

Perceived Needs of Veterans Transitioning from the Military to Civilian Life

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Abstract

Despite existing separation services provided by the military, many transitioning to civilian life report continued or even worsening issues, including anger outbursts, PTSD, sustained substance use, and strained family relationships. Further, only 61% of the 1,906,754 veterans separated since 2002 participate in the VA health care system after separation, indicating that at least three quarters of a million veterans are not captured by research conducted in VA systems. The current study (N= 90) examined the perceived needs of veterans transitioning from the military to civilian life, assessed issues that prevent these individuals from participating in VA health care upon separation, and captured veteran recommendations to improve existing separation services, either prior to or after the transition to civilian life. Veterans identified several needs, including improved access to care, mental health and substance use counseling, and preparedness for adjustment and economical/financial issues. Implications for both care and policy are discussed.

Introduction

There are 1.4 million uniformed personnel currently serving in the four military branches of the U.S. Department of Defense (DoD), and close to 200,000 enlisted each year across branches.¹

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Recent research suggests that there are key transitional periods in the life of an active duty service member that may be critical for future functioning of the individual post-separation. One such time is the separation transition from active duty to civilian life. After the term of service is nearly complete, those in the military begin a transition period accompanied by limited services, which include brief screening for severe psychological distress or problematic substance use, and referrals for outside vocational or health services.

Although research on the transition from military to civilian life is sorely limited, the separation services offered at the end of active duty do not appear to be universally adequate to ease this transition for the large population of new veterans, approximately 200,000 of whom separate every year.¹ According to Pew Research Center Social and Demographic Trends, at least 44% of the veterans who served in the modern era armed forces report that they have had difficulties readjusting to civilian life.² The reason for this difficulty comes from many possible sources, including some socioeconomic and educational challenges prior to enlisting,^{1,3} the dramatic decline in supervision and structure, as well as the loss of camaraderie and friendships formed in the military. Further, some individuals separating do not have plans for employment in civilian life, and others lack concrete living arrangements, suggesting potential poverty and homelessness upon separation. Finally, a significant portion of individuals who separate carry with them psychological issues associated with serving in the military, regardless of whether the individual was deployed or was involved in combat assignments. Research suggests that 47% of veterans have experienced frequent outbursts of anger following separation, 48% report strained family relationships, and close to a third report depressive/post-traumatic stress disorder (PTSD) symptoms.⁴⁻⁷

Many times, these issues lead to poor coping strategies, resulting in severe and chronic substance use issues that may originate in active duty. Data from the 2011 DoD Health Related Behavior Surveys suggest that, across all military branches (Army, Navy, Marine Corps, Air Force), 84.5% of those in active duty report using alcohol and over 25% report moderate to heavy use, problem use numbers that are considerably higher than those of civilians (16%).^{8,9} Post-separation reports indicate that the rates of substance use are maintained even after separation; Norman and colleagues assessed individuals serving in the Navy or Marines at pre- and post-separation.¹⁰ Of the original sample, 46% reported problematic alcohol or substance use during active duty, and among the follow-up sample, 42% reported continued problem use at post-separation. Golub and Bennett assessed a range of substances in 269 veterans who returned to low-income communities in New York City.¹¹ Although alcohol use prevalence decreased from 80.0% during active duty to 60.2% following separation, other forms of substance use increased: daily cigarette use rose from 38.3 to 48.1%, marijuana use increased from 20.0 to 34.0%, and prescription painkiller misuse increased from 1.6 to 7.3%.¹¹

In addition to chronic substance use, many veterans are at risk for other severe issues. Data from the Department of Veterans Affairs indicates that in 2014, 20 veterans committed suicide every day, a rate much higher than that in the general population.¹² After adjusting for differences in age and gender, risk for suicide was found to be 21% higher among veterans when compared to U.S. civilian adults.¹² Notably, the majority (70%) of these suicides were committed by individuals who did not actively utilize the VA system, which may indicate that many of these veterans were not utilizing health care services.¹² Regardless, substance use and suicide rates point to the need for continued focus on veterans' mental health from providers across settings to address this population at risk.

