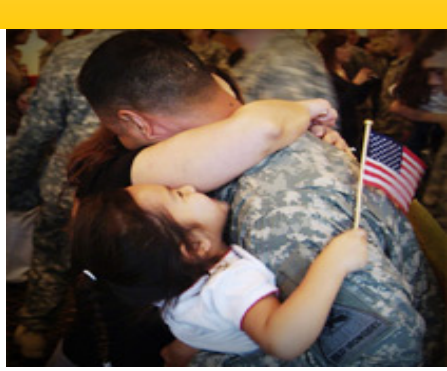
HOUSTON / HARRIS COUNTY

Veterans Behavioral Health Initiative

A Community Collaboration





A Report to
Harris County Judge Ed Emmett and
Houston Mayor Bill White

SEPTEMBER 2009

MHA
Mental Health America
of Greater Houston

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VETERANS BEHAVIORAL HEALTH INITIATIVE

EXECUTIVE SUMMARY

Research shows that veterans deployed in Iraq and Afghanistan may experience behavioral health (mental health and substance abuse) needs that compromise their successful return to their families and their communities. This is particularly important locally, because the Houston/Harris County area has one of the largest populations of military service members and families in the nation. With this recognition, in August 2008, Harris County Judge Ed Emmett and Houston Mayor Bill White charged Mental Health America of Greater Houston (MHA) with facilitating the development of a plan to address the behavioral health needs of veterans and their families in Houston/Harris County. This report is the culmination of that planning process, which involved 6 workgroups and engaged over 100 individuals from 70 agencies (see Appendix A: List of Organizations/Agencies) to focus on the successful community reintegration of our returning veterans.

It is increasingly evident, both from national and local data, that the behavioral health needs of veterans returning from deployment in Iraq and Afghanistan are not being adequately met by our current systems of care. Approximately 1 in 5 veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) meet the criteria for depression or Post Traumatic Stress Disorder (PTSD), yet only half of them have received mental health care.[1] Families of military service members also do not have adequate community support—ninety-four percent of military families feel that the non-military community does not understand or appreciate the sacrifices they make.[2] Dissolution of a military family can contribute to tragic outcomes, including substance abuse, loss of employment, family violence, poverty, criminal prosecution, homelessness and suicide. These issues have a significant impact on community behavioral health and place a direct burden on community systems and resources.

Fortunately, veterans and their families can be highly resilient and, with targeted assistance and outreach, thrive in the community. **A focus on health is the key to successful outreach.**

The following recommendations represent a compilation of the deliberations of the work groups and additional best practices as identified by national experts.

[1] Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery/Terri Tanielian, Lisa H. Jaycox

[2] Blue Star Families – Life Issues Survey, May 5, 2009. www.blueshieldcafoundation.org.

RECOMMENDATION 1: INCREASE ACCESS TO CARE

The City of Houston and Harris County should promote the behavioral health of OEF/OIF veterans and the sustainability of their families by increasing access to appropriate behavioral health services and supports, thereby reducing the negative impact on other city/county systems. This would entail:

- Implementing a suicide prevention campaign;
- Expanding the implementation of integrated physical and behavioral health care;
- Expanding trauma training for non-military, behavioral health care service providers;
- Ensuring access to appropriate housing through linking veterans and their families to existing housing and expanding the availability of new housing;
- Developing specialized training for law enforcement to help them appropriately address the behavioral health issues of returning veterans;
- Implementing a specialized veterans behavioral health court/docket;
- Advocating for increased private funding available for veterans and their families to be directed to the Houston/Harris County area; and
- Exploring the possibility of developing a centralized database tracking veterans' behavioral health care indicators.

RECOMMENDATION 2: INCREASE FAMILY ADVOCACY AND PEER SUPPORT

The City of Houston and Harris County should promote the behavioral health of OEF/OIF veterans and the sustainability of their families by establishing a Military and Family Advocacy Program (MFAP). This program would:

- Coordinate outreach to spouses and children of veterans prior to, during deployment, and after they return;
- Direct veterans and family members to needed community services; and
- Utilize evidence-based practices, particularly peer support.

RECOMMENDATION 3: INCREASE OUTREACH AND PUBLIC AWARENESS

The City of Houston and Harris County should promote the behavioral health of OEF/OIF veterans and the sustainability of their families by carrying out a broad public outreach initiative that recognizes and celebrates the contributions of veterans and their families to the community and promotes awareness of behavioral health issues. Such a campaign would include:

- Special recognition days for veterans and their families and increased awareness of veteran support activities;
- Increased awareness of community resources through promoting 2-1-1 and the Veterans Resource Directory; and
- Information about evidence-based practices and available resources.

HOUSTON / HARRIS COUNTY VETERANS BEHAVIORAL HEALTH INITIATIVE: A COMMUNITY COLLABORATION

SEPTEMBER 2009

Over 200,000 veterans of military service live and work in Houston/Harris County, making it home to one of the largest populations of military service members and families in the nation.

Research continues to show that veterans deployed in Iraq and Afghanistan may experience a variety of issues that can compromise their successful return to their families, jobs, and community. The failure to adequately address these issues can place a significant burden upon local systems.

