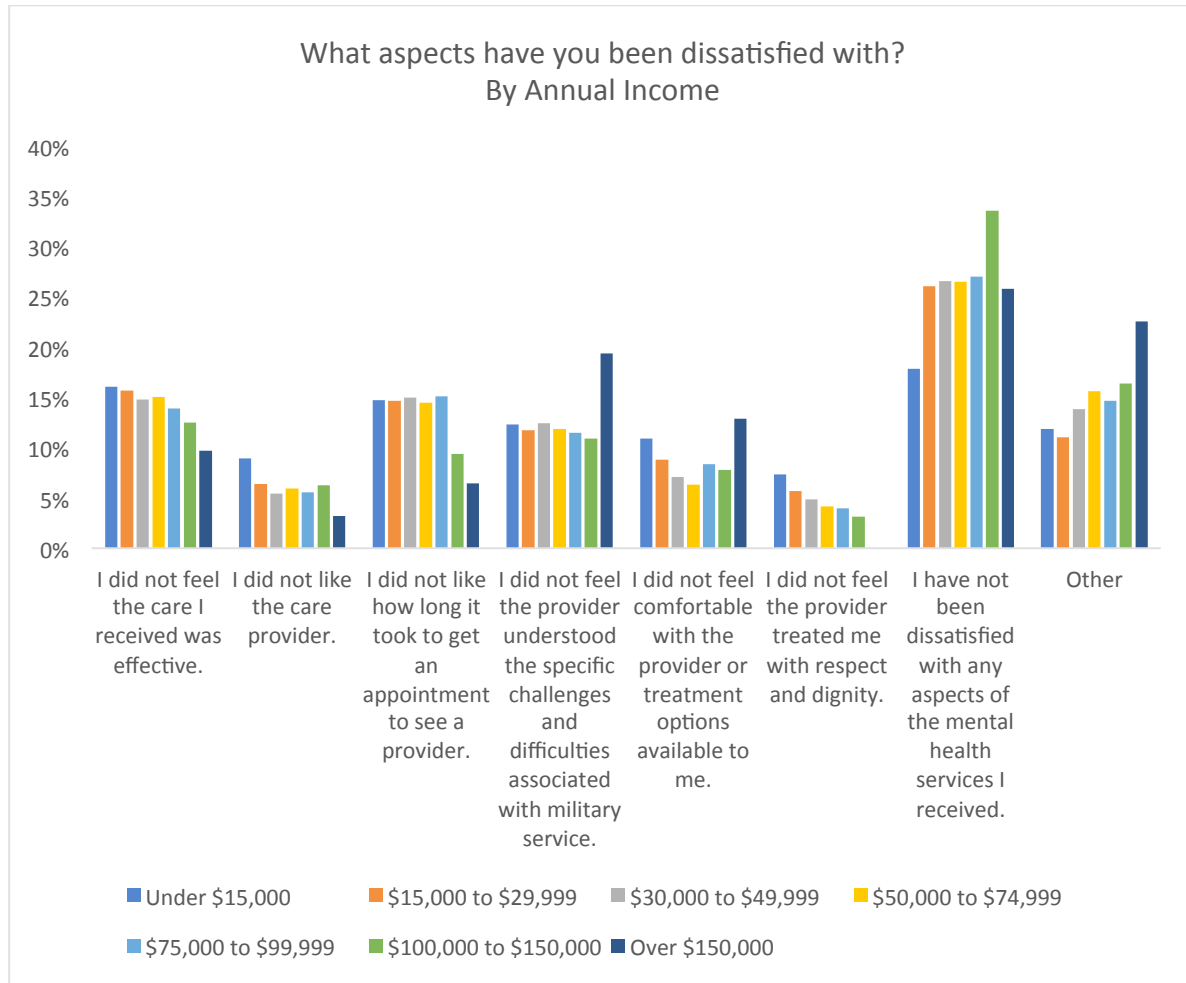


	I did not feel the care I received was effective.	I did not like the care provider.	I did not like how long it took to get an appointment to see a provider.	I did not feel the provider understood the specific challenges and difficulties associated with military service.	I did not feel comfortable with the provider or treatment options available to me.	I did not feel the provider treated me with respect and dignity.	I have not been dissatisfied with any aspects of the mental health services I received.	Other	Total
Northern	245	97	224	196	135	80	382	213	983
Southern	128	56	129	99	67	46	233	116	551
Eastern	6	3	7	6	3	2	28	11	54
Out of State	20	13	21	18	12	8	31	19	86
No Reply	20	7	22	19	12	7	27	19	73

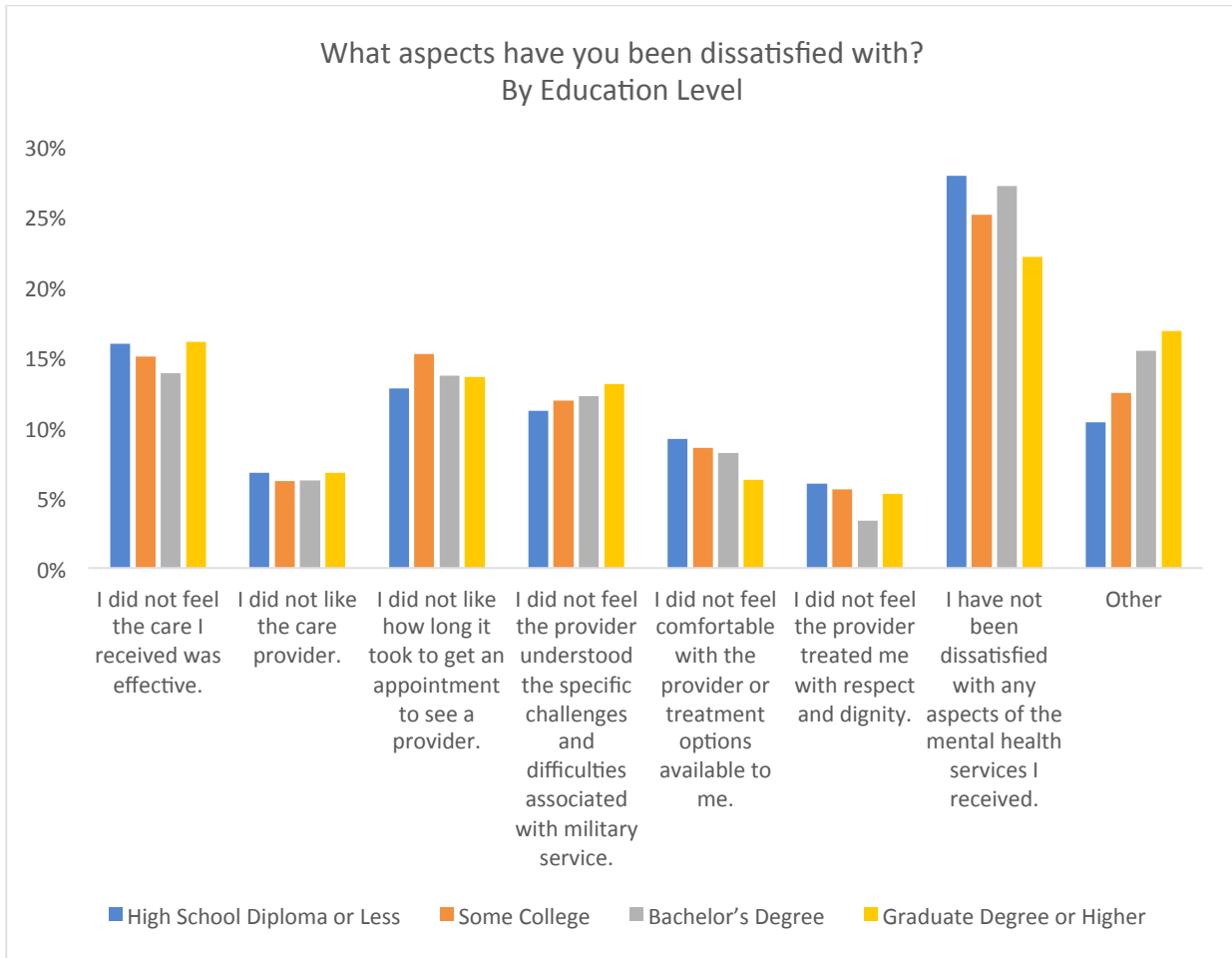
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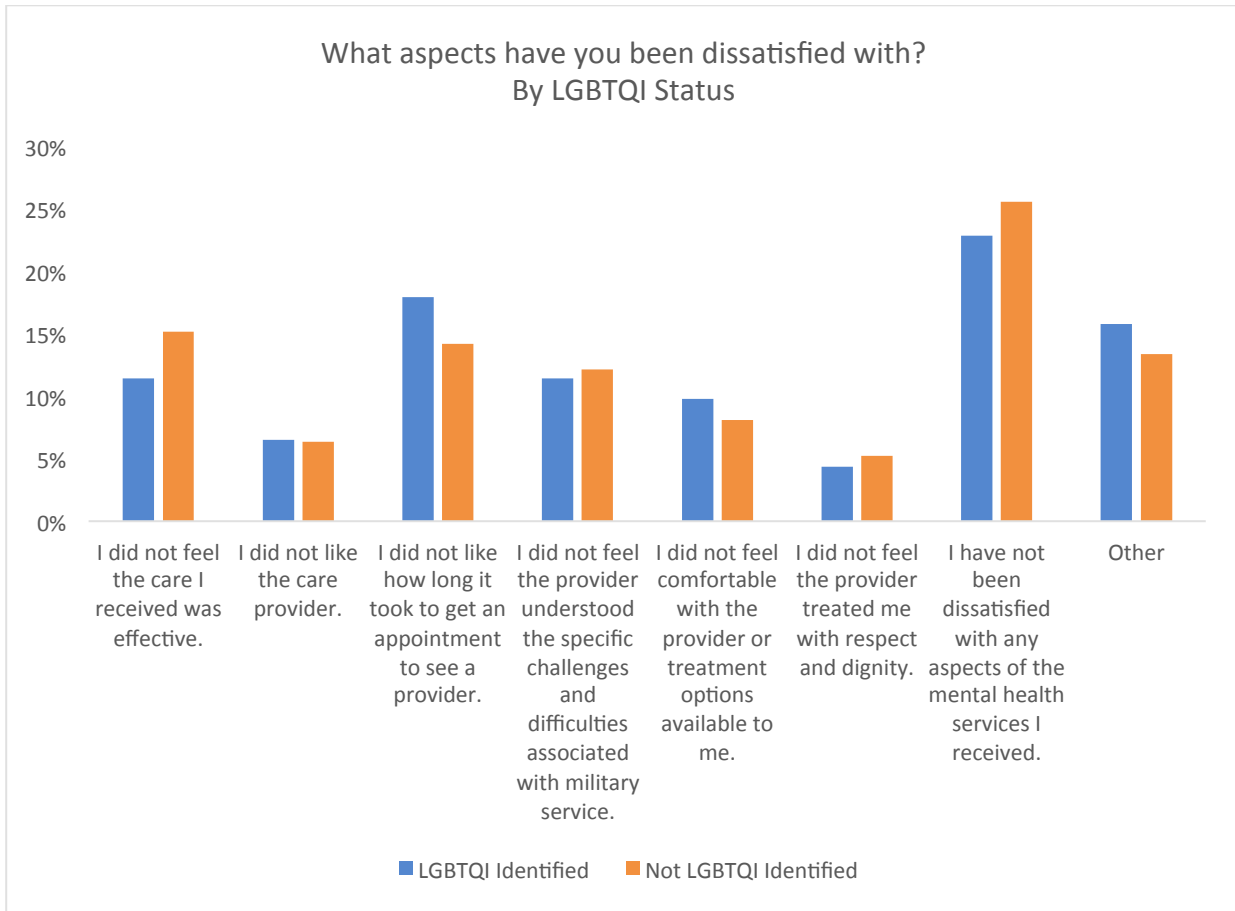
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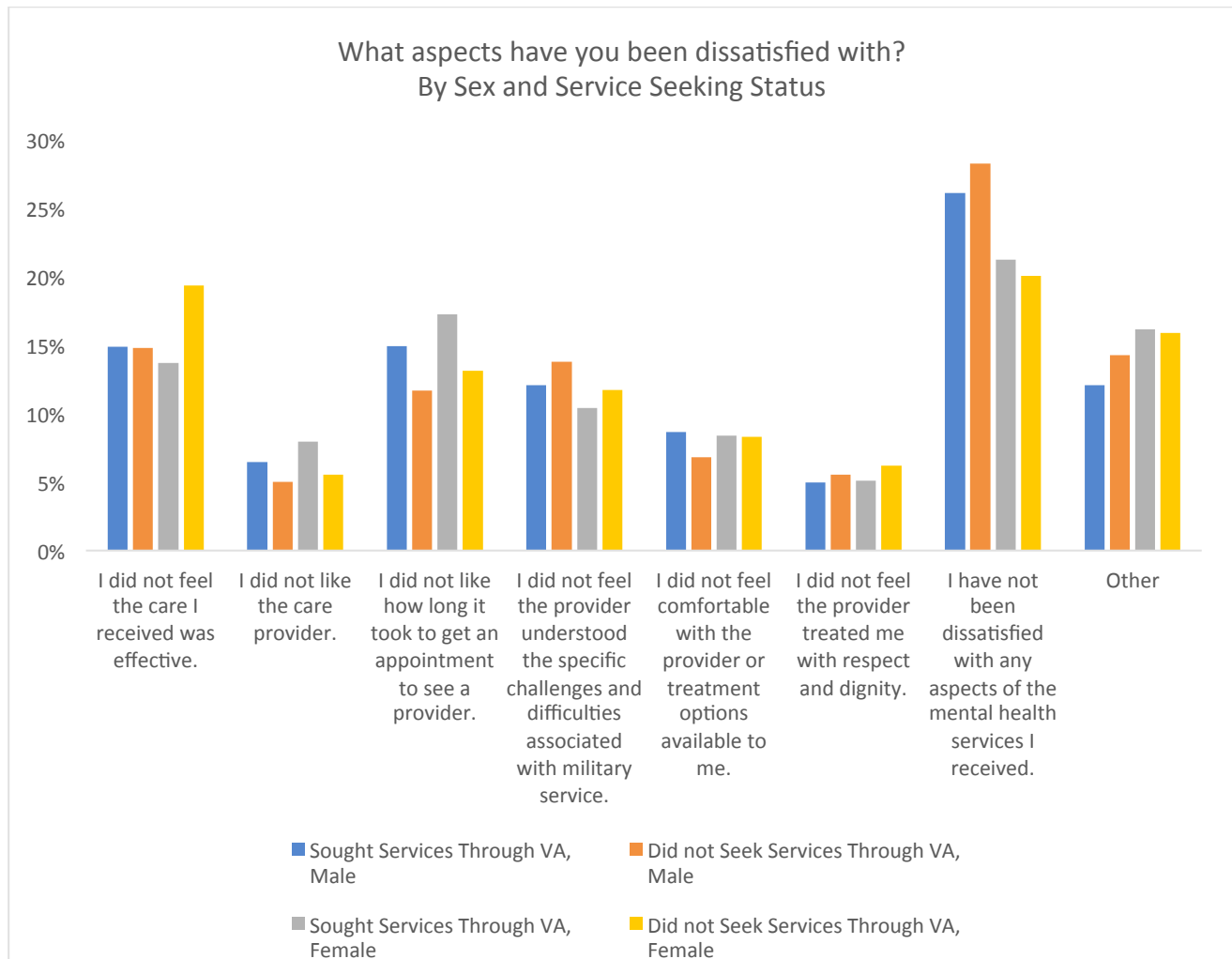
41.



42.



43.