The Scope of the Problem

Based upon the evidence of high rates of mental health and substance use issues, there is a clear need to address the mental health needs of veterans returning to civilian life during this critical period of transition. The lack of studies on separation adjustment period is no small oversight;

veterans comprise nearly 10% of the U.S. population, indicating that addressing the transition problems facing this group could have a significant impact in terms of public health.¹²

Many studies of Veterans' Administration (VA) populations and their transition needs exist. For instance, recent reports summarizing these studies have identified that problems navigating the DoD and VA systems, ineffective communication between the DoD and VA, veteran stigma regarding mental health and substance abuse problems, geographic access, and unreasonable waiting times have been consistent barriers to patient health care at the VA.^{13,14} Similarly, a recent study found that among OEF/OIF veterans, long wait times were the top barrier to VA care use.¹⁵ Even though this information is valuable, only 61% of the 1,906,754 separated since 2002 participate in the VA health care system, suggesting that at least three quarters of a million former military personnel are not captured by research conducted in the VA.¹⁶ Further, very few research studies have explored adverse outcomes during the transition from military to civilian life,^{11,17} and none to our knowledge have examined the perceived needs of veterans across the separation transition.

Research on the provision of mental health care for transitioning veterans allows a closer view of veterans' needs during the separation transition and affords the health community opportunities to find innovative ways to meet these needs. A recent study that included more than 200,000 OEF/OIF veterans enrolled in the VA found that 36% of these veterans received a new mental health diagnosis (including PTSD, depression, and substance use disorder) and only 67% of them had at least one mental health visit at a VA within a year of their diagnosis. Further, only 30% of those who started mental health care attended the minimum number of recommended treatment sessions.¹⁸ The clear underutilization of mental health and substance use treatment warrants further research in this area. In such work, the VA, health care providers, researchers, program officers, policy makers, and other stakeholders can focus on the perceived needs and access to care of those separating from the military to identify potential disparities. While separating veterans do not fall into a traditional disparity category, perceived lack of resources and access to care may signal the importance of exploring this possibility in greater depth.¹⁹

The Current Study

The current study explored qualitative responses from veterans regarding their perceived needs across the military to civilian transition. This study was designed to elicit a broad array of responses to estimate the degree to which veterans identified specific mental health and substance use issues without being guided to these answers. Importantly, this study was not limited to veterans who utilize the VA system, thereby allowing for the examination of these behaviors outside of the extant literature. To elicit honest responses from veterans, individuals were contacted after the separation transition to ensure that there would be no repercussions for potentially negative communications about the U.S. Military, a research protocol utilized by other researchers.¹¹ To identify perceived needs and recommendations, researchers asked veterans about common issues they experienced or witnessed during the transition, recommendations for help before and after the transition, perceived or experienced issues with the VA system, and what services could be provided by health professionals to transitioning veterans. The current study serves as a basis for future work in the assessment and development of services for veterans transitioning to civilian life.

Methods

Participants

Participants ($N=99$) were recruited through word of mouth from an initial seed sample of five veterans (i.e., snowball sampling). These five veterans were each known to a different member of

the research staff and were contacted individually by email. Veterans were provided a link to the online questionnaire and were asked to pass the link and study instructions on to other veterans they knew. Eligibility required individuals to have served for at least 12 months in an active duty branch of the U.S. Armed Forces (Army, Navy, Air Force, Marines) and to have been separated from the military for at least 6 months. Veterans who had retired from the U.S. Military ($N=9$) were not included in the analyses due to the typical long duration of service and potentially different separation experiences.

Of the original respondents, 90 veterans met criteria and completed the survey. Respondents were located across multiple states within the U.S.A., including Hawaii, Alaska, Kansas, Iowa, Florida, Texas, North Carolina, Tennessee, Kentucky, Vermont, and California. The median year of separation was 2012 and the modal year was 2015.