HISTORY OF INITIATIVE & REPORT DEVELOPMENT

In June 2007, Harris County Judge Ed Emmett and Houston Mayor Bill White began addressing the overall needs of returning veterans to Houston/Harris County by organizing a summit that called together all levels of government (federal, state and local), along with military, faith-based, nonprofit, education, media and service organizations. The result of this first summit was to identify four specific issue areas crucial to returning veterans:

- Logistics of living;
- Education and career;
- Interaction with public assistance programs; and
- Mentoring.

Further fact-finding took place at a second summit, resulting in a number of positive developments:

- Establishment of a dedicated website for veterans returning to Houston, www.houstonreturningvets.org, launched in November 2007, and in continued development;
- Creation of the City of Houston Office of Veterans Affairs to collaborate with the Harris County Veterans Service Office and other community organizations in assisting all veterans of the United States Armed Forces through advocacy, referral and counseling;
- Development and dissemination of a Veterans Resources Directory, detailing services available to all of the men and women who have served in our nation's armed forces;
- Development of a foldout wallet-sized version of the Resource Directory by the Harris County Community Services Department for easier reference upon initial return to Harris County; and
- Hiring of a Veterans Specialist for United Way 2-1-1.

In August 2008, Harris County Judge Ed Emmett and Houston Mayor Bill White charged Mental Health America of Greater Houston with facilitating the development of an integrated, comprehensive plan to address the behavioral health needs of returning veterans and their families in the Houston/Harris County area. In accepting this charge, Mental Health America of Greater Houston recognized that successful recommendations must:

- Engage the entire community;
- Allow for efficient implementation; and
- Lead to significant improvements in the lives of our Houston/Harris County military service members and their families.

To begin this process, MHA, in conjunction with the offices of Judge Emmett and Mayor White, convened a meeting in August 2008 at the George R. Brown Convention Center. Individuals representing 46 community organizations were in attendance at this initial meeting. There was broad consensus regarding the need to develop a plan to better coordinate access to behavioral health services for returning veterans. At the conclusion of the meeting, attendees agreed to participate in specific work groups to identify and address the needs of veterans and their families in the following areas:

- Outreach Coordination;
- Screening And Referral;
- Access to Services;
- Overcoming Stigma;
- Benefit Coordination; and
- Funding Streams.

The workgroups met several times throughout the fall of 2008. The process consisted of extensive deliberations, brainstorming and discussions among participants, as well as a site visit to the Michael E. DeBakey Veterans Affairs Medical Center (VAMC). The workgroups developed recommendations that were presented at a final meeting held in March of 2009, which also included input from national experts. The recommendations were reviewed and edited by subject matter experts to yield the final recommendations contained in this report. It is noteworthy that, from the initial meeting and throughout the course of the workgroup deliberations, over 100 individuals representing 70 city, county, and state agencies and organizations participated in this process.

This report focuses on achieving and maintaining behavioral health and on enhancing local community services that promote the successful community reintegration of veterans. The recommendations do not attempt to correct flaws in federal or state systems of care for veterans, even where those systems may need improvement. In particular, the report seeks to avoid duplication of community services provided to veterans through the Veterans Administration (VA). The recommendations are designed to build on existing local resources, meet documented community needs, and guide veterans and their families to community resources. We believe these activities will promote health and resiliency, can be absorbed by local government, and are worthy of local community support.

WORKGROUP DISCUSSIONS - KEY ISSUES AND BARRIERS TO CARE

The workgroup process identified a number of concerns and needs relating to the behavioral health of veterans. Unfortunately, there is little consistently collected local data about the behavioral health needs of veterans. We do know that more than 200,000 veterans live in Houston/Harris County and that 18,000 have returned or moved to this area since September of 2001. We also know that there are more than 13,000 veterans from Iraq and Afghanistan currently being tracked by the Michael E. DeBakey Veterans Affairs Medical Center (VAMC).

In order to appropriately address their needs, it is important to understand the key issues and barriers to care that they are facing. These issues, as identified by the workgroups, are detailed below.

SUICIDE

Perhaps the most distressing statistic related to veterans is the rising suicide rate. As reported in a recent *New York Times* article, 192 active-duty and inactive reserve soldiers committed suicide in 2008, a number that is twice as high as in 2003. In addition, 129 soldiers committed or are suspected to have committed suicide between January and mid-July of this year—more than the number of soldiers who died during combat during the same time period.[3] While there is no current data about suicides among Harris County veterans, there is no reason to believe it would differ from national trends. This alarming rate of military suicides, which shows no signs of abating, is arguably the most critical public health issue that needs to be addressed among our returning veterans.

ACCESS TO CARE

The VAMC is the primary point of care for most returning veterans, serving over 6,000 in the Houston/Harris County area. 90% of those served at the VAMC are men, and 21% have been diagnosed with some form of depression or PTSD. 30% of those screened at the VAMC are diagnosed with Traumatic Brain Injury (TBI).

