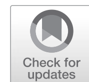

Veterans' Services

Liliya Gershengoren, Pantea Farahmand,
and Adam Wolkin

Introduction

The US Department of Veterans Affairs (officially "DVA" but still widely referred to as "VA") is a Cabinet-level agency that is directed by the Secretary of Veterans Affairs. Integrity, commitment, advocacy, respect, and excellence (iCARE) are the core values of the VA. The largest component within VA is the Veterans Health Administration (VHA), responsible for healthcare and related services (the other divisions include Veterans Benefits Administration and National Cemetery Administration). The identified missions of VHA include an emphasis on *clinical care*, advancement in *medical research*, upholding the *educational efforts* of medical training programs, as well as *assistance during national medical emergencies* (US Department of Veterans Affairs 2020a).

VA endeavors to meet the medical, surgical, and mental health needs of veterans who have been discharged from the military under honorable conditions. Increasingly over recent decades, VA has prioritized mental health care and recognized that mental health is an essential element of overall health and well-being. VA strives to consistently integrate mental health services, including substance use-associated conditions, with the other components of health care. This creates the foundation for a comprehensive and progressive healthcare system and is the basis by which mental health care for military veterans has evolved in the quality and the breadth of the multitude of services offered by the VA.

The "Uniform Mental Health Services" Handbook (Department of Veterans Affairs 2008) exemplifies the principle that mental health concerns are essential and impact the physical wellness and quality of life of veterans. It establishes the minimum mental health program requirements that are to be executed across all VA facilities in order to increase access to mental health care. The implementation of the healthcare programs is facilitated through the operation of multiple VA medical centers (VAMC), community-based outpatient clinics (CBOC), and VA community living centers (VA nursing home). Medical services continue to be expanded as there has also been a longstanding initiative to shift care from inpatient facilities to the community. In addition to the clinical services provided, VA recognizes the impact of mental health stigma on adherence with mental health care. Systematic study of the enduring effects of combat trauma in veterans along with possible effective treatments

L. Gershengoren · A. Wolkin (✉)
VA NY Harbor Healthcare System, NYU Grossman School of Medicine, New York, NY, USA
e-mail: liliya.gershengoren@va.gov; Adam.Wolkin@va.gov

P. Farahmand
NYU Grossman School of Medicine, New York, NY, USA
e-mail: Pantea.farahmand@nyulangone.org

© The Author(s), under exclusive license to Springer Nature Switzerland AG 2022
W. E. Sowers et al. (eds.), *Textbook of Community Psychiatry*,
https://doi.org/10.1007/978-3-031-10239-4_45

has been a research focus with wide-reaching implications. Consideration of what we now identify as post-traumatic stress disorder (PTSD) was initially shaped by the experiences of Vietnamese veterans and is now a widely recognized implication of combat. In addition to PTSD, there have been notable contributions in the areas of traumatic brain injury research as well as substance use disorders.

This chapter provides an in-depth look at the ways that VA strives to realize its four missions for the benefit of veterans, caregivers, and their communities.

History and Evolution of the VA

Caring for military veterans is a viewed as a societal imperative throughout the world and the United States has one of the most comprehensive systems of any other nation. Going back as far as the Plymouth Colony in 1636, disabled soldiers were provided with much needed support by the colony. Later on, the Continental Congress of 1776 offered pensions to the disabled soldiers of the Revolutionary War. Initially, states and communities were tasked with providing medical and hospital care to veterans (US Department of Veterans Affairs 2020a). However, during the nineteenth century, the federal government authorized the first military veterans medical facility and expanded the program to include benefits and pensions to veterans as well as their widows and dependents:

> …to care for him who shall have borne the battle and for his widow and his orphan. (Abraham Lincoln, second inaugural address)

During the post-World War I era, Congress combined all the veterans programs including disability compensation, insurance, and vocational rehabilitation, to create the Veterans Bureau. During this time, as the nature of the war and weapon utilization began to change, it became apparent that soldiers who were exposed to various chemicals and fumes during their service would require specialized medical care. As a result, specialized medical hospitals, such as tuberculosis and neuropsychiatric hospitals, were created to better service the needs of veterans. Furthermore, veteran benefits were also extended to cover the medical and mental health needs of veterans that were not considered to be service-related. In 1930, President Hoover created the Veterans Administration elevating it to a federal administration position.