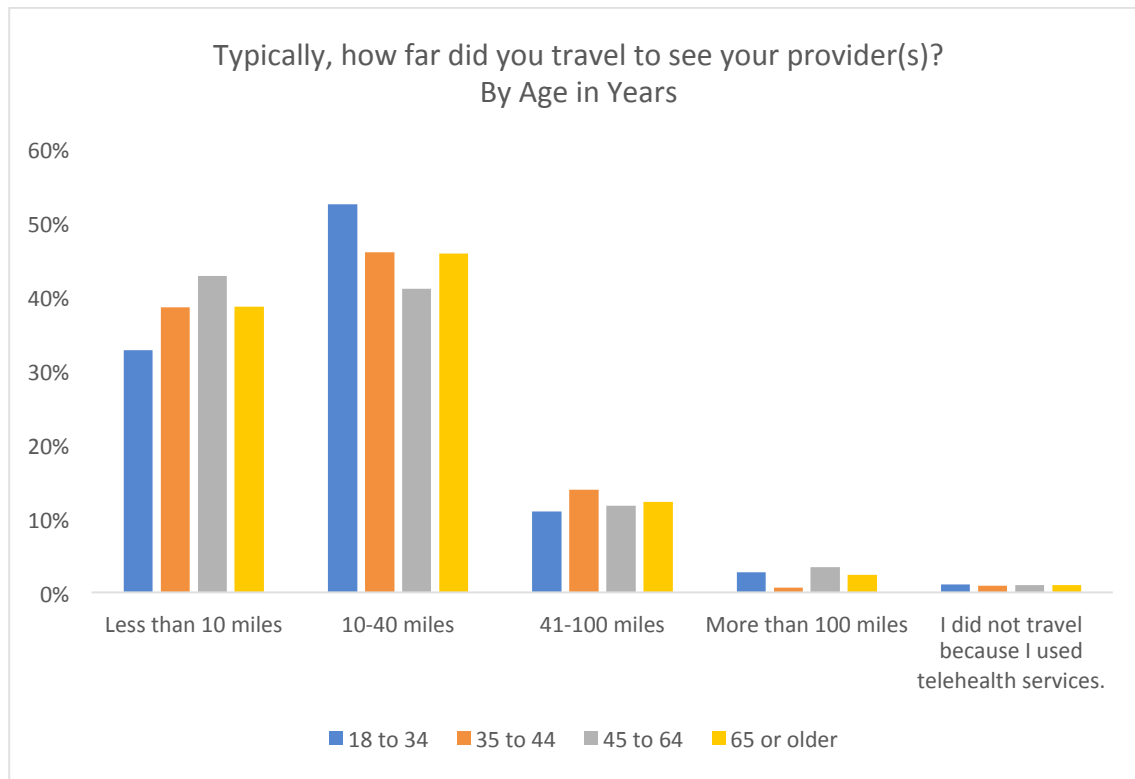


Question 16: Typically, how far did you travel to see your provider(s)?

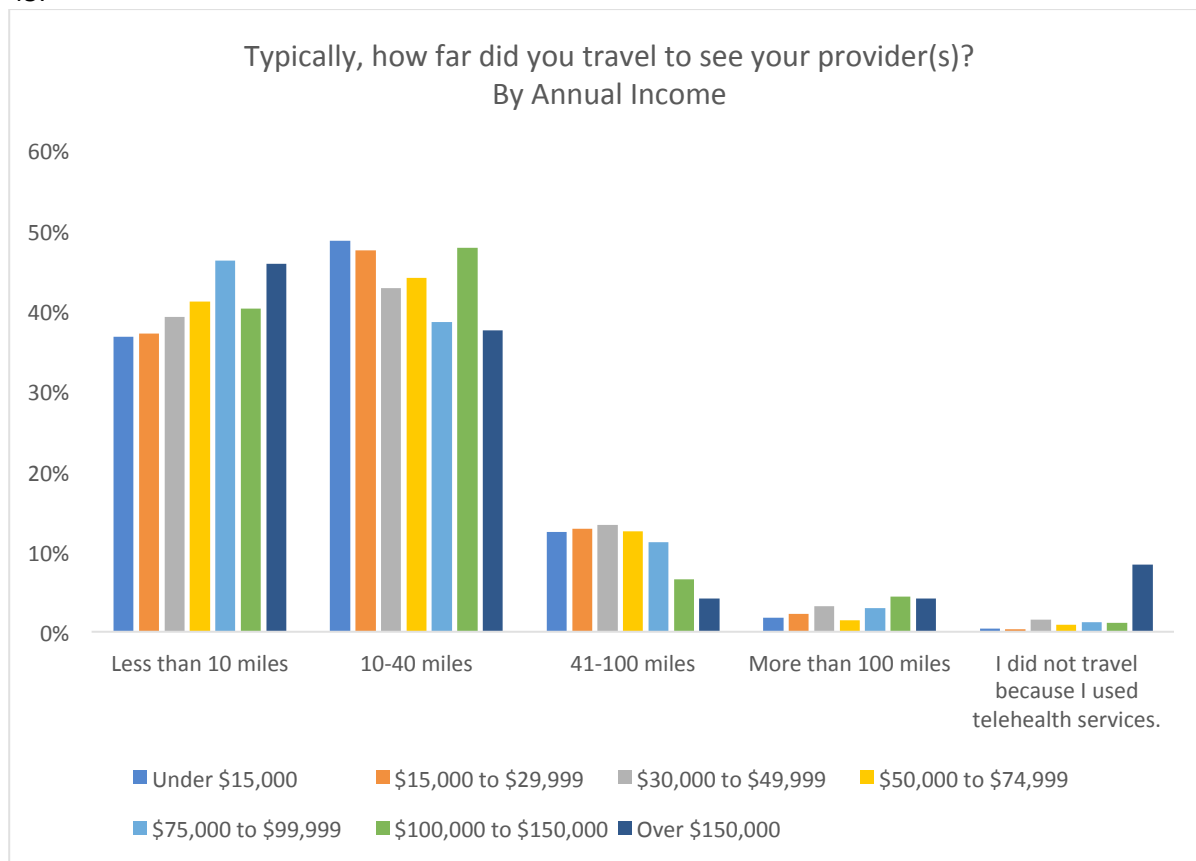
N = 1754

Respondents must have: served in the US Military or National Guard, and sought mental health services in the last two years either within or outside the VA.

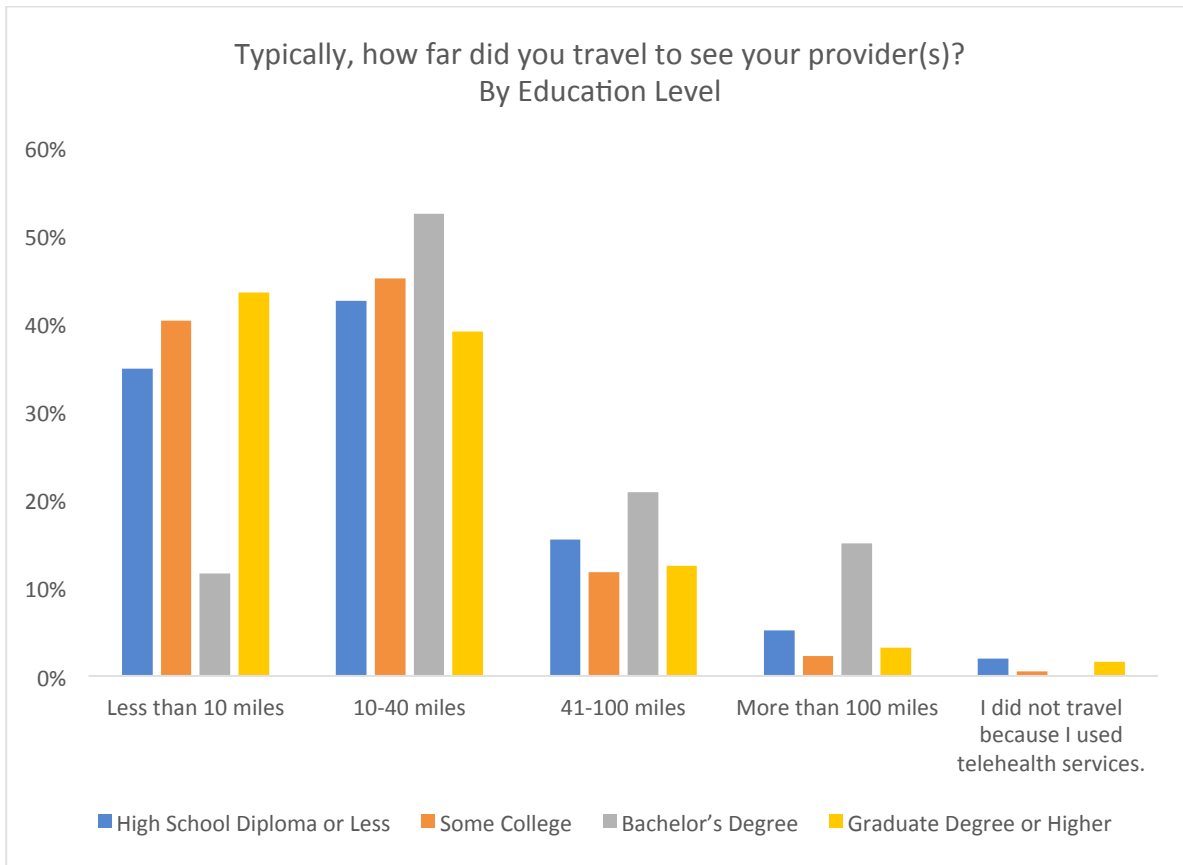
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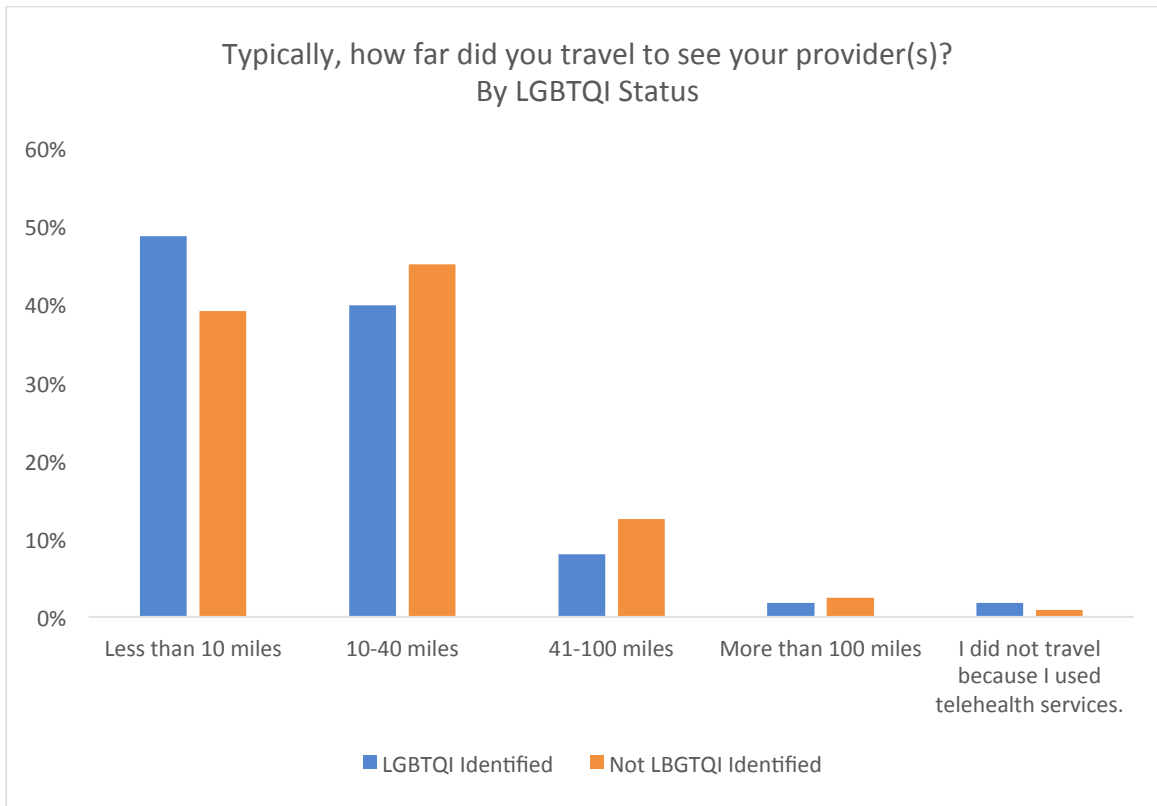
45.



46.



47.

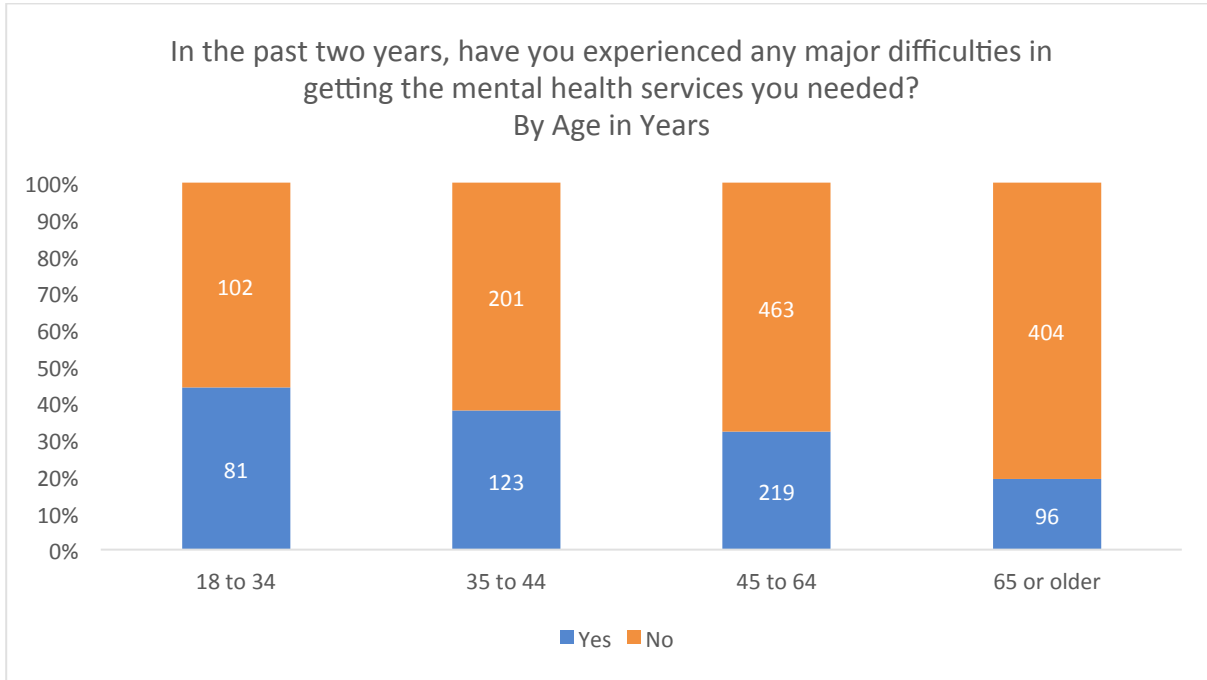


Question 17: In the past two years, have you experienced any major difficulties in getting the mental health services you needed?

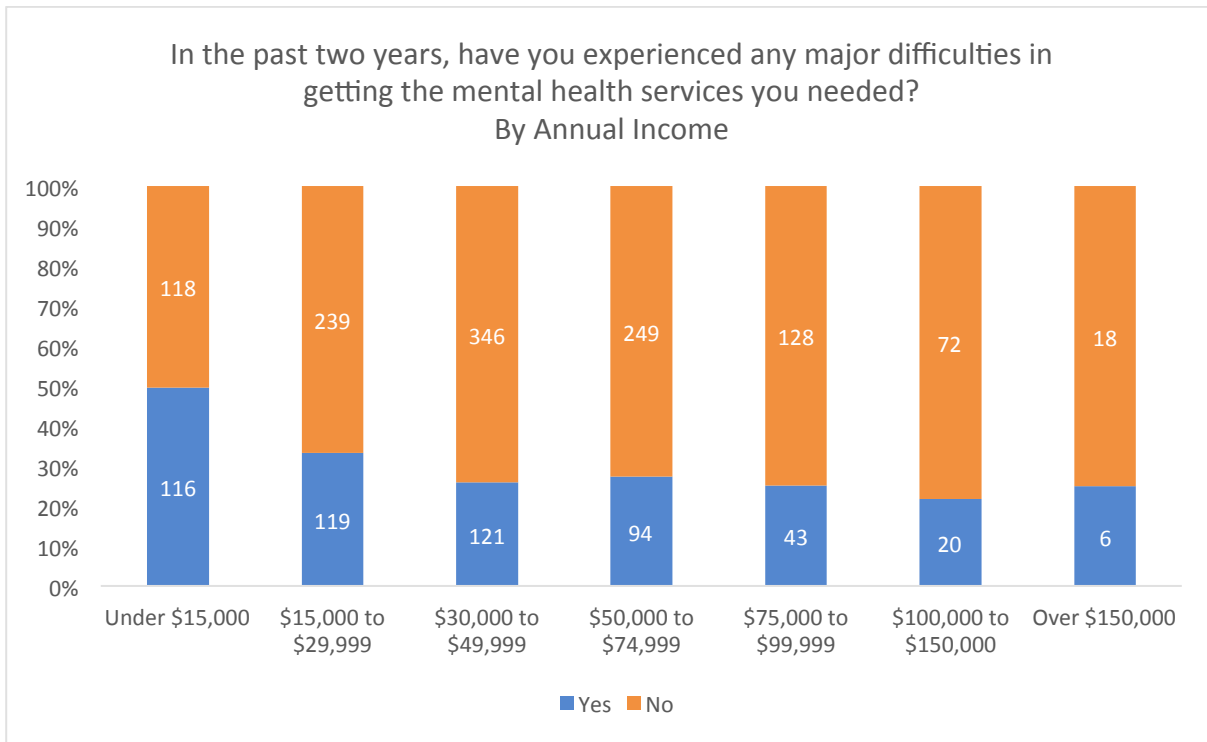
N = 1754

Respondents must have: served in the US Military or National Guard, and sought mental health services in the last two years either within or outside the VA.