Procedures

Data was collected online via Qualtrics software. All data collection was anonymous. Informed consent was obtained from all individual participants included in the study. Participants who completed the survey were provided a \$25.00 gift certificate to [Amazon.com](https://www.amazon.com). The protocol was approved by the Institutional Review Board at the University of Tennessee Health Science Center.

Measures

Open-ended questions assessed perceived needs prior to, and following, the military transition. These questions included: “In your opinion, what is the most common issue you see during the separation transition?”, “In your opinion, what would be the most helpful thing to do for veterans to prepare for the separation transition?”, “In your opinion, what would be the most helpful thing to do for veterans after the separation transition?”, “In your opinion, what is the biggest issue with the VA system?”, and “In your opinion, what do health providers need to be providing servicemen who are separating?” Responses were open-ended.

Perceived Needs Qualitative Response Coding

Qualitative response themes for each open-ended question were decided by three judges (one faculty and two graduate students) in a group setting. For example, responses to the question “In your opinion, what is the most common issue you see during the separation transition?” were coded into the following themes: (1) readjustment issues (difficulty relating to family, civilians), (2) mental health and substance use, (3) economic/employment, and (4) difficulty accessing services. After themes were identified, responses were then coded into these thematic categories independently by each of the judges. When a discrepancy was found, judges independently reviewed the response again and decided whether they would retain their original code or modify it. Remaining discrepancies were resolved through discussion between coders. Interjudge reliability was assessed via intraclass correlation coefficients. Remaining discrepancies were resolved through discussion between judges.

Results

Sample Characteristics

Table 1 presents overall characteristics of the sample. Participants averaged 9.7 years in an active duty branch of the U.S. Military and had deployed an average of 3.3 times. The gender composition of our sample was similar to other veteran studies, with 90.1% of participants being

male.²⁰ The branches were differentially represented in this sample; 64.2% of participants served in the Army, 28.4% served in the Air Force, and 7.4% served in the Marines. No participant reported serving in the Navy. Similar to national standards, 68% of respondents reported using the VA system. Regarding separation preparedness, 9.9% reported not having a place to live and 43.0% reported being unemployed during the first 6 months of civilian life.

Perceived Issues and Needs

Table 2 provides quantitative values for the number of occurrences of the responses to open-ended questions, as well as sample items from each category.

“In your opinion, what is the most common issue you see during the separation transition?” Four themes were identified from 87 total responses, including *readjustment issues (difficulty relating to family, civilians), mental health and substance use, economic/employment, and difficulty accessing services*. Coding of these responses (intraclass correlation coefficient = .99) indicated that the majority of responses fell into the *readjustment issues* category ($n = 47$), followed by *mental health and substance use* ($n = 18$) and *economic/employment* ($n = 18$) and *difficulty accessing services* ($n = 4$).

“In your opinion, what would be the most helpful thing to do for veterans to prepare for the separation transition?” Four themes were identified from 81 total responses, including *economic/employment counseling, veteran mentorship/social services, improved access to services, and mental health and substance use counseling*. Coding of these responses (intraclass correlation coefficient = .94) indicated that the majority of responses fell into the *economic/employment counseling* category ($n = 33$), followed by *veteran mentorship/social services* ($n = 25$), *improved access to services* ($n = 15$), and *mental health and substance use counseling* ($n = 8$).

“In your opinion, what would be the most helpful thing to do for veterans after the separation transition?” Five themes were identified from 68 total responses, including *veteran mentorship/social services* category followed by *improved access to services, economic/employment counseling, leisure/fitness, and mental health and substance use counseling*. Coding of these responses (intraclass correlation coefficient = .97) indicated that the majority of responses fell into the *veteran mentorship/social services* category ($n = 25$), followed by *improved access to services*

Table 1
Sample characteristics

Variable	Mean (SD)	%
Length of service (in years)	9.7 (7.47)	
Male		90.1
Number of deployments	3.3 (11.15)	
Branch		
Army		64.2
Navy		0.0
Air Force		28.4
Marines		7.4
Currently use the VA system		68.0
Post-separation: homeless		9.9
Post-separation: unemployed		43.0