Participants reflected, however, that there were many other points of access to behavioral health care that need to be examined. Many veterans, for example, access emergency psychiatric care from the Neuro-Psychiatric Center (NPC). The NPC stabilizes the acute psychiatric crisis that resulted in the request for help, but if it is determined that the presenting individual has VA benefits, he/she will not receive services through the Mental Health and Mental Retardation Authority of Harris County (MHMRA); the individual will instead be referred back to the VAMC for continued care.

Vet Centers, part of the U.S. Department of Veterans Affairs, provide no-cost readjustment counseling and outreach services for combat veterans and their families. Readjustment counseling services range from individual counseling to benefits assistance to substance use assessment. Counseling for military sexual trauma is also available. There are two Vet Centers in Houston that fill gaps in needed services and provide a stigma-free alternative to obtaining behavioral health services in others settings. In addition, shelters, emergency rooms and a wide array of non-profit service organizations complete the service array.

[3] "Suicide's Rising Toll – After Combat, Victims of an Inner War", *New York Times*, August 1, 2009.

While we know that family members and children of returning veterans are greatly affected by the impact of war and military service, very little data currently exists, either nationally or locally, to address this issue. Sadly, many of the negative consequences of behavioral health issues in returning veterans relate to family issues (Sherman, et. al, October 2006). However, involvement of family members may be the most important step in engaging veterans who are reluctant to seek behavioral health care.

Access to VA health care services is dependent upon a number of factors, including discharge status, enrollment within a fixed period of time after discharge, service needs that are a direct result of combat employment, length of active duty service, and priority level in terms of overall need. Eligibility status is confusing to even those with firsthand knowledge, however veterans and their family members may obtain additional information at http://www.va.gov/healtheligibility/eligibility/PriorityGroupsAll.asp (See Appendix B: Eight Priority Levels).

Many efforts have been made in the past year to encourage enrollment among Reservists, National Guard members and active duty returnees. If enrolled within five years, these individuals have unlimited health care and benefits, including medications. This enrollment period is particularly critical for individuals with behavioral health needs, which tend to be chronic, and for which medications can be quite expensive. After the enrollment period has lapsed, returning veterans can still access VA health care benefits, but again, access is determined by the eight priority levels.

Some returning veterans are not eligible for behavioral health benefits and/or services because of discharge status (e.g. less than honorable discharge), diagnosis (e.g. those not covered in the Department of State Health Services priority population definition) or failure to reinstate benefits after release from incarceration (http://www.mhmraharris.org/Adult-Mental-Health-Services.asp).

Filling gaps in the behavioral health service system will require effective screening and identification, accurate communication about benefits and eligibility factors, ability to access benefits across agencies, identification of individual service needs, and implementation of best practices in providing services.

OUTREACH

Among key workgroup findings were that, despite significant outreach efforts, many returning veterans continue to avoid seeking mental health services. Family members and children of veterans are also significantly affected, although the numbers and formal outreach efforts for them are difficult to document.

While outreach has historically been a problem for returning veterans, recent media attention to their unmet behavioral health needs has resulted in significantly increased attention to this issue. Work group members reflected that there are a variety of outreach efforts, both formal and informal, taking place for active military, as well as for National Guard members and Reservists.

In Houston, since 2008, outreach to National Guard members and Reservists serving in deployed units was perceived to be the most effective. Virtually 100% receive a clinical interview upon return as mandated and are tracked through military command channels. Post deployment activities not only included standardized military programs, but also “mini-fairs” at all return points, designed by various service organizations to engage individuals through a number of different media.

Active military personnel and Individual Ready Reserve (IRR) augmentees appear to be more difficult to engage in outreach efforts for a number of reasons. Veterans returning from active duty have a very formal return system at their military bases but return to Houston at a staggered pace upon release from active duty. There is no system informing the community of returning combat veterans and therefore no formal outreach mechanism outside of voluntary request of services through the VA hospital system. Furthermore, there appeared to be a higher perceived stigma about behavioral health issues among active military. Additionally, IRR service members return in small clusters or as individuals with a lower level of cohesiveness than National Guard members or Reservists who return as a unit.

There is also a great deal of concern that inadequate outreach efforts were being targeted to the family members of returning veterans. As cited above, it has been well documented that relationship instability is a major contributing factor to poor readjustment upon a veteran's return, yet spouses are only included informally in outreach efforts. Even more concerning was the almost total lack of outreach for the children of veterans, for whom mental health consequences can be significant.

For returning veterans with no VA benefits (e.g., those less than honorably discharged,) behavioral health outreach is even more complicated. While a number of non-profit organizations in the Houston/Harris County community address this issue, it is difficult to know what gaps continue to exist.

HOUSING

In Houston/Harris County, approximately 23% of the adult homeless population has served their country in the Armed Services. This means that almost 2,500 veterans (male and female) are homeless on any given night and perhaps three times as many experience homelessness at some point during the course of a year.[4] Many other veterans are considered near homeless or at risk for homelessness due to poverty, lack of support from family and friends, and dismal living conditions in cheap hotels or in overcrowded or substandard housing (United States Department of Veterans Affairs). To add to this problem, over half of the homeless veterans have diagnosed mental illnesses and/or substance use disorders, the treatment of which can be complicated by housing instability. Therefore, ensuring the accessibility of safe and affordable housing for returning veterans is essential to the success of any behavioral health intervention.

