

Partnering With Communities to Address the Mental Health Needs of Rural Veterans

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RESEARCH HIGHLIGHTS:

- In this study researchers report on the Arkansas Yellow Ribbon Task Force program, aimed at encouraging veterans to seek out mental health care and developing partnerships between stakeholder groups and the Central Arkansas Veterans Healthcare System.
- Rural areas have fewer mental health providers and smaller, denser populations. As a result, rural veterans may not always receive the anonymity desired when seeking out mental health care. However, untreated mental illnesses in veterans can result in self-medication with drugs and alcohol, relationship difficulties, poor job performance, family alienation, homelessness and criminal charges.
- Because of the success of this pilot program, the authors suggest the program be used as a model for clinical leadership at the VA in other southern states due to the similarities in religious practices, community college networks, criminal justice systems and rural designations.

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ABSTRACT:

Purpose: Many veterans who face mental illness and live in rural areas never obtain the mental health care they need. To address these needs, it is important to reach out to community stakeholders who are likely to have frequent interactions with veterans, particularly those returning from Operations Enduring and Iraqi Freedom (OEF/OIF).

Methods: Three community stakeholder groups—clergy, postsecondary educators, and criminal justice personnel—are of particular importance for OEF/OIF veterans living in rural areas and may be more likely to come into contact with rural veterans struggling with mental illness or substance abuse than the formal health care system. This article briefly describes the conceptualization, development, initial implementation, and early evaluation of a Veterans Affairs (VA) medical center-based program designed to improve engagement in, and access to, mental health care for veterans returning to rural areas.

Findings: One year since initial funding, 90 stakeholders have attended formal training workshops (criminal justice personnel = 36; educators = 31; clergy = 23). Two training formats (a 2-hour workshop and an intensive 2.5-day workshop) have been developed and provided to clergy in 1 rural county with another county scheduled for training. A veteran outreach initiative, which has received 32 referrals for various student services, has been established on 4 rural college campuses. A Veterans Treatment Court also has been established with 16 referrals for eligibility assessments.

Conclusions: While this pilot program is in the early stages of evaluation, its success to date has encouraged program and VA clinical leadership to expand beyond the original sites.”

Implications

FOR PRACTICE

The Yellow Ribbon Task Force program, developed and pilot-tested in Arkansas, aimed to develop partnerships between stakeholder groups and the Central Arkansas Veterans Healthcare System to promote and encourage engagement in mental health care for veterans. The steps taken by the Yellow Ribbon Task Force can be easily replicated in other rural communities to benefit rural veterans, and should be pursued by community members, veteran families and veteran service organizations. These steps include: the establishment of an advisory board, creation and distribution of a toolkit created to outline psychosocial issues for OEF/OIF veterans and services available to them, standardized curriculum to educate clergy on program objectives, outreach programs for veterans in the criminal justice system and college campus outreach projects. Combining these efforts under one initiative not only increases the chances of meeting the needs of rural veterans, it also establishes a community of early responders, veteran service organizations, veteran peers and family members to support veterans in their recovery and care.

FOR POLICY

The success of the Arkansas Yellow Ribbon Task Force program was largely due to its connections to the VA medical center, which ensures that any services needed are readily available for veterans and their families. Policy makers need to focus on creating state-specific policies that enhance already existing clinical practices to increase standards of care, anonymity and support for rural veterans. Policies providing funding for program pilot testing are also greatly beneficial, as they will provide crucial information about the strengths and weaknesses of current organizational infrastructure and details of how best to coordinate programs in multiple states and regions. New policies should also focus on training and funding for Central Arkansas Veterans Healthcare System personnel and military chaplains who work directly with veterans and their families because they are most informed about the needs of rural veteran populations.

FOR FUTURE RESEARCH

Although this pilot program was successful in Arkansas, results cannot be generalized to all rural veterans across the nation. Future research should focus on evaluating initial program implementation and pilot testing in a variety of states and rural populations, with diverse groups of veterans. Although this program may be easily replicated in other southern states due to the similarities in religious practices, community college networks, criminal justice systems and rural designations, there may be additional challenges to program success because of differences in population demographics and resource availability. Researchers should also examine the benefits and drawbacks of using interactive video conferencing in areas with few or no Veteran Treatment Courts (VTC) personnel members. Researchers can also focus on the evaluation of international program implementation, as veterans in countries such as Canada and Australia face similar challenges as soldiers in the U.S. military and could also benefit from the Yellow Ribbon Task Force model.

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