Table 2
Coded qualitative responses

Question and themes	Number of responses	Sample responses
Most common issue you see during the separation transition?		
Readjustment issues (difficulty relating to family, civilians)	47	Being able to relate or adequately convey my experiences to non-military people. The civilian/military divide is so vast that any attempts to discuss and talk through my experiences or issues with my friends and family inevitably led to me giving up and bottling up my anger, anxiety, stresses, etc. until I exploded. No one teaches us how to come home. You train for months to deploy and get 10 days of reintegration training when you come back. Feeling lonely or feeling useless (in the military I was important, in civilian life I didn't feel like I was).
Mental health and substance use	18	Alcoholism, mostly. Most people drink a lot while they're in and that doesn't really change when you get out. If anything, you drink more because you're not being watched so closely and stress tends to put more bottles in your hand. There is no help for those with emotional issues ie [sic] PTSD.
Economic/employment	18	Finding a career that suites the skills you learned in the military. The ability to keep employment.
Difficulty accessing services	4	The need for appointments were not available always was told the VA would handle it. Major delays in accessing VA benefits.
<i>Total number of responses</i>	<i>87</i>	
Most helpful thing to do for veterans to prepare for the separation transition?		
Economic/employment counseling	33	A resource that provides military members with job opportunities and places of employment who are willing to hire veterans. Direct job placement and helping them find a place to live. A resume writing class was offered, but not mandatory. I think it should be. I wish I had been more prepared for job interviews and it would have been nice to have a great resume, filled with my military experience, ready for potential hiring managers.
Veteran mentorship/social services	25	Create a formal network in each city where vets can reach out to meet other vets--start with social ideas then work in business concepts. Most of us have done this naturally via Facebook or through texts--still hard to get and meet people you like and care about, but it's a

Table 2
(continued)

Question and themes	Number of responses	Sample responses
		start.
		Have networking events to meet other veterans who have separated already
Improved access to services	15	The VA isn't going to help you as much as you had when on active duty.
		Contact info for veterans' services in their local area.
Mental health and substance use counseling	8	I think sensitivity training and coping courses and VA assistance for suicide help is greatly needed.
		Encourage [vets to] prepare for separation, deal with family issues that predate joining the military.
<i>Total number of responses</i>	81	
Most helpful thing to do for veterans after the separation transition?		
Veteran mentorship/social services	25	Having a network of people to talk to if they need help. That would also require the veteran to know when they need help, before it's too late.
		Keep in contact with other vets.
		Contact them to see how they are doing and offer support. Let them know they are not forgotten.
Improved access to services	20	Provide health coverage for a year after separation.
		Make sure they received the benefits they earned.
Economic/employment counseling	15	Make sure they have a place to live regardless of their situation.
		Most veterans are good at killing but have no real life skills applicable to the civilian world.
Leisure/fitness	4	Take time off and relax and enjoy some personal time.
		Stay active and keep up with the physical training.
		Don't let yourself become lazy.
Mental health and substance use counseling	4	Have a case worker at the VA call them up every week or so to talk about how they're doing. Ask targeted
		questions that look for signs of mental health struggles.
		Pay for counseling of my choosing. I do not want to see a VA counselor so I have to pay out of pocket (my insurance deductible) to see someone I am comfortable with talking to.
<i>Total number of responses</i>	68	
Biggest issue with the VA system?		
Difficulty accessing services	35	The VA health care system is flawed. I was never able to get an appointment to been seen for my back pain (which I got while serving.) I would call the hotline (you can't make an appointment otherwise) and then leave a message about my issue. I'd then have to wait

Table 2
(continued)