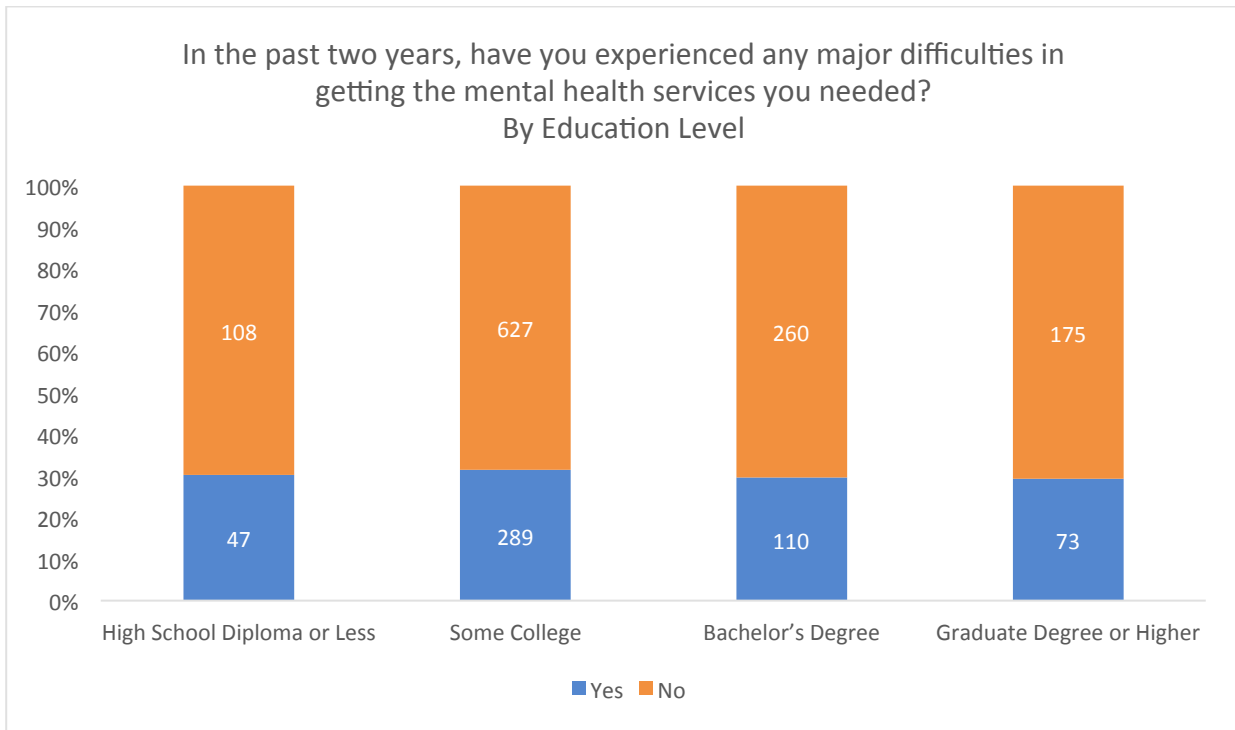
48.



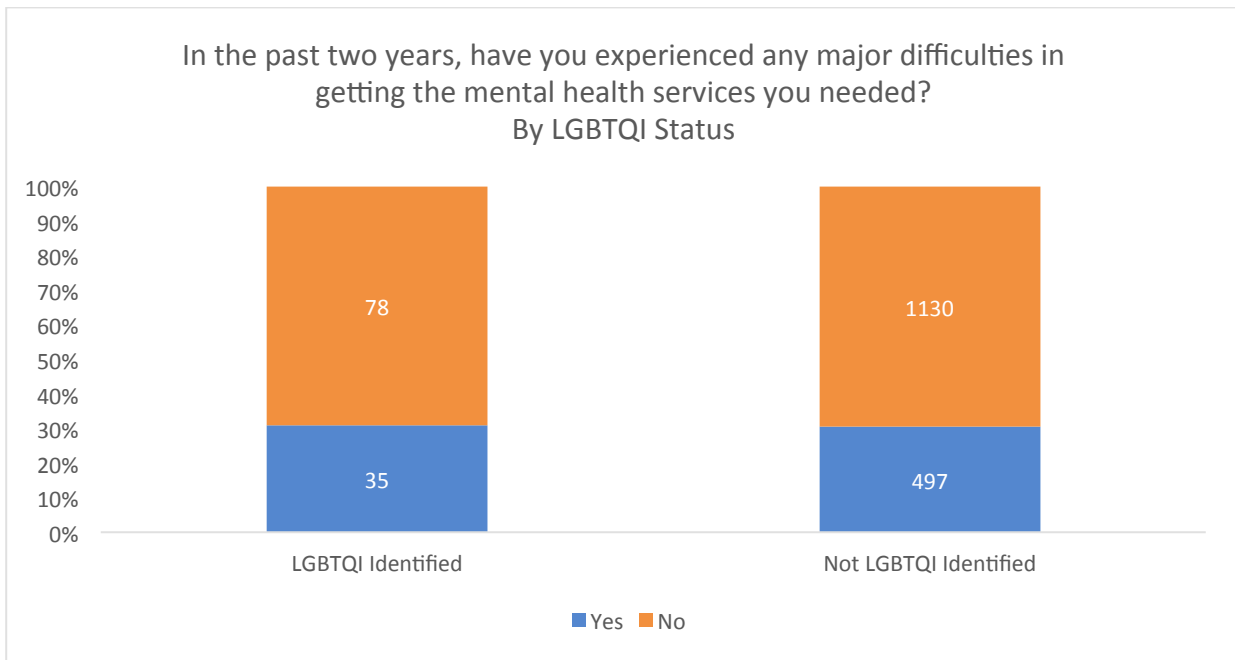
49.



50.



51.

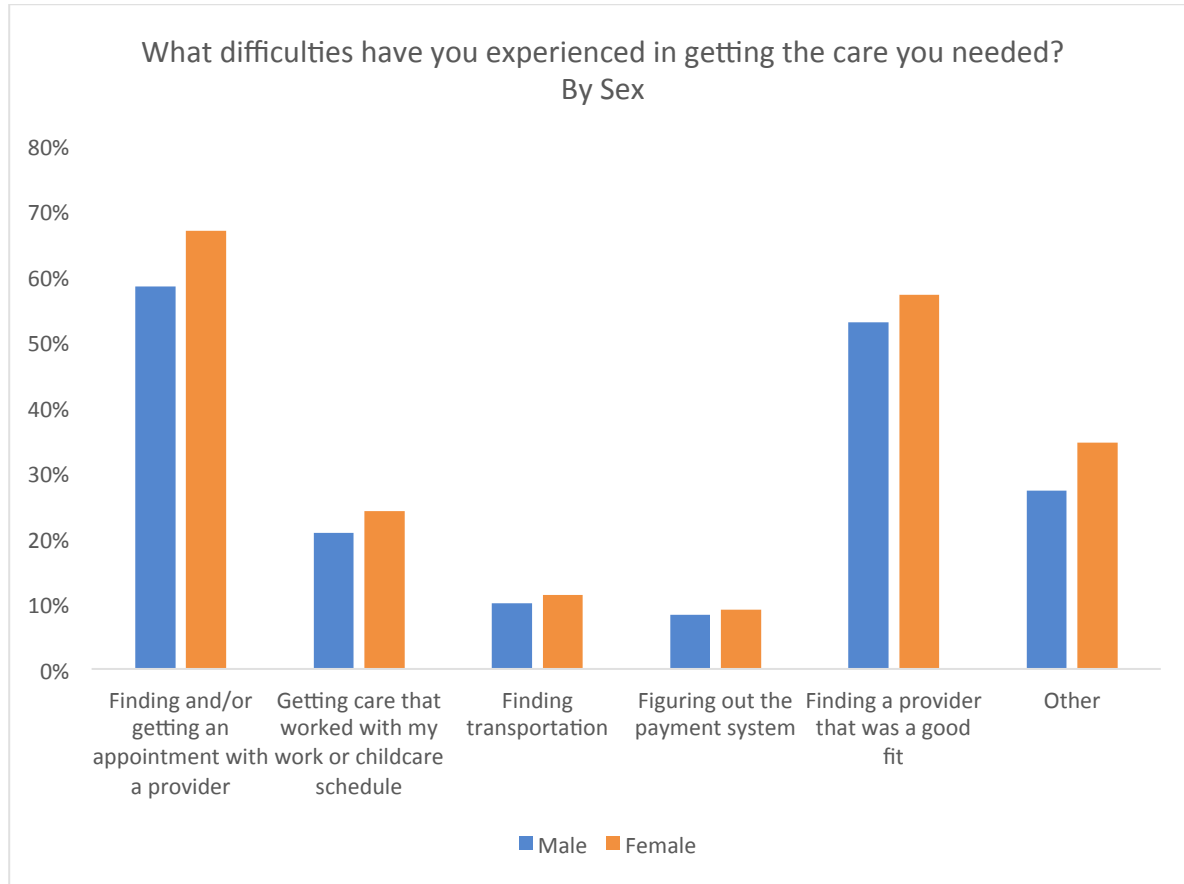


Question 18: What difficulties have you experienced in getting the care you needed? (Please select all that apply)

N= 536

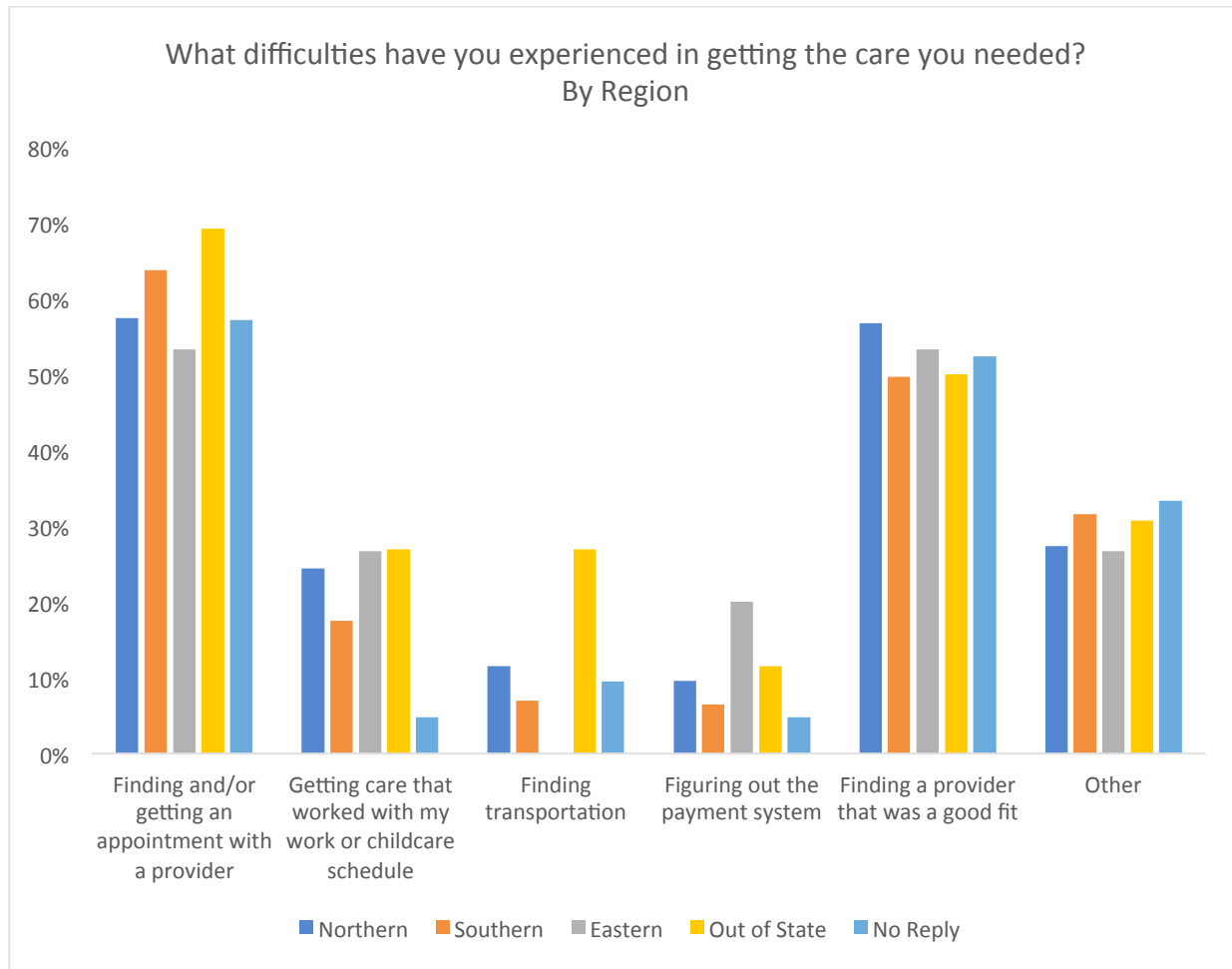
Respondents must have: served in the US Military or National Guard, sought mental health services in the last two years either within or outside the VA, and experienced any major difficulties getting the care they needed

52.



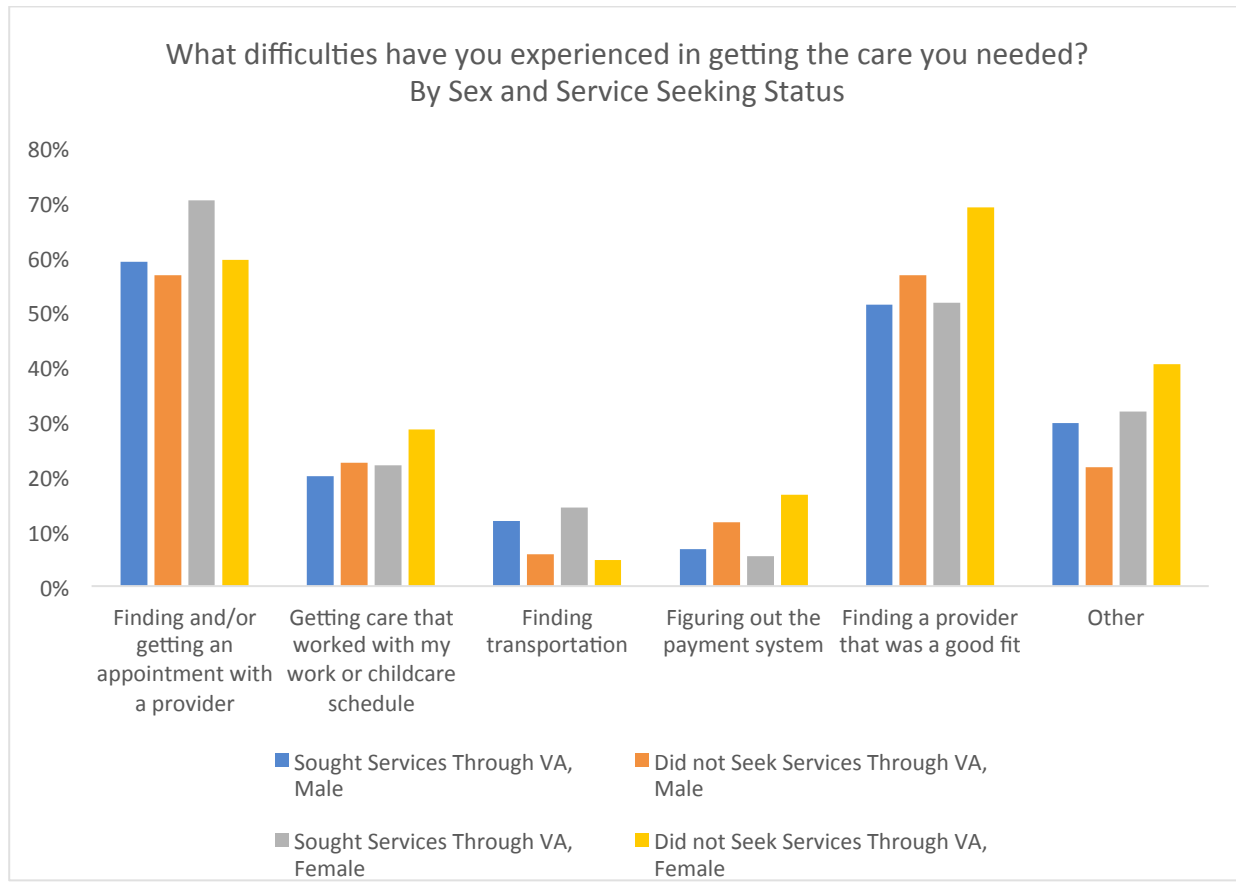
	Finding and/or getting an appointment with a provider	Getting care that worked with my work or childcare schedule	Finding transportation	Figuring out the payment system	Finding a provider that was a good fit	Other	Total
Male	227	81	39	32	206	106	389
Female	89	32	15	12	76	46	133

53.



	Finding and/or getting an appointment with a provider	Getting care that worked with my work or childcare schedule	Finding transportation	Figuring out the payment system	Finding a provider that was a good fit	Other	Total
Northern	174	74	35	29	172	83	303
Southern	109	30	12		85	54	171
Eastern	8	4	0	3	8	4	15
Out of State	18	7	7	3	13	8	26
No Reply	12	1	2	1	11	7	21

54.