JUSTICE SYSTEM INVOLVEMENT

Behaviors that promote survival within the combat zone (e.g. hyper vigilance and aggression) may cause difficulties during a veteran's transition back to civilian life and potentially result in involvement with the criminal justice system. On any given day, veterans account for nine of every 100 individuals in U.S. prisons and jails (Noonan & Mumola, 2007; Greenberg & Rosenheck, 2008). Although VA health benefits are discontinued while a veteran is detained in prison or jail, they are payable immediately upon his/her release, provided that there is written notification that he/she has been released and he/she contacts the regional VA office. Failure to follow these steps may result in veterans with behavioral health disorders "falling through the cracks" of the system.

[4] 2006-2007 Homeless Enumeration and Needs Assessment, Coalition for the Homeless of Houston/Harris County: http://www.homelesshouston.org/hh/Strategic_Plan_to_Address_Homelessness_EN.asp?SnID=795766139

INEFFECTIVE SCREENING FOR BEHAVIORAL HEALTH DISORDERS

Studies show that many veterans who are "screened out" for behavioral health disorders present later for care. Sometimes this is due to delayed effects and sometimes due to soldiers presenting false information to screeners, so as not to be labeled as needing further mental health treatment. This is particularly significant because psychiatric literature shows that early intervention for behavioral health disorders results in better prognosis and outcomes.

LACK OF EDUCATION/AWARENESS OF RESOURCES & ADDRESSING STIGMA

On a national level, it is well documented that veterans and active military are often hesitant to seek mental health care. According to the Rand Corporation, in 2008 the top five barriers to seeking mental health care were:

- Medication side effects (45%)
- Harm to career (44%)
- Denial of security clearance (44%)
- Family and friends are preferable (39%)
- Loss of co-worker confidence (38%)[5]

Local data is not available, but we anticipate that similar factors influence access to behavioral health services in Houston/Harris County.

[5] Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery/Terri Tanielian, Lisa H. Jaycox

REPORT RECOMMENDATIONS

Based upon the barriers to care and gaps in services that were identified through the workgroup process, and by drawing upon the expertise of national authorities on veteran and family issues, the following recommendations are being made:

RECOMMENDATION 1: INCREASE ACCESS TO CARE

The City of Houston and Harris County should promote the behavioral health of OEF/OIF veterans and the sustainability of their families by increasing access to appropriate behavioral health services and supports, thereby reducing the negative impact on other city/county systems. This would entail:

- Implementing a suicide prevention campaign;
- Expanding the implementation of integrated physical and behavioral health care;
- Expanding trauma training for non-military, behavioral health care service providers;
- Ensuring access to appropriate housing through linking veterans and their families to existing housing and expanding the availability of new housing;
- Developing specialized training for law enforcement to help them appropriately address the behavioral health issues of returning veterans;
- Implementing a specialized veterans behavioral health court/docket;
- Advocating for increased private funding available for veterans and their families to be directed to the Houston/Harris County area; and
- Exploring the possibility of developing a centralized database tracking veterans' behavioral health care indicators.

DISCUSSION

There is a growing gap between the need for behavioral health services and veterans' access and use of those services. 65% of military members who met the criteria for a mental disorder felt that seeking treatment would be perceived as a sign of weakness, and half felt that it would have a negative impact on their career.[6] Unfortunately, the stigma of mental illness is keeping many veterans from receiving the help they need. Other service members are willing to access needed services but are unable to due to a fragmented and oftentimes confusing system of care. Without treatment, many of these veterans will risk long-term, damaging consequences that may extend to family members and span generations. Meeting the behavioral health care needs of veterans and their family members will require a multi-faceted approach and a collective effort by a diverse range of community organizations and resources.

[6] "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care"***, New England Journal of Medicine, Volume 351;13-22***/Charles W. Hoge, M.D., Carl A. Castro, Ph.D., Stephen C. Messer, Ph.D., Dennis McGurk, Ph.D., Dave I. Cotting, Ph.D., and Robert L. Koffman, M.D., M.P.H. July 1, 2004

SUICIDE PREVENTION

Suicide has emerged as a major public health problem and is among the leading causes of death for veterans. While several groups in Houston/Harris County address various aspects of suicide prevention, there has been no systematic planning and coordination of suicide prevention efforts targeting veterans. In order to stem the tide of veteran suicides locally, organizations must be willing to work collaboratively to produce a major suicide prevention campaign that engages a broad cross-section of the community.

SERVICE INTEGRATION

It is well documented that there is a high prevalence of behavioral health disorders, as well as other medical conditions, among recently returned veterans. Separate treatment approaches for these conditions create significant challenges in providing appropriate care to these veterans. Efforts to develop and sustain clinically integrated physical and behavioral health service delivery approaches, particularly within the primary care setting, are sorely needed.

TRAUMA TRAINING

Virtually all returning veterans have some history of trauma. While there is a growing body of literature about trauma-informed services nationally, it has not been substantially implemented in Texas. As many veterans will at some point receive behavioral health services in a non-military setting, it is important that these providers have sufficient knowledge of trauma in order to provide effective care.