Question and themes	Number of responses	Sample responses
Corruption	16	<p>for a phone call from a nurse to see if I was worthy of an appointment (I guess). If you miss that call, you start over. I had an appointment set up once, but after 3 months of waiting for the date, I was called two days before and told that it was rescheduled for another 2 months later. I gave up. I know many more veterans that had to do the same.</p> <p>If I can only choose one I feel it would be delays and the difficulty of getting services. Midway through the process of attempting to get help for PTSD my wife and I decided it would just be better to pay for civilian services then to have to deal with the VA.</p>
Poor customer service	10	<p>It's corrupt and doesn't really care about vets. People skating by with job titles that don't do their jobs.</p> <p>Being treated like I'm a con. That my service and medical issues are a joke.</p> <p>The support staff. Most of the care is decent, and 75% of the doctors are OK. But the support staff at most VA's are horrible. They are rude, unresponsive and seem self entitled.</p>
Poor quality of care	10	<p>They dont [sic] listen they just throw medicine at you and try their dam [sic] hardest to not pay you.</p> <p>It is almost split in half with the type of quality. One side you get the doctor who 'mmhms' through whatever you talk about, asks what you want, and writes a script just before pushing you out and the next chump in. The other half will (in more creative ways) imply that you are healthy, lying, or wanting something more than you deserve (which is weird when you are just going for a checkup.)</p>
No issues	2	
<i>Total number of responses</i>	73	
What do health providers need to be providing servicemen who are separating?		
Mental health counseling	26	<p>Required testing for PTSD. I was certain that I was fine or would at least be able to work things out on my own. It was my spouse that pushed me into seeking professional help. It has been made evident to me that this couldn't have been taken care of on my own which would have likely ending my marriage.</p> <p>Everyone should be referred to mental health and it should not be months to get in. They should not push pills but teach actual coping skills.</p>

Table 2
(continued)

Question and themes	Number of responses	Sample responses
General health services	21	A resource to reach out to in time of need and drug/alcohol counseling and consequence training. Basic health access. The care they need and deserve. Give everyone a physiological eval [sic] on the way out no matter what the cost.
Client-centered treatment	13	Having a conversation about any concerns the Veteran may have. Honest attention not hurry up and get out the door.
Access to care	9	Information on how the private health insurance system works. Most if not all veterans are used to having a universal healthcare system and do not know how to navigate health insurance in the civilian world. A way to be able to pay for things like counselling [sic] or medicine. I didn't have a way and just had to go without anti depressants and counselling [sic].
<i>Total number of responses</i>	69	

(*n* = 20), *economic/employment counseling* (*n* = 15), *leisure/fitness* (*n* = 4), and *mental health and substance use counseling* (*n* = 4).

“*In your opinion, what is the biggest issue with the VA system?*” Four themes were identified from 73 total responses, including *difficulty accessing services*, *corruption*, *poor customer service*, *poor quality of care*, and *no issues*. Coding of these responses (intraclass correlation coefficient = .88) indicated that the majority of responses fell into the *difficulty accessing services* category (*n* = 35), followed by *corruption* (*n* = 16), *poor customer service* (*n* = 10), *poor quality of care* (*n* = 10), and *no issues* (*n* = 2).

“*In your opinion, what do health providers need to be providing servicemen who are separating?*” Four themes were identified from 69 total responses, including *mental health and substance use counseling*, *general health services*, *client-centered treatment*, and *access to care*. Coding of these responses (intraclass correlation coefficient = .90) indicated that the majority of responses fell into the *mental health and substance use counseling* category (*n* = 26), followed by *general health services* (*n* = 21), *client-centered treatment* (*n* = 13), and *access to care* (*n* = 9).

Discussion

This study examined qualitative responses to open-ended questions about perceived needs and service provision during the military to civilian separation transition. Similar response themes emerged across different question types. The theme of limited access to services was noted across each question, suggesting that veterans in this nonprobability sample are having prominent issues in this area. While this is not necessarily a newly discovered problem,^{15,21} the responses further elucidate that the difficulty accessing services is not always simple delays in getting appointments,

but also other issues including traveling unreasonable distances to receive affordable services. This suggests that some veterans from this and other studies are less likely to attend regular appointments, even when they are available, due to hardship associated with proximity of affordable care.¹⁵