Over the years and with each subsequent military conflict, the VA has continued to evolve to the present-day Department of Veteran Affairs, which continues to emphasize ambulatory care and community access. Over time, VA healthcare system has increased from 54 hospitals in 1930 to over 1500 healthcare facilities including 144 VA medical centers serving about nine million enrolled veterans each year.

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act) fundamentally transformed the VA's healthcare system as it established a new veterans community service program. Veterans are empowered to seek medical care in VA healthcare facilities as well as in the community. Consequently, Veterans can continue to receive efficient, timely, and quality medical services which are covered by their VA benefits.

Patient Demographics

When the United States eliminated the draft in 1973, the military force transitioned from those drafted to an all-volunteer force. As a result, the military became a more selective experience and far less common for Americans. The veteran population declined from 26 million to 18 million, and presently about 1 in 8 adult men and 1 in 100 adult women have ever served in the military. Close to 62% of veterans who served in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), or Operation New Dawn (OND) from 2003 through 2017 have utilized VA health care since 2001. The most common diagnoses include musculoskeletal disorder (62%), conditions that do not appear to have an immediate obvious cause (59%), and mental disorders

(58%). Many veterans have multiple diagnoses. About five million veterans live in rural areas making accessibility to health care a priority for the VA (US Department of Veterans Affairs 2017).

Women became part of the military with the creation of the Army Nurse Corp in 1901, although in addition to nurses, women served as cooks, spies, and soldiers. Since 1973, when the draft ended, women have been able to enlist, occupy many different roles in all the branches of the military, and take part in combat. The number of women in the military has been steadily increasing, and today they comprise 20% of new recruits. About 9% (1.7 million) of all veterans are women. Of all the post-9/11 veterans, 17% are women. This is a substantial increase from the Vietnam War era when women made up 4% of all veterans. When compared to the general population of women, female veterans are more likely to have a college degree and earn a higher salary during full-time employment. In fact, a greater portion of today's veterans, both men and women, have completed higher levels of education than those from older periods such as the Vietnam War era (US Department of Veterans Affairs 2017).

Clinical Services: Mental Health

Clinical Services: Inpatient Psychiatric Care

VA is the largest integrated healthcare systems in the United States and perhaps, most notably, boasts a universal electronic medical record system, which allows for better coordination of care, patient follow-up, and patient safety efforts (Marcus et al. 2018). Veterans with acute emotional and behavioral symptoms and those who may pose a risk to self or others require a higher level of care such as inpatient psychiatric hospitalization, focusing on stabilization. VA inpatient services follow the recovery paradigm and provide evidence-based psychiatric care specifically tailored to the needs of each veteran. Each facility provides safe and private rooms for women veterans that include locking bedrooms and bathrooms. As the number of women joining the military service continues to increase, the inpatient psychiatric units have undergone remodeling to accommodate their growing number. There are on average more than 100,000 discharges from inpatient units annually (True et al. 2017).

Clinical Services: Residential Rehabilitation and Treatment Programs

Residential rehabilitation and treatment programs (RRTPs) treat veterans with a wide range of illnesses and rehabilitative needs (Department of Veterans Affairs VHA Handbook 2010; Department of Veterans Affairs VHA Handbook 2008). Programs includes medical, psychiatric, educational, vocational, substance use disorder, and homelessness, among other rehabilitative services. Programs specific to mental health are identified as MH-RRTP and include psychosocial rehabilitative treatment programs, post-traumatic stress disorder programs, substance abuse residential rehabilitative treatment programs, compensated work therapy, transitional residence, and domiciliary care for homeless veterans. Veterans in need of specialized, 24/7 structure, due to mental health or substance use MH-RRTPs, can seek treatment at 1 of 97 programs in the nation (Ellerbe et al. 2017). Evidence-based psychosocial services are the required treatment modalities provided at the MH-RRTPs—such as Seeking Safety, motivational interviewing for recovery-based programs. All VA medical centers are required to provide access to MH-RRTP services and can be met on local and regional basis through service agreements with other VA hospitals. Each must have programs with full capacity to serve veterans, including women, who suffer from serious mental illnesses, with trauma syndromes, and with substance and alcohol use disorders. These embrace subpopulations with homelessness and/or co-occurring mental illness and substance misuse. They also provide ongoing monitoring and case management referral ability (Department of

Veterans Affairs VHA Handbook 2010; Department of Veterans Affairs VHA Handbook 2008). To routinely monitor the performance of all mental health services including residential treatment programs, the Office of Mental Health Operations developed the mental health information system, using up to 15 required metrics to assess access and quality of services, including average lengths of stay, and access to treatment measures (Trafton et al. 2013; Ellerbe et al. 2017).