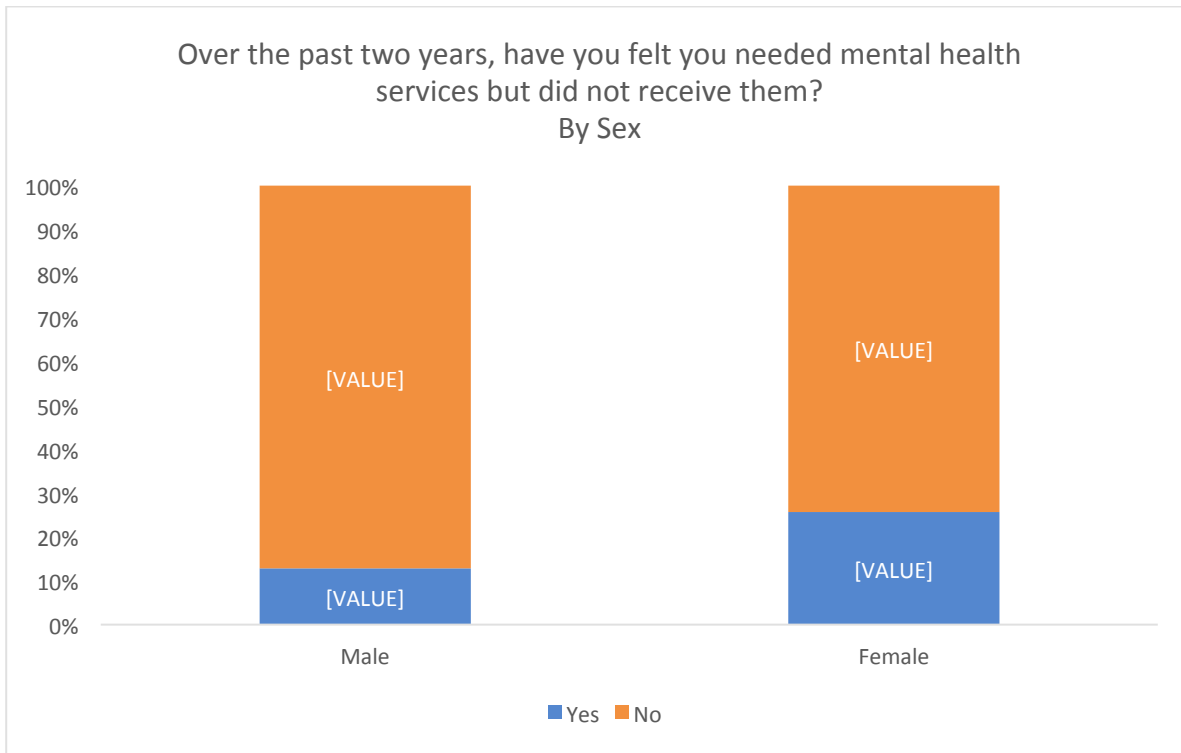


Question 19: Over the past two years, have you felt you needed mental health services but did not receive them?

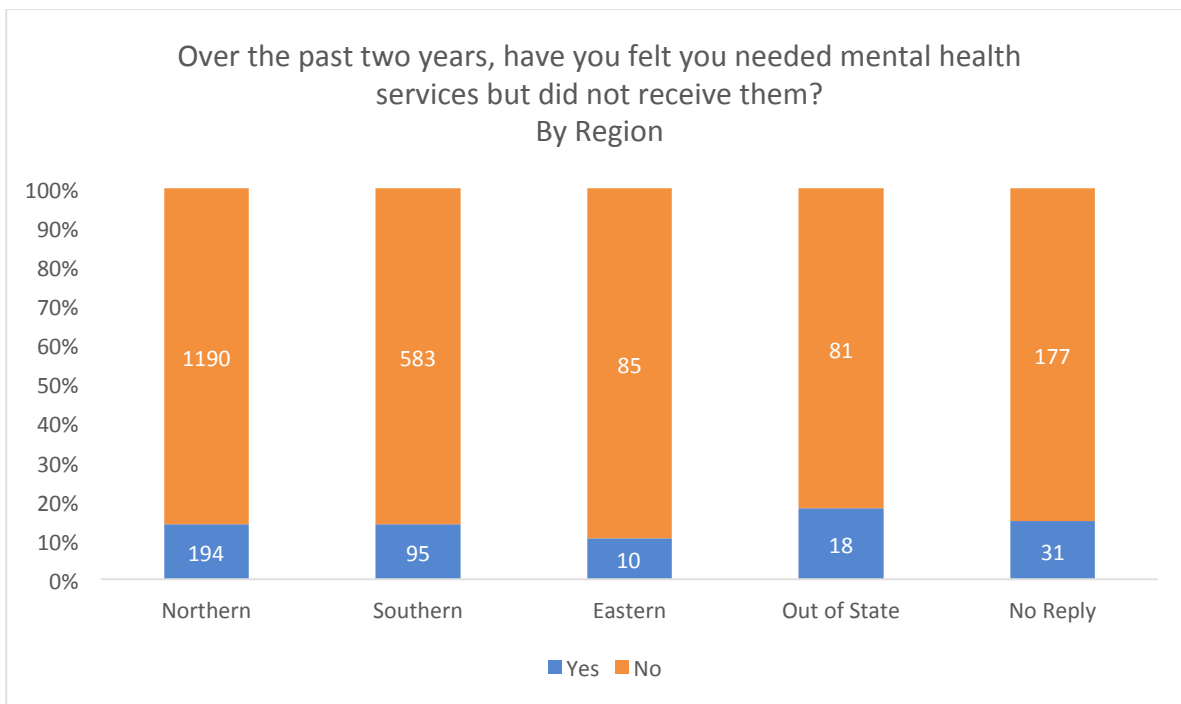
N = 2464

Respondents must have: served in the US Military or National Guard, and NOT sought mental health services in the last two years either within or outside of the VA

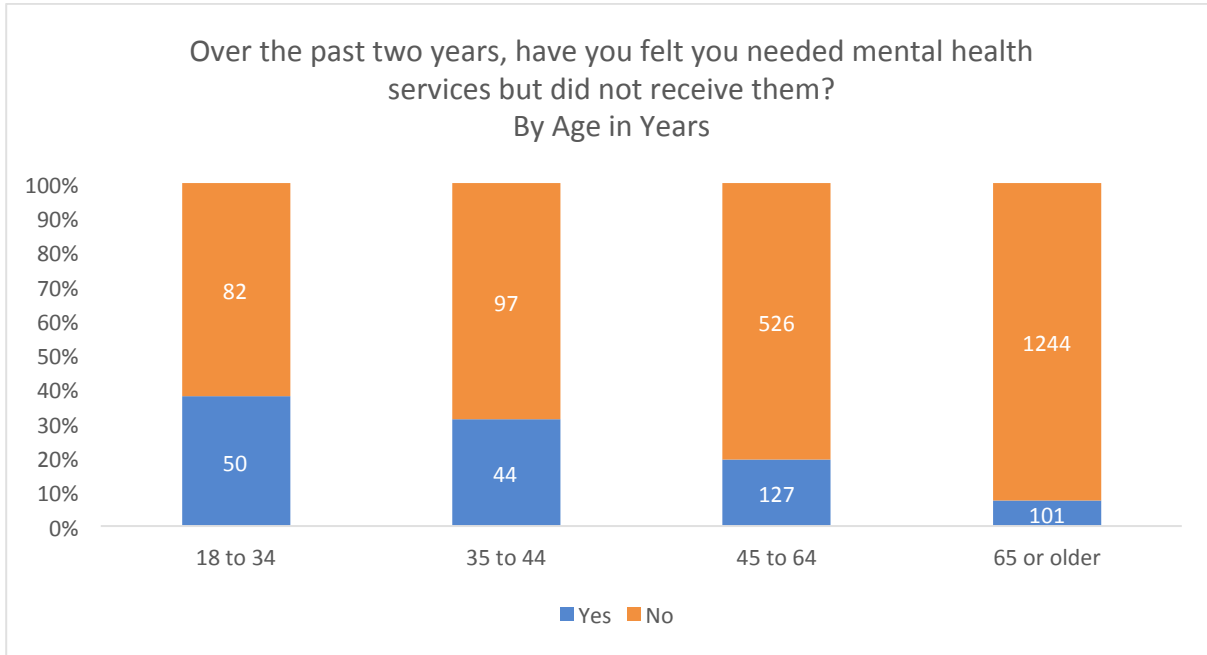
55.



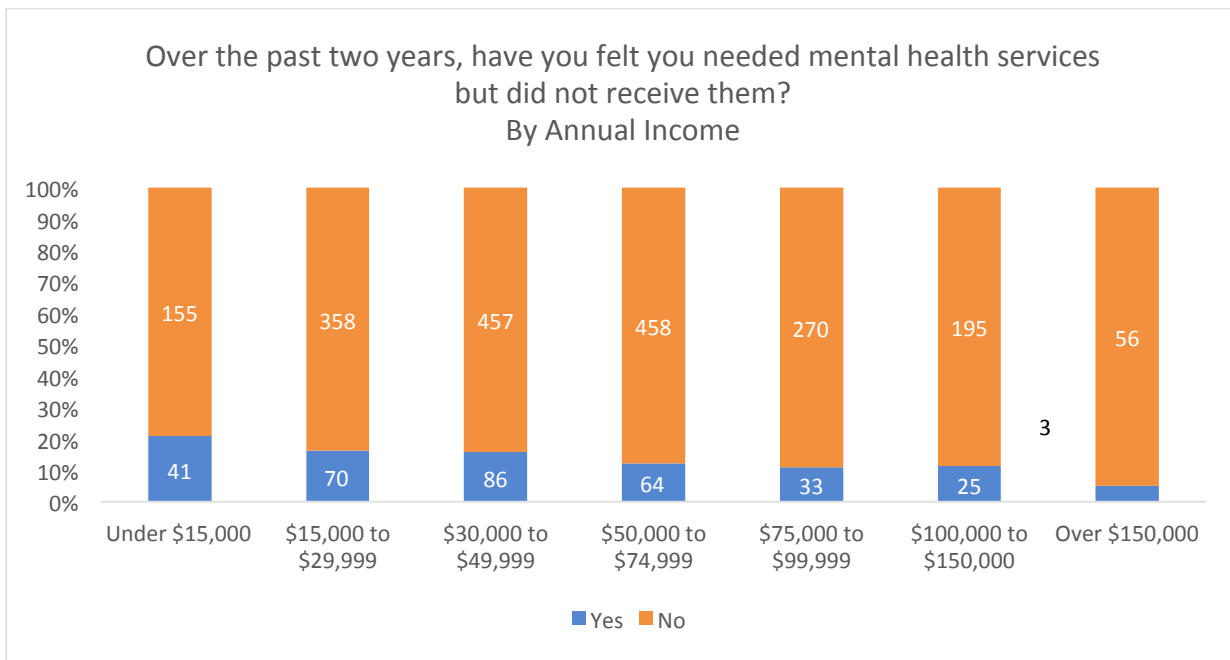
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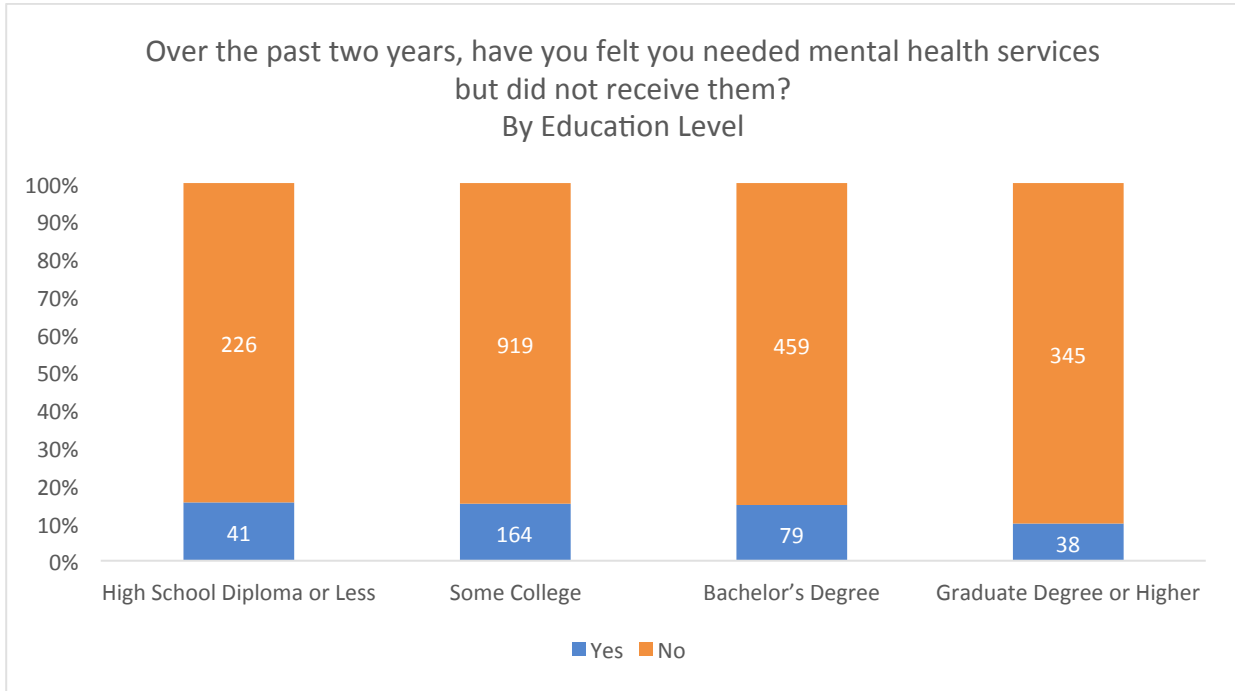
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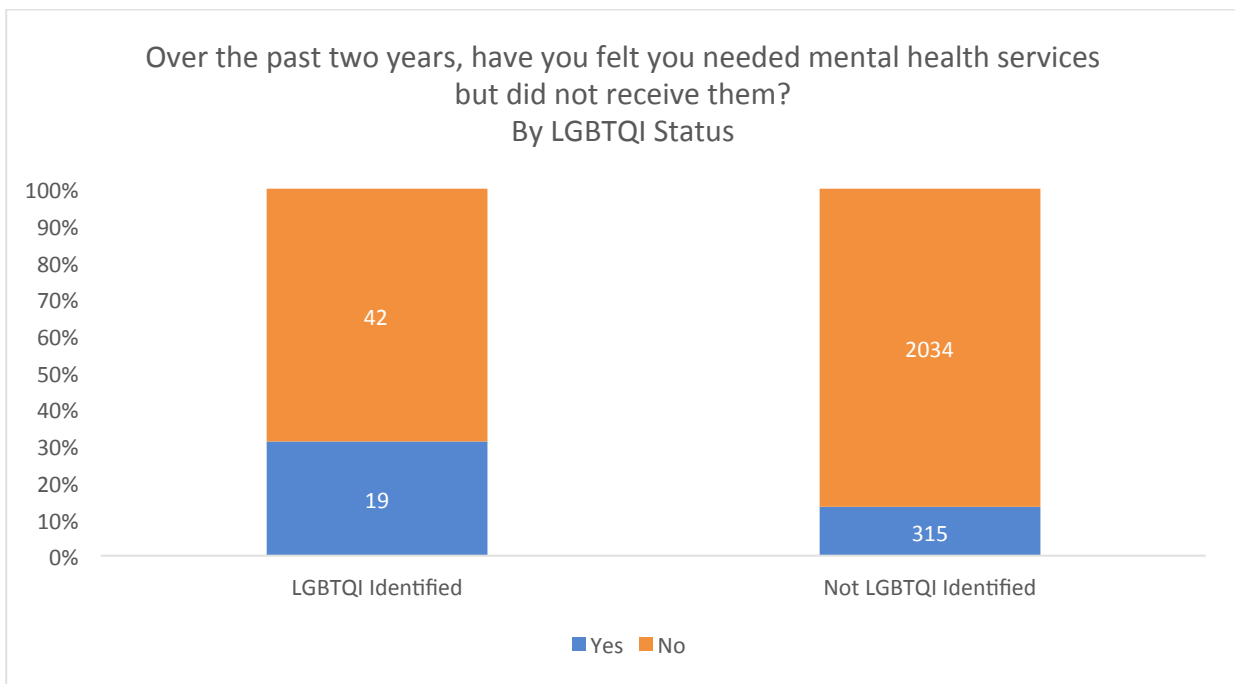
58.



59.



60.