Another major theme that emerged across most questions was the need for mental health and substance use counseling. Veterans' responses indicated a variety of related needs in this category, including suicide, substance use, and PTSD treatment, as well as the recommendation for monitoring veterans over time to detect issues as they arise. The combination of rising mental health and substance use issues and perceptions of a health care system that is inaccessible may foster a context that is unlikely to adequately address the mental health needs of this population. Interestingly, results showed that, although only a few participants thought that mental health and substance use counseling would be helpful before and after separation, more than a third of participants thought care providers should offer mental health and substance use counseling. Perhaps, veterans do not initially prioritize seeking mental health services over economic and social support services but may still be interested in providers assessing and referring them to mental health and substance use counseling. It is possible that reducing barriers to mental health access from the providers' side may also decrease the stigma related to these issues and the likelihood of veterans initiating mental health services.

Readjustment issues were also prominent in this group. The movement from an active military career to civilian setting appeared to be a major stressor that these sampled veterans were not adequately prepared for. Given the lack of preparation for this transition, it is little wonder that this transition often elicited strong emotions such as anxiety, anger, loneliness, or uselessness among veterans who participated in this study. Further, multiple responses indicated a need to be in contact with other veterans to better prepare for separation and transition into civilian life, as well as more personalized and considerate care from the VA system. It appears that veterans in this sample felt the unintended effects of a medical system that struggles to provide a more structured and supportive transition into civilian life.

Finally, another overriding concern of veterans interviewed in this study was economic or financial preparedness for the transition. In this sample, 10 veterans reported not having a place to live and 43 reported being unemployed during their first 6 months of civilian life. Such financial strain can have lasting impacts on general and mental health and can add further barriers to access to care. While not a mental health concern per se, if many veterans experience such hardship, the health care community should consider appropriate steps forward in treating this population.

Limitations and Future Directions

The current work was a preliminary study intended to gain a broad understanding of the perceived needs of veterans transitioning out of the U.S. Military. While informative, this sample was small ($N = 99$) and inherently limited as a result of our recruitment method. For instance, our sample may have particular limits with respect to generalizability due to the snowball recruitment method and likelihood that many participants were from shared social groups. Future work would do well to examine these issues in a larger sample, where innovative strategies could be employed. For example, a larger sample could address how open-ended responses cluster or relate to each other, could present different veteran profiles, and could examine differences in perceived needs based upon other characteristics, such as combat exposure. Further, to protect privacy and encourage honest responding, the current work was conducted anonymously, thereby not allowing for longitudinal data collection to assess whether the issues noted by our respondents were alleviated over time. Other limitations include reliance on retrospective recall of needs and emotional states. Such retrospective recall can have bias based on recent functioning as well as memory decay for behavior and emotions during military service and transition.

Notably, this study did not address the specific needs of veteran women, which may be dramatically different than those of men during the separation transition. Previous reviews have stated that women in the military are more likely to be single parents, which creates challenges in the arrangement of childcare and may complicate readjustment to civilian life even further.^{22,23} Moreover, in a system that has traditionally served the needs of men, VA health care facilities may not be ready to address these and other challenges specific to veteran women upon their return to civilian life. Specific questions to the challenges experienced by veteran women would have been useful in capturing the important needs of our veteran women.

Due to repercussions associated with negative statements about the U.S. Military, this study employed a single, retrospective data collection after participants had transitioned from the military. Continued work in this area should include longitudinal assessment procedures (beginning assessment prior to separation) to limit errors in recollection. Finally, this pilot work was designed for brief assessment of major existing issues; additional work in this area may employ more extensive assessment of specific issues identified here, as well as other factors that likely contribute to negative outcomes associated with the transition to civilian life.

Implications for Behavioral Health

Even though some VA facilities compare to the private sector in some metrics, there is evidence that many VA facilities may not provide timely care for patients.¹⁴ (p. 166), 21,24 Regarding reducing these inequalities, the way forward is not clear given a multitude of existing obstacles. However, there are several concrete recommendations that may serve to move the field forward.