HOUSING

Houston/Harris County, like many metropolitan areas across the U.S., lacks adequate housing resources for returning veterans. As mentioned before, roughly 23% of Houston's homeless are veterans—30% of homeless males are veterans. A number of OEF/OIF veterans are now beginning to return without an appropriate, safe place to live. Therefore, it is critical that Houston/Harris County expand available housing units.

LAW ENFORCEMENT TRAINING

The justice system in the Houston/Harris County area must also anticipate the needs of returning veterans who have experienced the trauma of war. The nature of their traumatic exposure often lends itself to behaviors that place them in direct contact with law enforcement. These encounters often present officers with complex post-deployment mental health issues; however, through specialized training, officers can learn a safer and more effective approach to de-escalating what can be high-risk situations.

VETERANS COURT/DOCKET

Intercepting veterans before they enter an already overwhelmed criminal justice system is an important goal, but interventions must also exist for veterans who face problems adjusting to civilian life and ultimately end up in the judicial system. These veterans would benefit from a specialized court that

recognizes their unique needs and challenges and stresses rehabilitation and community reintegration over punitive measures.

PRIVATE FUNDING

While Houston/Harris County is eligible to receive a large amount of federal funds for veteran services, funding is inadequate for services to military families. Millions of dollars are available for these services from private funding sources. However, to date, these funds have largely been directed to areas that are linked to military bases. Houston/Harris County needs to more assertively pursue private funding, especially from foundations and corporations.

DATABASE

In order to ensure that our community has the services necessary to meet the needs of our returning veterans, particularly those who are ineligible for behavioral health benefits, we must have the capacity to collect appropriate indicators for them. The development and maintenance of a database that provides information on how many of these individuals are in Houston/Harris County and where they are presenting for behavioral health care could help to drive policy changes and expand service system capacity to address the identified unmet needs. Creating such a database raises several issues (e.g. privacy, cross-system data-sharing, etc.), but it is a concept that is worth exploring.

STEPS TO IMPLEMENTATION

Recommendation #1 involves a multi-faceted approach to addressing the significant gaps that currently exist within our community behavioral health care system, which can cause many veterans to fall through the cracks and lead to over-utilization of other city/county systems (e.g. criminal justice system, acute health care system, etc.). Addressing these gaps will require effective identification of individual service needs, expansion of behavioral health services in non-behavioral health community settings (other than the VA) to reduce stigma, and a commitment to divert veterans from acute care and other settings into community-based services.

SUICIDE PREVENTION

Reducing the incidents of suicides locally will require a sustained focus on creating awareness surrounding suicide prevention. The Suicide Prevention Resource Center (www.sprc.org) recommends that states and communities conduct strategic planning for suicide prevention that encourages communities to work together to develop fundamental skills to plan and implement comprehensive suicide prevention plans. The key to success in developing this plan locally is collaboration—the process would have to engage veterans, family members, both public and private veteran-serving agencies, the medical community, governmental officials and the public at-large. The plan may include improved tracking of veteran suicides, media coverage as part of an overall suicide awareness campaign, and active support of governmental officials through resolutions, proclamations, and other means.

SERVICE INTEGRATION

A key goal of this initiative should be to expand and institutionalize Integrated Dual Diagnosis Treatment for returning veterans. This treatment is for people who have a co-occurring mental illness and substance use disorder and has been recognized as an evidence-based practice by the Substance Abuse and Mental Heath Administration. This treatment approach helps people recover by offering both mental health and substance abuse services at the same time and in one setting. Ensuring that these services are available in primary care settings and integrated with other medical care will also help to reduce the stigma associated with mental health/substance abuse treatment.

TRAUMA TRAINING

As PTSD and TBI are highly prevalent among returning veterans, the development and implementation of trauma-informed curricula for use within the VAMC and other public mental health providers must be a priority. Once these services have been well established in these systems, they should be incorporated into other community provider settings.

HOUSING

Because homelessness continues to be a significant problem facing many veterans, a strategy to expand available housing for veterans and their families should be developed and implemented. This strategy should include an inventory of currently available housing and the identification of funding streams (e.g., funds available through the "Returning Veterans" initiative, stimulus funding, etc) to develop new housing.

LAW ENFORCEMENT TRAINING

A specialized training module for officers who may interact with veterans should be developed for local law enforcement agencies. This training should include information on clinical issues and community resources and also make use of role plays. Because the Houston Police Department already has a Crisis Intervention Team, it could serve as the pilot site for this module, which ideally would eventually be expanded to other local jurisdictions.

VETERANS COURT/DOCKET

To assist veterans who have difficulty adjusting to civilian life and have PTSD, TBI and/or substance use disorders, the Veterans Administration, Harris County, the City of Houston and veterans groups have been working to implement a Veterans Court/Docket. This collaborative effort acknowledges the enactment of recent state legislation that allows for implementation of such a court and provides the opportunity for veterans to get the help and support they need while also resolving criminal issues in a positive manner. The group is also looking at ways to implement expanded outreach to veterans involved in the criminal justice system and/or to those who may be in need of behavioral health care. These efforts deserve the continued support of Harris County and the City of Houston to ensure the full and appropriate implementation of such a court/docket in Houston/Harris County.