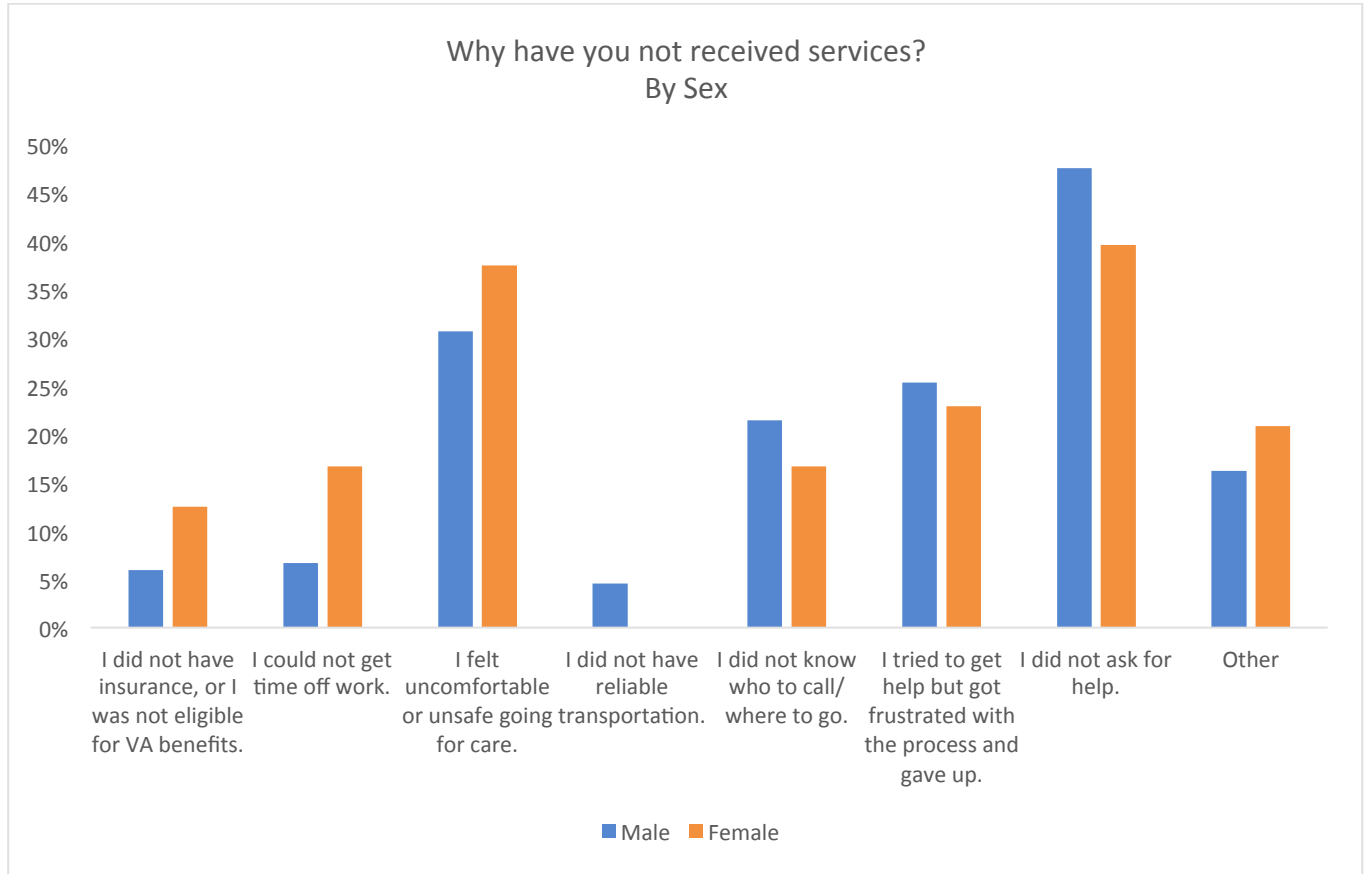


Question 20: Why have you not received services? (Please select all that apply)

N = 336

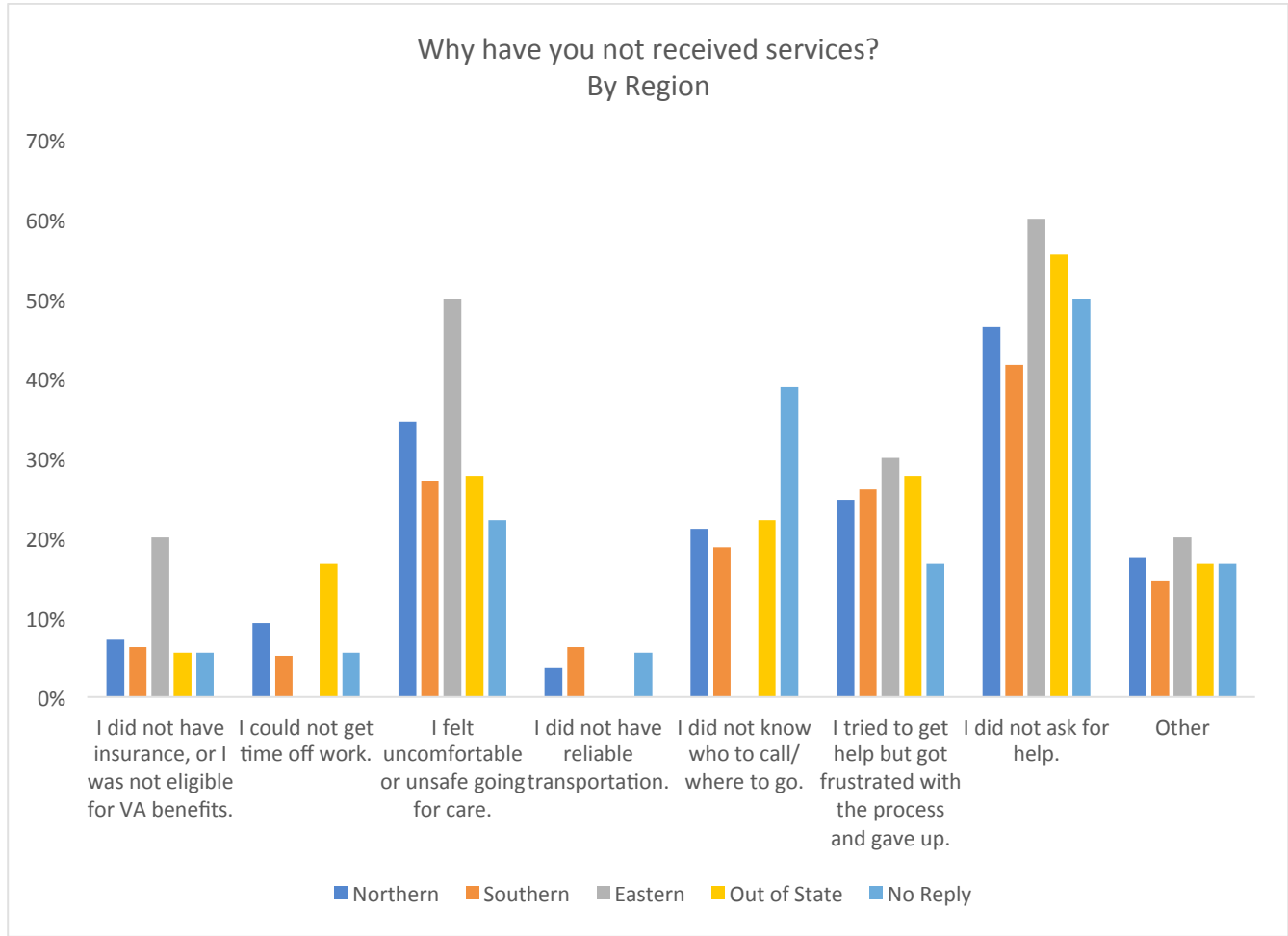
Respondents must have: served in the US Military or National Guard, and NOT sought mental health services in the last two years either within or outside of the VA

61.



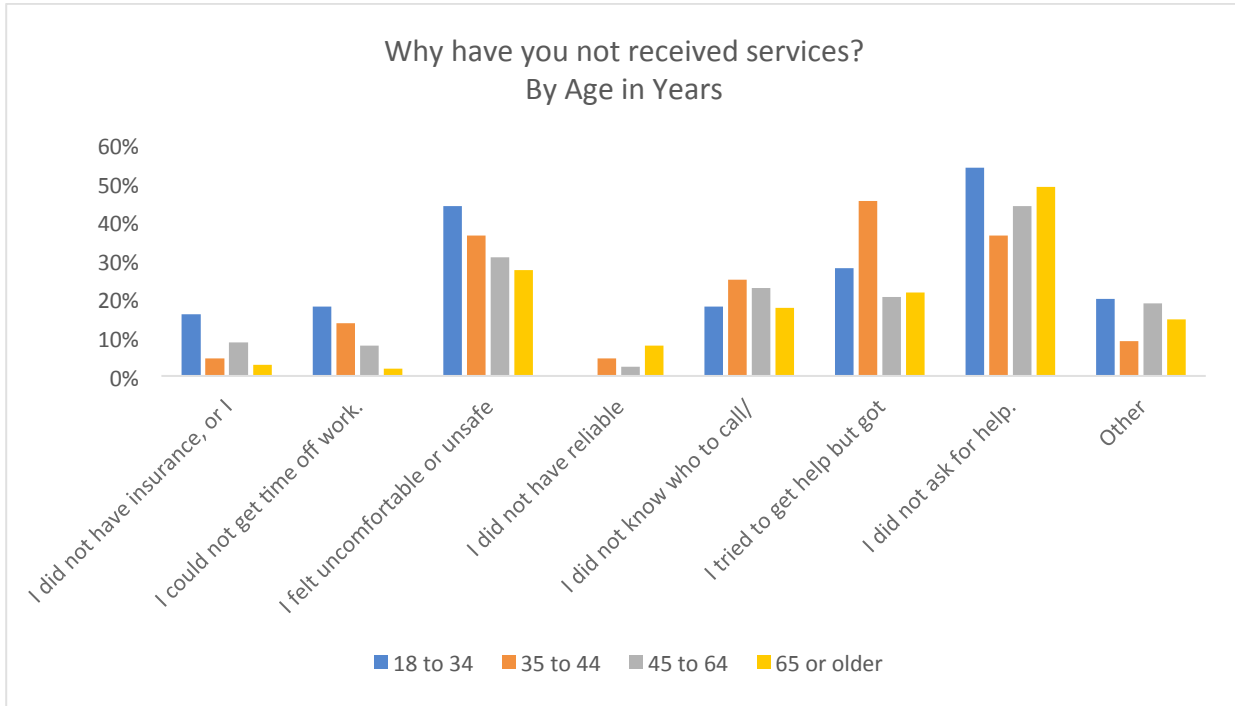
	I did not have insurance, or I was not eligible for VA benefits.	I could not get time off work.	I felt uncomfortable or unsafe going for care.	I did not have reliable transportation.	I did not know who to call/where to go.	I tried to get help but got frustrated with the process and gave up.	I did not ask for help.	Other	Total
Male	17	19	87	13	61	72	135	46	284
Female	6	8	18	0	8	11	19	10	48

62.

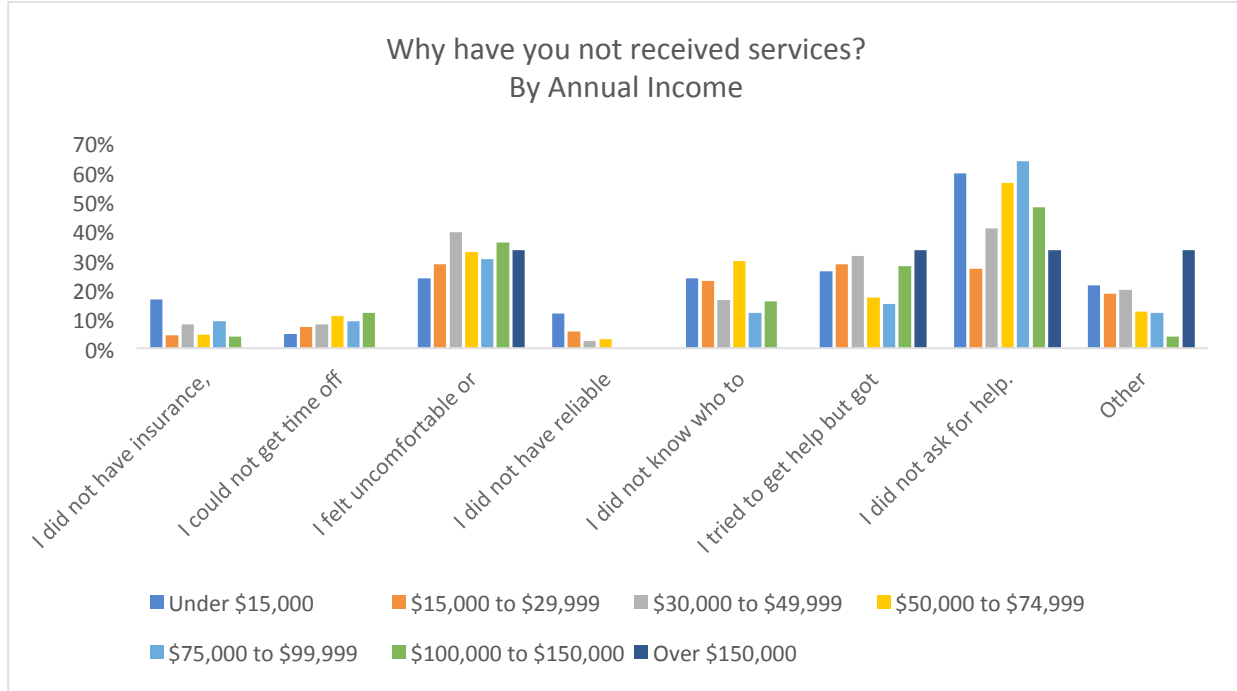


	I did not have insurance, or I was not eligible for VA benefits.	I could not get time off work.	I felt uncomfortable or unsafe going for care.	I did not have reliable transportation.	I did not know who to call/where to go.	I tried to get help but got frustrated with the process and gave up.	I did not ask for help.	Other	Total
Northern	14	18	67	7	41	48	90	34	194
Southern	6	5	26	6	18	25	40	14	96
Eastern	2	0	5	0	0	3	6	2	10
Out of State	1	3	5	0	4	5	10	3	18
No Reply	1	1	4	1	7	3	9	3	18

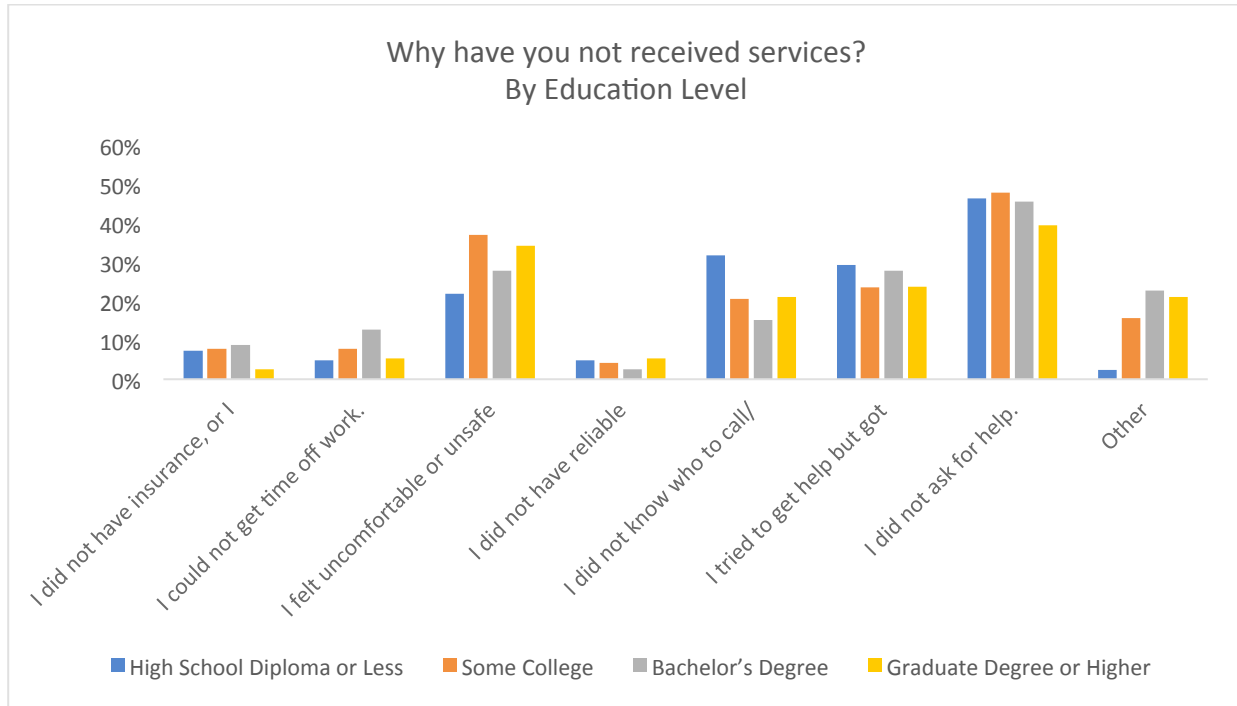
63.