First, it is clear that the veterans in our convenience sample are reporting several existing mental health and substance use issues that arise during and after their separation from the military. While some of these stressors are indeed related to military experience (e.g., combat and deployment), adjustment issues can arise for all veterans due to the abrupt transition process.²⁰ (p. 9) As such, it is recommended for all of those in the health field who work with veterans to acknowledge the difficulty associated with separating, and routinely ask veterans whether mental health services are needed. Brief needs assessments take little time and have the potential to have a large impact on future functioning. Such a brief assessment can be conducted by any health professionals, and is highly recommended; often, veterans' only point of health care contact is through primary care providers, thereby limiting their access to mental health professionals. In addition, active and consistent outreach programs could be created through Vet Centers, Community-Based Outpatient Clinics (CBOC), sponsored independent organizations, and state organizations where health care professionals and veterans provide information regarding mental health and substance abuse as well as information on treatment options. Preliminary findings on active outreach efforts indicate that they could be useful means to attract and inform veterans.²⁵ In addition, frequent information and outreach efforts delivered through electronic (e.g., email, texts, phone calls) and traditional (e.g., mailed pamphlets, magazines) methods could increase exposure, decrease stigma, and persuade veterans to seek mental health or substance abuse treatment.

Further, it is recommended that all health practitioners remain vigilant over time in their assessment of veterans' mental health needs and functional difficulties. Many veterans may initially delay seeking treatment due to the nature of the issues they experience, cultural expectations, or lack of awareness of risk. For instance, symptoms of military service-related issues (e.g., PTSD or other mental illness) have a delayed onset for some, thereby preventing the individual from seeking out services in a time-sensitive manner.²⁶⁻²⁸ Other individuals may choose not to seek medical or mental health services due to military cultural beliefs in toughness or being able to handle problems on their own.²⁸⁻³⁰ Still others may be unaware of the symptoms associated with problematic mental health or substance use issues, and may not believe services are warranted.^{31,32} In fact, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that in 2003,

85% of veterans who were dependent on alcohol or drugs had not received any treatment.³³ The same may be true for other mental health issues, including PTSD. In addition to mental health screeners, health practitioners could assess early in the separation process for functional difficulties. Previous research using data from recently separated veterans found that mental health screeners (e.g., PTSD, alcohol abuse, depression) were not predictive of veterans seeking mental health treatment.²⁵ Instead, problems with work, anger, social support, physical health, and sleep were predictive of seeking mental health treatment at a later time. These results suggest that early detection of functional impairment may be more relevant when connecting veterans to mental health services compared to early detection of diagnoses. Repeated assessments screening for mental health diagnoses as well as functional difficulties from a variety of health care providers can offer multiple opportunities to detect difficulties and provide referrals and for the veteran to voice needs regarding mental health, substance use, or other transitional issues that can be addressed.

Policy and Access to Care: Problems Without Clear Solutions

When considering next steps, it is important to also consider the role of responsible agencies and service availability. First, individuals in transition fall between potentially responsible organizations, making it unclear whether separation services should be supplied prior to exiting the U.S. Military or immediately upon separation by the VA or other federal agencies. Unfortunately, it is unlikely that the DoD will be able to offer extensive services during active duty given that individuals are exiting the military on a short timeframe. However, after the transition, services may be difficult to acquire; it is widely known that many VAs are unable to treat the number of patients in need, suggesting that alternative means should be considered.⁷

One such solution was believed to be the Veterans Access, Choice and Accountability Act of 2014, which gave the VA \$10 billion to set up a program that allowed eligible veterans to receive private health care in their communities if the local VA appointment wait time exceeded 30 days or travel barriers exceeded 40 miles. Unfortunately, this effort has met many problems, including Choice Program delays in paying local health care providers (thus, resulting in veterans' care being disrupted or veterans being charged for care and incurring credit issues), Choice Program referrals to community health care that is equally inaccessible due to long distances, and a complicated Choice Program referral process that often results in excessive delays for private health care appointments.