PRIVATE FUNDING

The utilization of innovative approaches to obtain funding to better serve our returning veterans and their families will assist Houston and Harris County in meeting the basic needs of this rapidly expanding population. The city and county should identify a core group of individuals who will serve as spokespersons and advocates on behalf of Houston/ Harris County veterans and their family members. These individuals would present information about needs of the veteran community to corporations and foundations in order to secure private funding to expand behavioral health service initiatives.

DATABASE

To begin exploring the possibility of developing a database, a workgroup should be convened that includes representatives from the City of Houston Health Department, Harris County Hospital District, the Harris County Sheriff's Office, MHMRA of Harris County, VAMC, Vet Centers, area emergency rooms and other appropriate agencies. The workgroup could discuss key de-identified information that could be collected for maintenance in the database (e.g., VA eligibility status, medical/behavioral health diagnoses, etc.), identify possible barriers to developing the database, explore ways to overcome them, and finally, make recommendations on whether or not development of such a database is feasible.

RECOMMENDATION 2: INCREASE FAMILY ADVOCACY AND PEER SUPPORT

The City of Houston and Harris County should promote the behavioral health of OEF/OIF veterans and the sustainability of their families by establishing a Military and Family Advocacy Program (MFAP) that would:

- Coordinate outreach to spouses and children of veterans prior to, during deployment, and after they return;
- Direct veterans and family members to needed community services; and
- Utilize evidence-based practices, particularly peer support.

DISCUSSION

An American Psychiatric Association survey highlights the issues that soldiers and their spouses cope with: More than one-third self report experiencing anxiety (military members--38%, military spouses--39%) and feeling depression (military members--40%, military spouses--33%) at least twice a week. In addition to stress caused by worry for their loved one serving in the military, spouses reported stress from handling domestic issues alone (60%) and single parenting (54%). Similarly, children must cope with the stresses of multiple deployments, as well as trauma and loss. However, spouses are seldom the focus of outreach, and the behavioral health needs of the children of military families have received little attention. Any efforts to promote health and resiliency among our returning veterans must include intense, focused programming geared toward the primary source of support for the vast majority of them: their families.

The recommendation to create a Military and Family Advocacy Program (MFAP) is positively focused on behavioral health with the objective of promoting the quality of life of military families in Houston/Harris County. Promoting healthy families complements the military mission and encourages positive partnerships and co-sponsorship with the Texas Military Forces and U.S. Department of Defense. However, it is a very appropriate objective for local government and is not duplicated by state or national governmental organizations. Such a program can leverage participation of strong local private organizations that serve families in Houston/Harris County.

Unlike a program focused on a specific need such as homelessness or jail diversion, MFAP would be designed to address the multiple and diverse needs of military families. The program would mobilize and engage a diverse range of human services providers and advocates—not just one sector—therefore leading to a partnership that can minimize duplication of effort.

STEPS TO IMPLEMENTATION

The Military and Family Advocacy Program should be established with program staff consisting primarily of OEF/OIF veterans and spouses who would be intensively trained in finding resources within local organizations. These services would build upon the Veterans Resource Directory and resources contained in the 2-1-1 Texas Information and Referral Network.

The Military and Family Advocacy Program would follow best practices, including:

- Peer-based guidance by OEF/OIF veterans;
- Maintaining confidentiality when requested;
- Advocacy by an individual who has access to resources and will follow through to problem resolution; and
- Performance-oriented data collection and program accountability based on number of clients, documented client needs, services provided, and longitudinal outcomes.

Peer-based guidance should be a cornerstone of MFAP, as a deep understanding of military culture is essential when interacting with veterans and military families. While the VA has utilized peer support through its Vet Centers, local organizations have been slow to develop peer support resources. Initiating this evidence-based practice as part of MFAP may also lead to its incorporation within other programs that may interact with veterans and their families.

MFAP staff would respond to requests for assistance from **all** veterans and military families, including those with a less than honorable discharge. The ability to serve all veterans is particularly important because veterans with a dishonorable discharge are not eligible for VA services and must rely solely on local behavioral health resources.

Because some veterans and their family members will not come forward to seek help until they experience a transitional event such as an arrest or health care crisis, MFAP staff would be available to serve as a resource for various systems, including: courts, Child Protective Services, schools, the VA and other organizations where peer-based guidance and advocacy may help veterans deal with family and behavioral health issues.

MFAP would also work to facilitate innovative programs that focus on the needs and resiliency of military children. This could include facilitating implementation of a pilot program on a school campus to appropriately identify youths whose parents are deployed and better assess their behavioral health and other needs. The screening question(s) could be utilized in conjunction with the Medicaid/CHIP questionnaire which is currently being used in the Houston Independent School District. Such screening could provide valuable feedback to MFAP staff so it can refine its programming and services for children.

MFAP staff also could be encouraged to advance from volunteer status to employment with local human services agencies, providing a career opportunity for participating veterans.