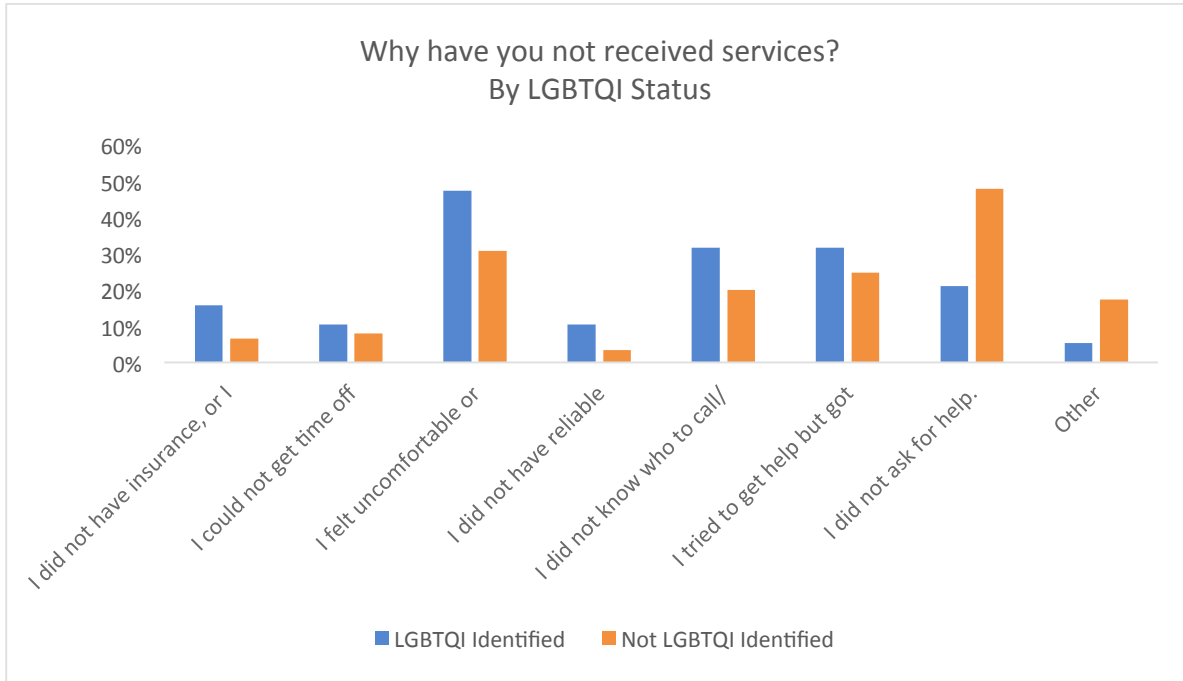
64.



65.



66.

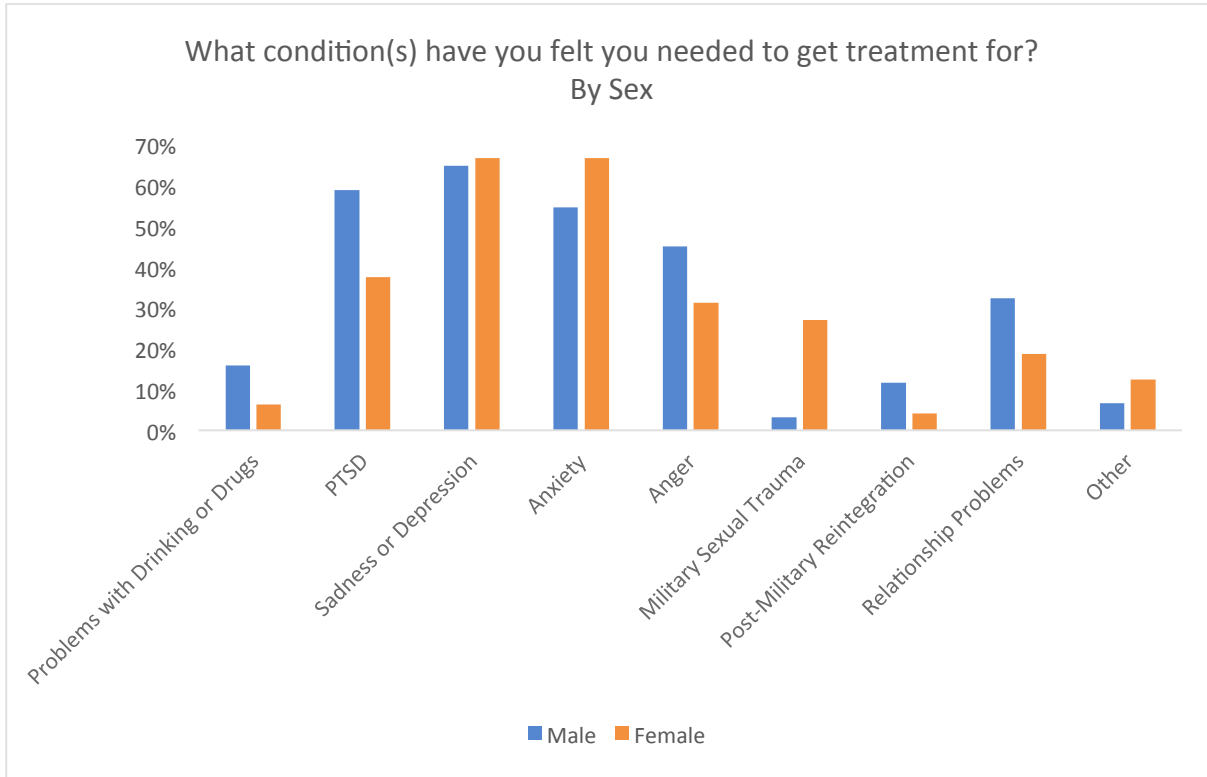


Question 21: What condition(s) have you felt you needed to get treatment for? (Please select all that apply)

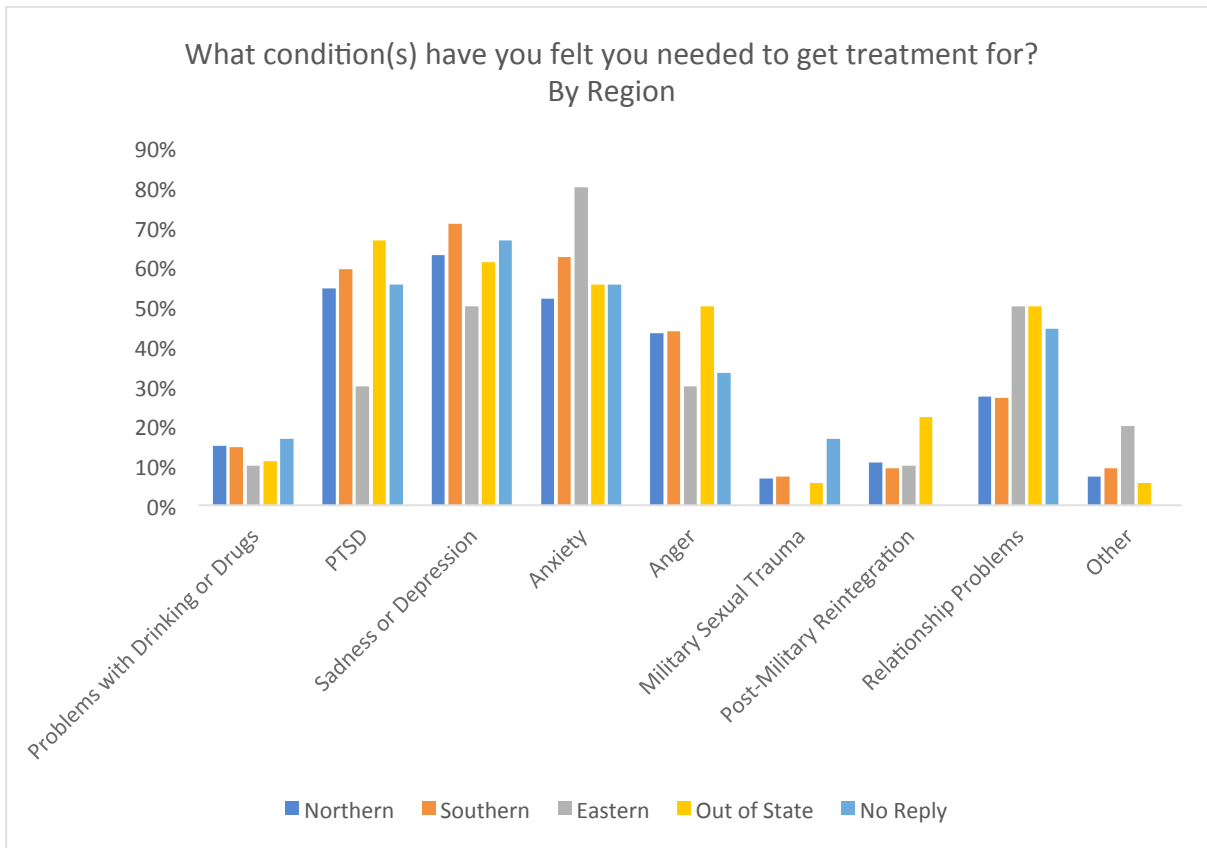
N = 336

Respondents must have: served in the US Military or National Guard, and NOT sought mental health services in the last two years either within or outside of the VA

67.



68.



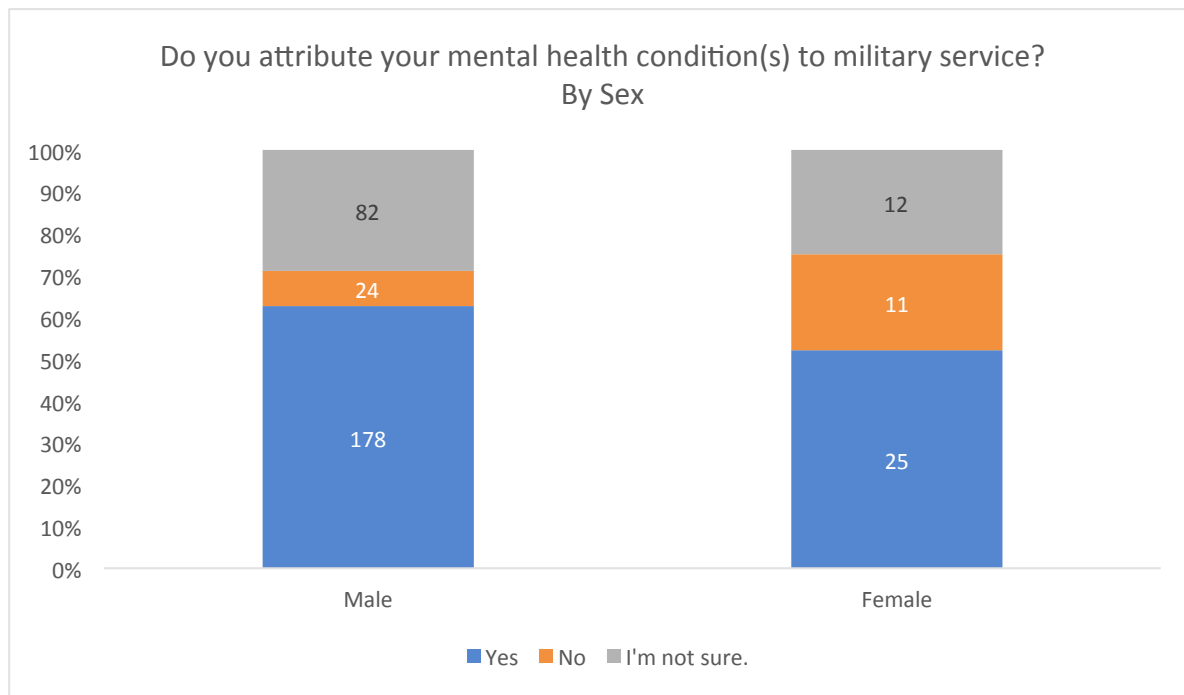
	Problems with Drinking or Drugs	PTSD	Sadness or Depression	Anxiety	Anger	Military Sexual Trauma	Post-Military Reintegration	Relationship Problems	Other	Total
Northern	29	106	122	101	84	13	21	53	14	194
Southern	14	57	68	60	42	7	9	26	9	96
Eastern	1	3	5	8	3	0	1	5	2	10
Out of State	2	12	11	10	9	1	4	9	1	18
No Reply	3	10	12	10	6	3	0	8	0	18

Question 22: Do you attribute your mental health condition(s) to military service?

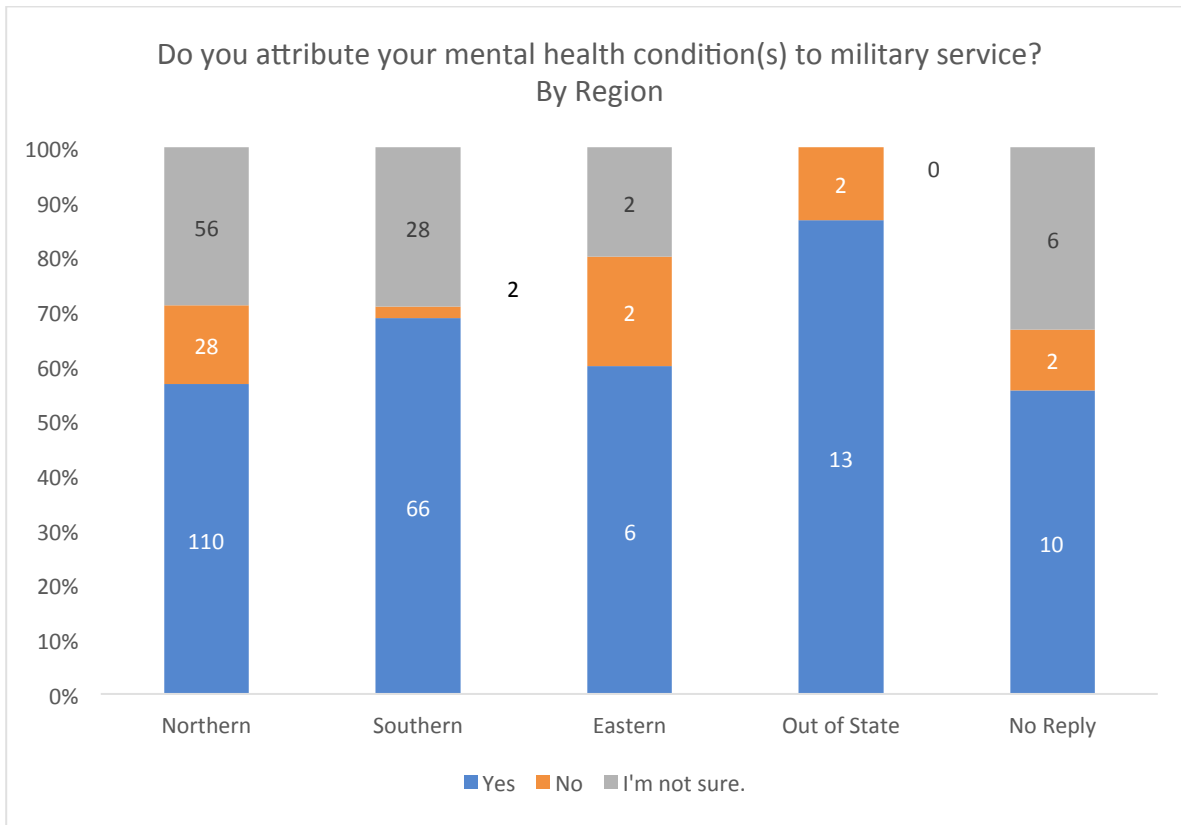
N = 336

Respondents must have: served in the US Military or National Guard, and NOT sought mental health services in the last two years either within or outside of the VA

69.



70.



APPENDIX G
Non-VHA Providers Interviewed

Organization	County	Community Mental Health Program (CMHP) or Coordinated Care Organization (CCO)
Cascade Health Alliance	Klamath	CCO
Clatsop Behavioral Healthcare	Clatsop	CMHP
Community Counseling Solutions	Grant	CMHP
Coos Health and Wellness	Coos	CCO
Deschutes County Health Services	Deschutes	CMHP
Mid-Columbia Center for Living	Sherman	CMHP
Options for Southern Oregon, Inc.	Josephine	CMHP
Umpqua Health Alliance	Douglas	CCO
Washington County Mental Health	Washington	CMHP
Yamhill Health & Human Services	Yamhill	CCO

APPENDIX H

Non-VHA Provider Interview Guide

Veterans Behavioral Health Services Improvement Project

Community Mental Health Programs/ Coordinated Care Organizations Survey Tool

Survey Participants:

- 1.
- 2.

Introduction:

The Rede Group, at the request of the Oregon Health Authority and the Oregon Department of Veterans' Affairs is conducting a statewide study regarding the delivery and use of, and barriers and access to, behavioral health services for veterans. Research indicates that veterans often struggle with issues pertaining to mental health, substance abuse, and other behavioral health challenges. This survey is a part of a project to understand strengths and weaknesses in access to behavioral health services offered to Oregon vets, and to make recommendations to improve access to and reduce barriers for veterans in need of these services. The Rede Group will be asking questions regarding services your health facility provides to veterans. The Rede Group has already conducted key informant interviews with the Oregon Health Authority, Oregon Department of Veterans Affairs, Veterans Health Administration providers, County Veterans Service Offices, and Tribal governments and has held focus groups across the state with veterans. Your agency was randomly selected for an interview because it is a Community Mental Health Provider or affiliated with a Coordinated Care Organization.