As alternatives to the VA system, federal organizations such as SAMHSA have begun to partner with the DoD and the VA to provide online substance use resources, but direct intervention alternatives have yet to become available.³⁴ Similarly, the Wounded Warriors Project is a nonprofit organization that provides online mental and physical health wellness information, career and benefits information, and veteran support materials for severely injured individuals who have served in the U.S. Military. Importantly, this program specifies that services are available for both physical and mental illness or injury, although benefits are primarily limited to resources and information, rather than direct delivery of care. For those practitioners who work with veterans, these resources provide a start in an otherwise difficult process of providing affordable, consistent, and accessible mental health and substance use care to veterans.

Clinical: the Best Use of Existing Resources

Based upon many issues at work, programs that work with those in active duty or veterans may do well to initially focus on identification of problems and raising awareness, rather than waiting for severe issues to arise. It is recommended that veterans are provided direct access (e.g., internet or pamphlets) to tailored materials that raise awareness of the susceptibility of veterans to substance use and psychological distress, as this may increase treatment seeking when problems

arise. Such access to materials could indeed be provided while individuals are in active duty, as they would not require considerable time or resources. Validating that such issues are common may push veterans to seek services in a timelier fashion before more complex and entrenched issues begin.

When thinking about the provision of care, veterans in this sample felt a clear need to connect to other veterans in an effort to ease their transition to civilian life. While collaborating with the veteran community is rather unusual for medical and clinical settings, veteran partners could be particularly valuable. For example, other veterans who have had good transition experiences (e.g., those who have navigated the system to receive timely access to health care and social services, who have been properly informed about separation process, who have completed mental health and substance use treatment, and those who built a strong support system during transition) may be able to provide mentorship and assistance in navigating the VA and other existing assistance programs. Enrolling in unfamiliar programs can be a daunting process, but structured mentorship by former veterans may significantly reduce this burden. In addition, previously transitioned veterans could be recruited by the VA or sponsored programs (e.g., Vet Centers) through electronic means (e.g., myhealthvet.va.gov), flyers, or mail. These veteran mentors could be assigned to a small number of transitioning veterans and start communication with them prior to the separation process. Veteran mentors could talk to transitioning veterans in individual or group format before, during, and after the separation process about their experience with mental health or substance use. In addition, veteran mentors could be trained to conduct ongoing monitoring and future detection of functional impairment and more serious mental health and substance use issues in the transitioning population. Veteran mentors could educate transitioning veterans regarding how mental health disorders translate into concrete symptoms (e.g., anger outbursts, intrusive memories from combat, need for isolation, needing more of a substance to achieve the same effect as before). Although Internet and pamphlet prevention programs are likely to be sufficient for some, ongoing care from veteran mentors is clearly a necessity to identify issues and encourage help-seeking when issues arise. In fact, there is some evidence that veterans are amenable to peer support from other veterans during and after the separation process and that, through a structured veteran mentorship program, several of the barriers to mental health and substance use services can be overcome.³⁵⁻³⁷ Even though Vet Centers provide similar services to the ones suggested (e.g., outreach, substance abuse assessment, referrals, explanation of benefits), comprehensive program evaluations are still needed.³⁸

Concluding Remarks

This study examined perceived needs of veterans during the military to civilian transition. Veterans reported that mental health and substance use services would be useful during this adjustment period. Veterans reported multiple ongoing issues with the VA system, which suggests that many of the veterans in this sample experience barriers that prevent them from accessing the care they need. Finally, many of the veterans in this study reported the need for mentorship and social services from other veterans who may be able to help newly transitioning veterans prepare and acclimate to civilian life, as well as the difficulties navigating health care systems like the VA. Given the needs of this population, it is recommended that all practitioners who work with veterans should address possible mental health and substance use issues. While it would be difficult to change existing systems, which are already experiencing difficulty supporting this ever-growing population, it is possible that enlistment of successfully transitioned veterans would serve to provide consistency of contact and an early warning system for those to newly separating veterans in critical need.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

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