RECOMMENDATION 3: INCREASE OUTREACH AND PUBLIC AWARENESS

The City of Houston and Harris County should promote the behavioral health of OEF/OIF veterans and the sustainability of their families by carrying out a broad public outreach initiative that recognizes and celebrates the contributions of veterans and their families to the community and promotes awareness of behavioral health issues. Such a campaign would include:

- Special recognition days for veterans and their families and increased awareness of veteran support activities;
- Increased awareness of community resources through promoting 2-1-1 and the Veterans Resource Directory; and
- Information about evidence-based practices and available resources.

DISCUSSION

Most workgroup participants believed that behavioral health outreach has improved for veterans, but few formalized systems are currently in place for family members. One way to reduce the isolation of military family members and make them feel that they are integral members of the community is by hosting a series of celebratory events in order to recognize their contributions. These celebrations can build upon the existing local celebrations for veterans and include special programs for military children. It is also important to ensure that veterans and their family members are aware of the many social and support activities that are already taking place in our community.

The workgroup also recommended an organized public outreach campaign to encourage veterans and their families to use the services for which they are eligible. A recent Houston Chronicle article cited the fact that roughly half of the estimated 13,000 Houston-area veterans who served in Iraq and Afghanistan have not taken advantage of a special VA program to help with their reintegration into the community.[7] A question frequently asked during the planning process was "Why don't people like to go to the VAMC?" In particular, there was a general perception that the VAMC is particularly unwieldy for individuals with behavioral health disorders. To investigate this, several members of the Access to Services workgroup visited the VAMC with an eye toward how accessible it would be for individuals with significant behavioral health needs. All of the participants in this site visit reflected that the VAMC was quite accessible and user friendly, even for those with behavioral health disabilities, but that there needs to be greater awareness of these services.

In addition, the public outreach campaign must include promotion of other available community-based services. Several non-profit and community organizations are willing and able to provide needed services to returning veterans, but the services they provide are not widely known. Because there are still a large number of veterans who simply will not seek care through the VA, it is important to highlight the availability of these other community services. Faith-based initiatives that are available must also be better publicized, as many veterans and their families may be more comfortable receiving behavioral health services in these settings.

[7] "VA Urges More Vets to Seek Help", *Houston Chronicle*, Section B, May 25, 2009.

STEPS TO IMPLEMENTATION

Outreach to veterans and their families should be promoted through a broad local public awareness campaign.

Any local celebration and recognition of veterans and their family members should coincide with already-existing national days, weeks, and months that have been set aside for these purposes. These include:

- Month of the Military Child (April);
- Military Appreciation Month (May), which includes Military Spouses Day; and
- Military Family Appreciation Week (November).

There should also be a special designation of a Military Family Day in Houston and Harris County, during which military families are celebrated and thanked in the media, schools, and businesses. A separate event entitled "Children of Heroes" should also be held to emphasize the bravery of the military children who have made sacrifices for the war efforts. Banners celebrating military families should be placed on local armories, and businesses that contribute to the program could be asked to describe the nature of their participation and their motivation to support local families. These celebrations also could serve to highlight the work and services of the Military and Family Advocacy Program. Staff of MFAP would be profiled through a description of their military and reintegration experiences and their motivation to help other military families. Also included in such a campaign could be success stories of families (de-identified) who have been assisted through the program.

The awareness campaign should also seek to promote existing social and support activities that are not as well known. Emerging social networking media, such as Facebook and Twitter, can be used to post events, benefits news, and other commentary. Online newsletter-based calendars, such as the one maintained by the Houston Military Affairs Committee, can also be more widely publicized through this campaign.

Another community awareness campaign should be conducted with the specific focus of heightening awareness of available services. A diverse representation of local organizations working with veterans and their family members should work together to develop a public relations campaign to improve the visibility and perception of accessibility of the VAMC for those with behavioral health disorders. Behavioral health services available in other settings should also be a part of the awareness campaign, which could be supported by the 2-1-1 telephone information system and the resources of the newly created MFAP. Faith-based initiatives, such as "Bridges to Healing", an outreach recovery program for combat veterans and their families, must be well-publicized as well.

Finally, local organizations should conduct a comprehensive community awareness campaign targeting schools, service providers, funding sources, veteran organizations, families and corporations. This campaign would include education about mental health issues, substance use disorders, evidence-based practices, and available resources for returning veterans and their families.

CONCLUSION

In conclusion, the physical, social and psychological toll of war can be quite traumatizing with potentially damaging effects that can manifest across the span of a veteran's lifetime. These issues can affect family relationships, work, interpersonal functioning and ultimately the community at-large, yet all too often they go unaddressed.

The findings of this study clearly demonstrate that many factors deter veterans from receiving behavioral health care. However, veterans are most likely to seek help when services are integrated into overall social services and health care. Peer-based support, while it may not be enough for complete behavioral health treatment, is a critical component. Normalizing the psychological impact of trauma also is a key element of overcoming stigma and fear.

Statistics in the report verify that families may experience high levels of stress when a member of that family is deployed or returns from serving in a war. The findings also concluded that the level of social support a veteran receives from his or her family and community can have a major impact on his or her successful reintegration. Thus, services for military families are of great importance. The good news is, the community is beginning to recognize the need to make families of deployed and returning service members aware of, and help them access, available resources, as well as build out new ones where necessary.