This interview will take no more than 45 minutes. We will be taking notes and recording the interview so that we can analyze the information in our report to OHA and ODVA. The recording will not be shared with anyone outside of the Rede Group and will only be used as a reference to verify information in our notes and for accuracy of reporting. The final report will be made available to you. Your comments will not be attributed to you in the report, nor will they be shared with the Oregon Department of Veterans' Affairs. We will only include your name as a person interviewed if we receive your permission to do so. Do you mind if we record the interview?

In this interview we would like to gather as much information as we can about behavioral health services provided at/through _____.

We understand your agency may be receiving extra behavioral health funding, as a recipient of the Certified Community Behavioral Health Clinic grant. This extra funding may have allowed you to increase your service level for specific populations, including veterans. For the purpose of this survey, we would like you to tell us about the services you currently provide using “core” behavioral health funding streams. At the end of the survey we will give you the opportunity to tell us about special or extra programs and services you have been able to provide as a result of the CCBHC grant.

Do you have any questions before we begin?

Survey Questions:

1. Are military veterans identified by your agency during the intake or screening process? YES or NO
2. If YES, is this information documented in the Electronic Medical Record to help inform care?
3. Does your facility provide assessment, treatment, and services for post-traumatic stress disorder (PTSD)?
If YES, please describe the services.
4. Does your facility provide behavioral health services in an environment/setting designed to cater to veterans, specifically?
If YES, please describe the services and format.
5. To your knowledge, has anyone on your staff undergone Star Behavioral Health Providers (SBHP) training or other training on understanding military culture?
6. Have counselors at your facility been trained to screen and treat patients who are experiencing PTSD, SUD, major depression, or other mental health challenges *as a result of Military Sexual Trauma (MST)*?
7. Does your facility offer services outside of normal business hours, on evenings or weekends.
8. If your organization is a recipient of the CCBHC grant, please describe any additional programs/services/initiatives that funding has allowed you to provide.
9. What referral resources for Veterans are you aware of in your community?

10. Are there additional services you would like to be able to provide to veterans? If YES, please describe.
11. Is there anything else you would like us to know about the behavioral health services provided to veterans at your facility?

Thank you, so much, for your time and attention today. If you have any questions, or want to follow-up on anything we talked about today, please call or email me.

APPENDIX I
List of Tribal Interviews

1. Confederated Tribes of Grand Ronde
2. Confederated Tribes of Warm Springs
3. Veteran Administration Office of Tribal Government Relations

APPENDIX J

Tribal Interview Guide

Veterans Behavioral Health Tribal Interview Guide

Participants:

- 1.
- 2.
- 3.

[Introduction]

The Rede Group, at the request of the Oregon Health Authority and the Oregon Department of Veterans' Affairs, is conducting a statewide study regarding the delivery and use of, and barriers and access to, mental health service for veterans. Research indicates that veterans often struggle with issues pertaining to mental health, substance abuse, and other behavioral health challenges. Additionally, data show that the mental health care needs of American Indians are great. Some surveys conducted by the Indian Health Service show high rates of suicide, mortality, depression and substance abuse. This survey is a part of a project to understand strengths and weaknesses in access to behavioral health services offered to Oregon vets, and make recommendations to improve access and reduce barriers among veterans accessing services. As a component of this research project, we're gathering as much information as possible about veterans across the state in an effort to ensure vets from all regions and identities are represented. In this interview, we'd like to gather as much information as possible about the landscape of mental health care and services available to Tribal veterans in particular.

This interview will take no more than 45 minutes. We will be taking notes and recording the interview so that we can analyze the information in our report to OHA and ODVA. The recording will not be shared with anyone outside of the Rede Group and will only be used as a reference to verifying information in our notes and for accuracy of reporting. The final report will be made available to you. Your comments today will not be attributed to you in the report, nor will they be shared with the Oregon Department of Veterans' Affairs. We will not attribute any information to you in the report, and will only include your name as a person interviewed if we receive your permission to do so. Do you mind if we record the interview?

Do you have any questions for us before we begin?

In this interview we'd like to gather as much information as possible about the landscape of mental health care and services available to veterans in Tribal communities.

How common do you believe mental health issues are in the Tribal veteran population?

How likely do you believe Tribal veterans are to seek treatment for mental health issues?

What services are available for Tribal veterans with mental health issues in Oregon in the regions where tribes are located (Warm Springs, Umatilla, Coos, Grand Ronde, Siletz, Coquille, Burns Paiute)? (e.g. traditional or ceremonial healing practices, tribal elders, Indian Health Services, the VA, local mental health clinic, etc.)

Do you have a sense of how many vets in the Tribe access mental health services through the VA, as opposed to other facilities?

Follow up question: Do you have a sense of why Native vets choose not to use VA mental health services despite high rates of certain psychiatric disorders?

Are there services that you wish were available in or for these community that currently aren't?

For Tribal veterans seeking treatment for mental health issues, which options for treatment do you feel are the most important ? (e.g., programs facilitated by veterans, programs facilitated by Native American veterans, family involvement, location, cost, associated with the VA, not associated with the VA, etc.)

Other things to ask about:

Rural telehealth/telepsychiatry

Culturally appropriate models of mental health provision for Native vets

Is there any other information about Native American veterans and treatment for mental health that you would like us to know?

Is there any other information you feel it would be useful for us to have in terms of where and why gaps in services exist?

Those are all the questions we have. We are sincerely grateful for your time and input. If you have any questions or want to follow-up on anything we talked about today please call or email me.

APPENDIX K
Overview of Focus Group Participants

Focus Group	Number of Participants
Bend Men	4
Bend Women	2
Eugene Men	7
Eugene Women	11
La Grande Women	3
Portland LGBTQI	8
Portland Men	9
Portland Women	11
Roseburg Men	2
Roseburg Women	6
Total Number of Focus Group Participants	63

Age range of focus group participants: 24-76

Range of dates served by focus group participants: 1963-2015

Branches of service represented by focus group participants:

- Air Force
- Army
- Coast Guard
- Marines
- National Guard
- Navy

APPENDIX L

Focus Group Interview Guide

Veterans Behavioral Health Focus Group Guide

Group Location _____

Number in Group _____

[Introduction] [Make sure all name badges are visible]

Thank you for agreeing to help us with this project. We appreciate your willingness to share your time and expertise. We are with the Rede Group and are working on a project to understand more about Veterans mental health care.

I am [moderator] and I will be moderating this discussion. We will be recording this discussion and taking notes. We are taping this discussion because we don't want to miss any comments but we will only use first names today and there will not be any names attached to the comments on the report. Moreover, the Rede Group will not use this video for any purpose other than developing the report.

What you say here is confidential. We are interested in hearing your experiences: your name will not be included in any reports. If you have any questions about this interview or the project after we leave, you can call us at this number, or you can talk to Erin or me.

[Hand out business cards.]

As we discuss topics, I want you to talk to each other rather than to me. I will start the conversation out with a question, but after that I will only jump in to get us back on track if you've gotten off the topic, or to bring up something we are interested in that you have not covered.

We are interested in hearing your opinions, thoughts and experiences, how you remember them. During our conversation today it's very important that you speak to your personal experience, opinions and beliefs as a consumer of mental health care. Sometimes it's tempting to talk about other in your circle of friends or relatives but we want to focus just on you. Feel free to disagree with me or with what others have said or give another opinion; you won't hurt my feelings or make me feel good with whatever opinions you might share; the more different ideas we hear, the more information we will have to work with.

We will finish our group by [finish time] at the latest and I will let you know when we are near the end of our time. If you have to use the restroom, just slip out quietly and come back as quickly as you can.

I am going to make every effort to keep the discussion focused and within our time frame. If too much time is being spent on one question or topic, I may move the conversation along so we can cover all the questions. Also, because we want to hear from everyone, I may ask those who have spoken up more to yield the floor to those who have not. This is not meant to be rude but rather to be sure we hear from any many perspectives as possible. This may mean that I interrupt you while you are talking. This is not meant to be rude but may need to happen just to keep the discussion moving.

Are there any questions before we begin?

[Focus group discussion begins.]

Let's start with introductions. Please introduce yourself – you're welcome to use only your first name. Let's just go around the table, starting with _____.

[Engagement/Rapport Question]

Tonight we're going to be talking about behavioral health which covers addiction treatment and other mental health issues such as anxiety, PTSD, etc. This is a big topic that might bring up thoughts, memories and emotions for you. What comes to mind when I say the term mental or behavioral health care?

[Exit Question]

Is there anything else?

Short paper survey: Where do you receive your health care services? Conditions you've been treated for in the past 18 months.

[Exploration Question]

We want to talk about what's important to you when it come mental health care. When you are making a decision about going to a provider what is the main thing that determines where you go to get care?

[Transition Statement]

Now I want to ask you to talk about your thoughts and experiences with mental health care in the last year or so.

[Lead-in Question]

Thinking back over the last year or so, how many of you have gone to other mental healthcare provider or your primary care provider for a mental health issue ?

How about more than once **[Record number]**

More than twice **[Record number]**

3 times [Record number]

4 times [Record number]

More than 5 times [Record number]

If, some attendees have not responded (from screener data we will know if there are group members who wanted but did not receive care.)

Have you felt that you wanted to see a mental health provider but did not do so for some reason?

[Exploration Question]

(For those we received care), when you did go to the mental health care provider what did you like most about your experience?

[Exit Question]

Is there anything else you would like to say about what you liked least?

[Exploration Question]

When you did go to the mental health care provider what did you like least about your experience?

[Exit Question]

Is there anything else you would like to say about what you liked least?

[Transition statement]

Now, I'd like to talk about reasons that going to the doctor or other mental health care provider might be difficult.

[Exploration Questions]

1. Has there been a time in the last 2 years when you wanted/needed see a mental health professional but didn't? Please raise your hand if that's the case. [Record number]
2. If, so why did you choose not to go see a provider?
3. Are there other things that make it difficult to get the mental health care you need? If so, what are those reasons?

[Transition statement]

Let's shift gears and talk about what you would make it easier to get the care you need?

[Exploration Question]

What are 1 or 2 things that would make it easier to get the care you need?

[Exit Question]

Is there anything else you would like to say about what would make it easier to get the care you need.

[Transition statement]

Now, I would like to talk about the “quality” of care you receive when you go the doctor or mental health care provider.

[Lead-in statement]

A few minutes ago we talked about what you liked least about your recent visits or interactions with the mental health care providers. I'd like you to think again about what you did not like about the quality of care you received.

This box is for interviewer reference and possible prompts

IOM 6 points of quality care

Safety - patients should not be harmed by the care that is intended to help them

Patient-Centered - care should be based on individual needs

Timely - waits and delays in care should be reduced

Effective - care should be evidence-based

Efficient - reduce waste

Equitable - care should be equal for all people

VA - ALL mental health services must be recovery oriented

[Exploration Question(s)]

What would you change about the care you received? Please be as specific as possible

[Possible reminder about context. Personal consumer only]

[Exploration Question(s)]

In your opinion, what is the most important thing that should change in mental health care for veterans?

Do you have anything else to add about mental health care for veterans or any questions?

Thank you very much for coming. You can pick your stipend up from the table. You will need to sign a statement that you received it.

We REALLY appreciate your input.

[Conclusion]

APPENDIX M

Literature Review

Many existing reviews of the literature have already resulted in documents that describe best practices for behavioral health (i.e., mental health and substance abuse) treatments for the veteran population. These reviews are complemented by federal policy, guidance, and clinical practice documents that describe best practices. Thus, the current review focused on drawing from these existing reviews and documents. The study team did not find documents in the literature that were specific to veterans in Oregon (or other states in the region). The study team used the resultant list of best practice behavioral health treatments for the veteran population in conducting the gap analysis of behavioral health services for Oregon veterans.

Overview

Two key documents provide overall guidance for providing behavioral health services to veterans. First, the *Guide to VA Mental Health Services for Veterans and Families* (USDVA, 2012) describes general principles that guide Veterans Administration (VA) mental health care for veterans. These principles include:

- Focus on recovery
- Coordinated care for the whole person
- Mental health treatment in primary care
- Mental health treatment coordinator
- Around-the-clock service
- Care that is sensitive to gender and cultural issues
- Care close to home
- Evidence based treatment
- Family and couple services

The *Guide* also describes how the VA is organized into Veterans Integrated Service Networks (VISN). Each VISN has at least two medical centers, and each medical center has outpatient clinics onsite and community-based outpatient clinics (CBOCs) throughout the VISN. CBOCs are classified according to their size (i.e., very large, large, mid-size, and small). VISNs provide treatment in several types of settings: short-term inpatient, outpatient care in a psychosocial rehabilitation and recovery center (PRRC), regular outpatient care, residential rehabilitation treatment program (RRTP), primary care, residential care, and supported work settings. Finally, the *Guide* lists the minimum mental health services VA medical centers and clinics are required to provide (page 22; the specific services vary based on the clinic size):

- Extended hours of care
- Emergency care
- Care for posttraumatic stress disorder
- Care for schizophrenia, schizoaffective disorder, bipolar disorder, depression, and anxiety
- Care for substance use disorders (alcohol, drugs, prescription medications, tobacco)
- Homelessness services

The topics in the *Guide* are consistent with the longer list of components specified in the VA Handbook *Uniform Mental Health Services in VA Medical Centers and Clinics* (USDVA, 2015). The handbook defines:

Minimum clinical requirements for VHA Mental Health Services. It delineates the essential components of the mental health program that is to be implemented nationally, to ensure that all veterans, wherever they obtain care in VHA, have access to needed mental health services (page 1).

The Veterans Administration and Department of Defense has also issued a set of *VA/DoD Clinical Practice Guidelines* (see <https://www.healthquality.va.gov/>). The guidelines were derived through determination of appropriate criteria such as effectiveness, efficacy, population benefit, or patient satisfaction; and literature reviews to determine the strength of the evidence in relation to these criteria. The guidelines provide recommendations for the performance or exclusion of specific services. Guidelines exist for opioid therapy for chronic pain, management of pregnancy, assessment and management of patients at risk for suicide, management of major depressive disorder, management of posttraumatic stress disorder and acute stress disorder, and management of substance abuse disorders.

Specific topics researched were drawn directly from the original Project Description to determine best practices for behavioral health treatments (preventative, promotional, and direct care) for Oregon's veteran population. These topics are briefly addressed in the following sections: substance use disorder, posttraumatic stress disorder/injury, traumatic brain injury, suicide, military sexual trauma, depression, military readjustment. Additional topics of interest to OHA were also researched, including: culturally competent services, reduction of stigma, diversion from criminal justice, and homelessness.

Substance Use Disorder

The *Guide to VA Mental Health Services for Veterans and Families* (USDVA, 2012) identifies types of treatments to be available for substance use disorder (page 14). These include:

- Medication
- Talk therapy: motivational enhancement therapy
- Talk therapy: cognitive behavioral therapy
- Opioid treatment programs
- Residential treatment programs
- Work therapies

The *VA/DoD Clinical Practice Guidelines for the Management of Substance Abuse Disorders* (USDVA and USDoD, 2015) were developed by an expert panel, drawing from a review of the literature that began with identification of 4,708 citations which were subsequently narrowed to 135 studies included in the review (page 68). The *Guidelines* includes two patient algorithms, one for screening and treatment and one for stabilization. The *Guidelines* provides recommendations regarding (pages 25-29):

- Screening
- Brief alcohol intervention
- Determination of treatment setting
- Treatment

- Pharmacotherapy (varies by substance type, see pages 25-27)
- Psychosocial interventions (varies by substance type)
- Promoting group mutual help involvement
- Co-occurring mental health conditions and psychosocial problems
- Follow-up
- Stabilization and withdrawal

The National Institute on Drug Abuse (NIDA)² is an agency that addresses addiction to a wide variety of drugs, including alcohol, and illicit and prescription drugs. NIDA serves as resource for healthcare providers, family members, and other stakeholders trying to address the myriad problems faced by patients in need of treatment for drug abuse or addiction. NIDA's *Principles of Addiction Treatment: A Research-Based Guide* details treatment approaches that have an evidence base, including:

- Pharmacotherapy (see pages 34-42 for pharmacological interventions)
- Long-term residential treatment
- Short-term residential treatment
- Outpatient
- Individualized drug counseling
- Group counseling
- Cognitive behavioral therapy
- Contingency management interventions
- Community reinforcement approach
- Motivational enhancement therapy
- 12-step facilitation therapy

Posttraumatic Stress Disorder/Injury

The *Guide to VA Mental Health Services for Veterans and Families* (USDVA, 2012) identifies types of treatments to be available for posttraumatic stress disorder (pages 14-15). These include:

- Medication
- Talk therapy: cognitive behavioral therapy
- Talk therapy: cognitive processing therapy
- Talk therapy: prolonged exposure therapy
- Residential treatment programs

The *VA/DoD Clinical Practice Guidelines for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder* (USDVA and USDoD, 2017) were developed by an expert panel, drawing from a review of the literature that began with identification of 1,667 citations which were subsequently narrowed to 122 studies included in the review (page 68). The *Guidelines* includes three patient algorithms, one for acute stress reaction/disorder, one for the assessment and diagnosis of posttraumatic stress disorder, and one for management of posttraumatic stress disorder. The *Guidelines* provides recommendations regarding (pages 33-36):

- General clinical management
- Diagnosis and assessment of PTSD
- Prevention of PTSD
- Treatment of PTSD

- Treatment selection
- Psychotherapy
- Pharmacotherapy (see pages 34-35 for pharmacological interventions)
- Technology-based treatment modalities
- Treatment of PTSD with co-occurring conditions
- Other treatment modalities with insufficient evidence for or against the modality

Traumatic Brain Injury

The *VA/DoD Clinical Practice Guideline for the Management of Concussion—Mild Traumatic Brain Injury* (USDVA and UDDoD, 2016a) were developed by an expert panel, drawing from a review of the literature that began with identification of 3,259 citations which were subsequently narrowed to 42 studies included in the review (page 46). The *Guidelines* includes two patient algorithms, one for initial presentation and one for management of symptoms lasting more than 7 days. The *Guidelines* provides recommendations regarding (pages 19-21):

- Diagnosis and assessment
- Co-occurring conditions
- Treatment for various symptoms
- Setting of care

The *Guidelines* note that no medication has been approved by the Federal Drug Administration for the treatment of any post-concussive neurological or psychiatric symptoms (page 36). They also note that co-occurring conditions should be treated in accordance with existing VA/DoD clinical practice guidelines for neuropsychiatry and behavioral neurology (PTSD, major depressive disorder, substance use disorder, and risk for suicide) (page 27).

Suicide

The *Guide to VA Mental Health Services for Veterans and Families* (USDVA, 2012) identifies three suicide prevention services (page 9). These include:

- Suicide prevention coordinators who work with mental health care teams
- Veterans Crisis Line
- Personal safety plan

The *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide* were developed by an expert panel, drawing from a review of the literature. The *Guidelines* includes three patient algorithms, one for. The *Guidelines* provides recommendations regarding:

- Medication
- Psychotherapy
- Improving adherence

O'Neil et al. (2012) conducted a systematic review of the evidence for suicide prevention interventions and referral/follow-up services. This review was conducted for the VA Health Services Research & Development Service, Quality Enhancement Research Initiative's Evidence-Based Synthesis Program. The authors concluded:

Though there are some [randomized controlled trials] RCTs of suicide prevention interventions, these trials are largely plagued by study design flaws and insufficient power...we found these two issues to be paramount to the lack of strong evidence for any interventions in preventing suicide and suicide attempts. We were most interested in RCTs related to Veteran and military populations...however, we found no such trials meeting our inclusion criteria published since 2005. We, therefore, examined trials in non-Veteran/military populations in the hopes of generalizing findings to our populations of interest... it is likely the best available evidence for interventions to prevent suicide is to use a combination of the most theoretically sound and well researched interventions available. For example, if a Veteran or member of the military is identified as being at risk for suicide, making sure that this person has adequate case management to assist with intervention attendance as well as family or other social support outside of the medical setting are both likely to be good clinical practice. Additionally, assuring that the individual has access to relatively immediate care such as inpatient hospitalization, outpatient therapy, and pharmacotherapy is also warranted depending on the individual's level of risk. Finally, providers should take into consideration which interventions are most likely to benefit the individual based on diagnosis or other relevant clinical factors... a comprehensive and multifaceted approach to suicide prevention care for Veterans and members of the military appears well warranted. (p. 35)

Helson et al. (2015) conducted a systematic review of suicide prevention in veterans. This review was conducted for the VA Health Services Research & Development Service, Quality Enhancement Research Initiative's Evidence-Based Synthesis Program. The authors concluded:

Methods derived from data from electronic medical records...were robust predictors of subsequent suicide. Studies of various clinician-rated or patient self-report risk assessment instruments indicated accuracy that varied across methods and cut-points. Studies of multi-component population-level suicide prevention interventions and individual cognitive behavioral therapy in active military populations showed reduced suicide attempts and suicide. However, evidence is limited... (p. 7)

Military Sexual Trauma

The *Guide to VA Mental Health Services for Veterans and Families* (USDVA, 2012) states (page 18):

Because [Military Sexual Trauma] MST is an experience, not a diagnosis, Veterans who experienced MST can benefit from the range of treatment options VA has available to treat conditions commonly associated with MST, including posttraumatic stress disorder (PTSD), depression, substance abuse, and others. VA also has MST-specific outpatient, inpatient, and residential services available to assist Veterans in their recovery.

The VA Military Sexual Trauma Website (<https://www.mentalhealth.va.gov/msthome.asp>) provides an overview of the topic, describes programs and services, describes help with services and benefits, provides articles and fact sheets, includes a community provider toolkit, and lists other resources. The web site notes that there are no formal guidelines or documents for treatment or management of MST, but because MST is associated with a range of mental health problems or comorbidities, the VA recommends following the guidelines for services for PTSD, depression, anxiety, and substance use disorders. Regarding services:

Outpatient

Every VA health care facility has providers knowledgeable about treatment for problems related to MST. Because MST is associated with a range of mental health problems, VA's general services for PTSD, depression, anxiety, substance abuse, and others are important resources for MST survivors

Many VA facilities have specialized outpatient mental health services focusing specifically on sexual trauma

Many Veterans Centers also have specially trained sexual trauma counselors

Inpatient

Include programs offering specialized MST treatment in a residential or inpatient setting

Some facilities have separate programs for men and women, and all residential and inpatient MST programs have separate sleeping areas for men and women

In addition, each VA health care facility has an MST Coordinator who serves as a contact person for MST-related problems, and all VA mental health and primary care providers must complete a mandatory training on MST.

Depression

The *Guide to VA Mental Health Services for Veterans and Families* (USDVA 2012) identifies the types of treatments to be available for depression and anxiety (page 12). These include:

Medication

Talk therapy: cognitive behavioral therapy

Talk therapy: acceptance and commitment therapy

Talk therapy: interpersonal therapy

The *VA/DoD Clinical Practice Guideline for the Management of the Management of Major Depressive Disorder* (USDVA and USDoD, 2016b) were developed by an expert panel, drawing from a review of the literature that began with identification of 4,601 citations which were subsequently narrowed to 124 studies included in the review (page 61). The *Guidelines* includes one patient algorithm for patients with suspected depression. The *Guidelines* provides recommendations regarding assessment and treatment of depression (pages 104-109), including:

As first-line treatment for uncomplicated mild to moderate MDD:

Evidence-based psychotherapy

Evidence-based pharmacotherapy

The *Guidelines* provide additional recommendations for specific categories of patients, such as patients with severe or recurring depression, patients at high risk of relapse, older adults, patients in relationship distress, treatment for pregnant or breastfeeding women, patients who depression has a seasonal pattern, etc.

Nieuwsma et al. (2011) conducted a systematic review of the evidence for brief psychotherapy for depression in primary care. This review was conducted for the VA Health Services Research & Development Service, Evidence-Based Synthesis Program. The authors concluded:

The collective evidence suggests that six to eight sessions of brief CBT or PST are more efficacious than control for the treatment of depression in primary care; however, the effects are modest... these treatments might be effectively delivered by providers of various professional disciplines, provided they receive adequate training and supervision. (p. 4)

Dedert et al. (2013) conducted a systematic review of the evidence for brief computerized Cognitive Behavioral Therapy for adults with depressive or anxiety disorders. This review was conducted for the VA Health Services Research & Development Service, Quality Enhancement Research Initiative's Evidence-Based Synthesis Program. The authors concluded:

We found moderate to strong evidence that cCBT is effective in improving short-term symptoms for mid-life patients with mild to moderate major depressive disorder, generalized anxiety disorder, and panic disorder. Treatment effects were smaller for patients with depressive symptoms...the level of therapist support was related to the magnitude of benefit, but additional head-to-head trials are needed to address this issue definitively. (p. 11)

Military Readjustment

The *Guide to VA Mental Health Services for Veterans and Families* (USDVA, 2012) notes that the VA operates 300 community-based counseling Vet Centers, which provide *readjustment counseling and outreach services* to all Veterans who served in any combat zone (page 18). There are 5 Vet Centers in Oregon, located in Bend, Salem, Eugene, Grants Pass, and Portland. The centers also provide military sexual trauma counseling, bereavement counseling, and services for family members for military related issues.

The *VA Readjustment Counseling Service Handbook* (USDVA, 2010) outlines requirements for Readjustment Counseling Services (RCS) provided at Vet Centers nationwide. The Vet Center Program addresses the psychological and social sequela of combat and armed conflict related problems. The *Handbook* delineates the core components of readjustment counseling services available at every VA Vet Center to serve veterans and their immediate family members. Vet Centers provide outreach, direct readjustment counseling services, and refer Veterans to local services. Readjustment Counseling Services include:

- Individual and group counseling for Veterans and their families
- Family counseling for military-related issues
- Bereavement counseling for families who experience an active duty death
- Counseling and referral for conditions related to Military Sexual Trauma
- Outreach and education including Post-Deployment Health Reassessment (PDHRA) events, other community events, etc.
- Substance abuse assessment and referral
- Employment assessment and referral
- Referral to the Veterans Benefits Administration (VBA) for benefits assistance
- Screening and referral for medical and mental health issues

Culturally Competent Services

The VA provides resources to help providers learn about military culture (<https://www.mentalhealth.va.gov/communityproviders/military.asp>). Learning about military

culture includes gaining an understanding of the structure of the military (for example, branches and ranks), and an understanding of the missions, ideals, and core values of military culture. In particular, the VA provides a *Military Cultural Competence* online course (<https://deploymentpsych.org/online-courses/military-culture>) and a *Military Culture: Core Competencies for Healthcare Professionals* online course (<https://deploymentpsych.org/military-culture-course-modules>).

Reduction of Stigma

As part of a RAND Corporation study of mental health stigma in the military, Acosta, et al. (2014) conducted a systematic review of theoretical works on stigma and prior studies of stigma-reduction programs. The authors identified 1,209 unique sources in the literature, of which 330 articles were included in the review (p. 109). The authors concluded:

In summary, our literature review revealed that *individual interventions to build cognitive coping skills in PWMHDs* [people with mental health disorders] may be the most direct way to reduce the negative impacts of stigma. However, *building the public mental health literacy, improving positive attitudes and reducing negative attitudes toward PWMHDs and mental health treatment, improving self-efficacy and skills to intervene with someone in emotional distress, and decreasing social distancing* may help reduce the negative influences of the public context. Within the institutional context, *reviewing policies and practices to ensure that they protect PWMHDs from discrimination and are not likely to inadvertently result in discriminatory treatment of PWMHDs* may also help reduce stigma. (p. 65, italics added)

Diversion from Criminal Justice

One program within the VA is the Veterans Justice Outreach program. As described on the program's web site (<https://www.va.gov/homeless/vjo.asp>):

The aim of the Veterans Justice Outreach (VJO) program is to avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible, justice-involved Veterans have timely access to Veterans Health Administration (VHA) services, as clinically indicated. VJO specialists provide direct outreach, assessment and case management for justice-involved Veterans in local courts and jails and liaison with local justice system partners.

Blodgett, et al. (2013) conducted a structured evidence review to identify treatment needs of justice-involved veterans, and associated psychological interventions. Regarding evidence-based or promising psychosocial treatments for justice-involved Veterans at a high risk of recidivism, the authors found that the promising interventions include *cognitive behavior therapy* (CBT) treatments that aim to change antisocial ways of thinking (the most well-known being Moral Reconciliation Therapy, Reasoning and Rehabilitation, and Thinking 4 a Change). The most consistent evidence of effectiveness was available for MRT. The evidence for R&R was less consistent. There is a much smaller amount of research for T4C, though it is widely implemented in criminal justice settings. *SUD treatment* was also associated with a lower risk of recidivism in addition to benefits on SUD outcomes. For justice-involved Veterans, *CBT treatments such as MRT which target criminogenic risk factors* (e.g., antisocial thinking) may be useful in treating specific offenses of particular concern for justice-involved Veterans.

Tsai, et al. (2018) conducted a national study of *veterans treatment court* (VTC) participants. The authors noted that there are over 400 veterans treatment courts in the country, but few studies on participant outcomes in functional domains. The authors also noted that their study's findings highlighted the importance of proper substance abuse treatment as well as employment services for VTC participants.

Homelessness

Balshem et al. (2011) conducted a critical review of the literature regarding homelessness among veterans. This review was conducted for the VA Health Services Research & Development Service, Evidence-Based Synthesis Program. The authors concluded:

Causal links between many individual level factors and homelessness have not been well-established in the literature, and there may be a bi-directional relationship between homelessness and risk factors such as mental illness, substance abuse and incarceration. Moreover, given that homelessness may not occur for many years after deployment, targeting military level risk factors may be difficult, especially during the post-deployment period. It may be important to repeatedly engage and evaluate Veterans both qualitatively and quantitatively for years after service.

The United States Interagency Council on Homelessness identified strategies and related tools to end veteran homelessness

(https://www.usich.gov/resources/uploads/asset_library/Ten_Strategies_to_End_Veteran_Homelessness.pdf). These include:

- Start at the top: get state and local leaders to publicly commit to and coordinate efforts on ending veteran homelessness
- Implement a housing first system orientation and response
- Implement a coordinated entry system
- Set and meet ambitious short and long-term goals by deploying all resources effectively
- Improve transitional housing performance and consider adopting different models and/or converting or reallocating resources into supportive housing
- Engage and support private landlords as partners
- Identify and be accountable to all veterans experiencing homelessness
- Conduct coordinated outreach and engagement efforts
- Increase connections to employment
- Coordinate with legal services organizations to solve legal needs

The VA has a variety of programs and tools intended to address veteran homelessness, for example:

Description of VA Programs for Homeless Veterans

<https://www.va.gov/HOMELESS/docs/Homeless-Programs-General-Fact-Sheet-JAN-2018.pdf>

US Department of Housing and Urban Development Vets@Home Toolkit

<https://www.hudexchange.info/resources/documents/Vets-at-Home-Identifying-and-Engaging-Veterans-Toolkit.pdf>

Ways Community Organizations Can Become Involved in Addressing Veteran Homelessness

<https://www.va.gov/HOMELESS/docs/TenWays-FactSheet.pdf>

Conclusion

This section listed best practices for behavioral health treatments for veteran populations. The document primarily drew from existing reviews of the literature on the topics of interest to OHA, as well as policy, guidance and clinical practice documents describing describe best practices that are available from federal agencies. The study team used this list of best practices as a reference point in conducting the gap analysis of behavioral health services for Oregon veterans.

APPENDIX N
Death Certificate Data & Vital Statistics Suicide and Opioid
Data Tables

Deaths by Suicide by Age Range and Veteran Status, 2013

	Total (18+)		18-34		35-54		55-74		75+	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Veteran	153	52.0	13	69.7	32	48.7	57	39.7	51	77.0
Non-Veteran	357	29.8	119	27.5	137	30.1	91	33.7	10	23.9

Source: Oregon Health Authority, Public Health Division, Vital Statistics 2013

Deaths by Suicide by Age Range and Veteran Status, 2014

	Total (18+)		18-34		35-54		55-74		75+	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Veteran	169	55.7	15	69.6	29	42.6	65	44.9	60	87.2
Non-Veteran	423	35.0	130	30.1	168	37.0	113	40.3	12	27.8

Source: Oregon Health Authority, Public Health Division, Vital Statistics 2014

Deaths by Suicide by Age Range and Veteran Status, 2015

	Total (18+)		18-34		35-54		55-74		75+	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Veteran	144	47.5	17	78.9	27	39.6	61	42.2	39	56.7
Non-Veteran	418	33.9	131	30.0	148	32.3	116	39.8	23	49.6

Source: Oregon Health Authority, Public Health Division, Vital Statistics 2015

Deaths by Suicide by Age Range and Veteran Status, 2016

	Total (18+)		18-34		35-54		55-74		75+	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Veteran	153	53.7	17	80.2	30	51.4	58	42.8	48	68.8
Non-Veteran	404	31.6	111	25.0	160	33.8	109	34.8	24	49.0

Source: Oregon Health Authority, Public Health Division, Vital Statistics 2016

Deaths by Suicide by Age Range and Veteran Status, 2017

	Total (18+)		18-34		35-54		55-74		75+	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Veteran	159	57.2	18	88.4	36	63.6	61	46.4	44	63.1
Non-Veteran	445	34.3	144	32.4	161	34.0	118	36.0	22	42.5

Source: Oregon Health Authority, Public Health Division, Vital Statistics 2017

Mortality with Opioids as Contributing Factor by Veteran Status, 2013-2017

	2013		2014		2015		2016		2017	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Veteran	33	9.8	35	10.6	32	9.8	27	8.7	36	11.4
Non-Veteran	296	7.6	335	8.5	330	8.1	306	7.6	342	8.3

Source: Oregon Health Authority, Public Health Division, Vital Statistics 2013-2017

**Veteran population estimates used for calculating crude death rates for all years were obtained from the US Department of Veterans Affairs, Vet Pop State Data Tables