Mental Health America of Greater Houston has been pleased to facilitate the deliberations and findings in this report and is committed to ensuring that these recommendations, if accepted by Harris County Judge Ed Emmett and Houston Mayor Bill White, are fully implemented. We are hopeful that both Harris County and the City of Houston will take decisive action to demonstrate their official support for this initiative and its importance not only to veterans and their families, but to the entire Houston/Harris County community.

APPENDIX A:

LIST OF PARTICIPATING ORGANIZATIONS

Organizations:

American Red Cross
AMVETS
Asian American Family Services
Bay Area Council on Drugs and Alcohol
Ben Taub Hospital
Career and Recovery Resources, Inc.
Catholic Charities
City of Houston Office of Veterans Affairs
Coalition of Behavioral Health Services
Coalition for the Homeless of Houston & Harris County, Inc.
Continuum Care, LLC.
Crisis Intervention of Houston, Inc.
Cypress Creek Hospital
DAPA
DeBakey Financial Resources
DeGeorge at Union Station
Department of Veterans Affairs
DePelchin Children's Center
Depression and Bipolar Support Alliance of Greater Houston
Family Services of Greater Houston
Gateway to Care
Harris County Attorney's Office
Harris County Community Services Department
Harris County Judge's Office
Harris County Precinct 1
Harris County Precinct 2
Harris County Precinct 3
Harris County Housing Resources Center
Harris County Veterans Service Office
Health care for the Homeless
Heart of Montgomery County
Hispanic Counseling Center
Houston City Council, At-Large, Position 3
Houston-Galveston Trauma Institute
Houston Vet Center
Inner Wisdom, Inc.
International Association of Human Values
IntraCare Behavioral Health
Legacy Community Health Services
Menninger Clinic
Mental Health America of Fort Bend County
Mental Health America of Greater Houston

Mental Health and Mental Retardation Authority of Harris County
Michael E. DeBakey Veterans Affairs Medical Center
Military Ministry
NAMI Metropolitan Houston
NAMI West Houston
Office of the Chief, Army Reserve
PTSD Foundation of America
Paralyzed Veterans of America
Santa Maria Hostel
St. Joseph Medical Center
Star of Hope
Texas Veterans Commission
The Bush Cares Project
The Gathering Place
The Right Step
Tri-County Mental Health and Mental Retardation Services
United Service Organizations
United Way of Greater Houston
Unlimited Visions Aftercare, Inc.
United States House of Representatives, District 22
United States Marine Corps Wounded Warrior Regiment
United States Veterans Initiative
University of Texas Harris County Psychiatric Center
Veterans Affairs Vet Center
Veterans Resource Center
Wellness Willows Counseling and Sleep Center
West Oaks Hospital
Worklife Institute

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APPENDIX B:

EIGHT PRIORITY LEVELS

ALL ENROLLMENT PRIORITY GROUPS

Priority	Description
Priority 1:	Veterans with VA-rated service-connected disabilities 50% or more disabling Veterans determined by VA to be unemployable due to service-connected conditions
Priority 2:	Veterans with VA-rated service-connected disabilities 30% or 40% disabling
Priority 3:	Veterans who are Former Prisoners of War (POWs) Veterans awarded a Purple Heart medal Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty Veterans with VA-rated service-connected disabilities 10% or 20% disabling Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, "*benefits for individuals disabled by treatment or vocational rehabilitation*"
Priority 4:	Veterans who are receiving aid and attendance or housebound benefits from VA Veterans who have been determined by VA to be catastrophically disabled
Priority 5:	Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income and net worth below the VA National Income Thresholds Veterans receiving VA pension benefits Veterans eligible for Medicaid programs
Priority 6:	World War I veterans Compensable 0% service-connected veterans Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki Project 112/SHAD participants Veterans who served in a theater of combat operations after November 11, 1998 as follows: Currently enrolled Veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for 5 years post discharge Veterans discharged from active duty before January 28, 2003, who apply for enrollment on or after January 28, 2008 are eligible for this enhanced enrollment benefit through January 27, 2011 **NOTE**: At the end of this enhanced enrollment priority group placement time period Veterans will be assigned to the highest Priority Group their unique eligibility status at that time qualifies for.

Priority 7:	Veterans with income and/or net worth above the VA national income threshold and income below the VA National Geographic Income Thresholds who agree to pay copays
Priority 8:	Veterans with income and/or net worth above the VA National Income Thresholds and the VA National Geographic Income Thresholds who agree to pay copays **Veterans eligible for enrollment**: Noncompensable 0% service-connected and: Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less **Veterans eligible for enrollment**: Nonservice-connected and: Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status Subpriority d: Enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less **Veterans not eligible for enrollment**: Veterans not meeting the criteria above: Subpriority e: Noncompensable 0% service-connected Subpriority g: Nonservice-connected

Source: U.S. Dept. of Veteran Affairs, http://www.va.gov/healtheligibility/eligibility/PriorityGroupsAll.asp

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