Clinical Services: Ambulatory Care

All new patients referred to mental health services are expected to receive an initial evaluation within 24 hours and are screened for urgent concerns such as hospitalization or immediate outpatient needs. The initial evaluation can be conducted by primary care or other referring licensed independent providers. More comprehensive diagnostic and treatment planning is expected within 30 days of the initial screen. Referrals to any service are expected to be completed within 30 days of the patient's desired appointment. Ambulatory care services include particular focus on issues such as PTSD, MST, homelessness, and specialty substance use treatment services (Department of Veterans Affairs VHA Handbook 2008).

One way the VA has increased access to ambulatory care services is through telemental health. Telemental health services require a qualified mental health professional at VA facility and support staff at the distal end to arrange the appropriate times, technical support, and space for the veteran. As a result of expansion in telemental health technologies, VA undertook initiatives to expand this service nationally. From 2003 to 2011, telemental health services expanded tenfold and continue to grow to address mental health needs across the United States (Godleski et al. 2012).

Ambulatory care settings offer comprehensive evaluation, individual and group psychotherapy (emphasizing evidence-based treatments), neuropsychological testing, family education, and case management supports (Department of Veterans Affairs VHA Handbook 2008). For individuals with severe mental illnesses and challenges with adherence to treatment, community outreach is conducted via the Mental Health Intensive Case Management (MHICM) program. MHICM consists of a multidisciplinary team which includes prescribing professionals, social workers, and visiting nurses. They provide services to patients within a 50 mile radius of a VA facility. Their services include crisis intervention, socialization skills, budget management, client advocacy (comparable to ACT teams in the community, medication management, and family/caregiver support). Their objectives are to minimize the need for hospitalization and improve function in the community (Mohamed et al. 2009).

Clinical Services: Minority-Specific Programs

According to the US Department of Veterans Affairs, minority veterans are identified as African Americans, Asian American/Pacific Islander, Hispanic, Native American/Alaska Native, and Native Hawaiian. Women veterans and lesbian, gay, bisexual, and transgender (LGBT) veterans are the two other groups who are now also identified as minority veterans. According to recent VA data analysis, minority veterans were more likely to have been diagnosed with post-traumatic stress disorder (PTSD) than non-minority veterans. This is often attributed to the reality that minority groups in the military are most likely to be exposed to trauma. Furthermore, Black and Latinx veterans are more likely to lack primary care physicians and adhere to treatment as compared to White veterans (Saha et al. 2008). In 1994, the Center for Minority Veterans was established to ascertain and address the healthcare needs of minority veterans. On a local level, each VA regional office is expected to have a minority veterans outreach coordinator to assist with benefits available to minority veterans. The Office of Health Equity was established in 2012 in order to further address the ongoing health disparities for veterans despite the prog-

ress that has already been made over the years. It offers training to healthcare providers on topics such as unconscious bias and cultural competence.

VA facilities offer the services of women veterans program managers to assist and advocate for women veterans. Specially designated women's health clinics at VA hospitals provide medical and mental health care suitable to their particular needs. Runnals et al. (2014) noted in their systematic review of the literature on veterans' mental health that the rates of depression and non-PTSD anxiety disorders are higher for women veterans as compared with male veterans. Women veterans also have higher rates of comorbidity of PTSD and depression. There are also higher rates of depression that is comorbid with medical conditions such as diabetes (Runnals et al. 2014). Women veterans show higher rates of health and functional impairments which is in part attributed to the availability of "gender-sensitive mental health services" (Runnals et al. 2014). An increasing number of VA hospitals are also developing special programs for women veterans which include services for homeless women veterans and those have been victims of domestic violence (US Department of Veterans Affairs 2015a).

There are more than one million veterans who identify as LGBT and are eligible for health care through the VA (Puntasecca et al. 2019). During their military service and upon returning to civilian life, LGBT veterans have encountered stigma, discrimination, and harassment.

Historically, military ethos has led to anti-LGBT sentiment and excluded LGBT people from military service. They were faced with the possibility of a dishonorable discharge and being court martialed if suspected of acts of sodomy (Byne and Wise 2020). It was not until the Department of Defense policy 1304.26 in 1993, also known as "Don't Ask, Don't Tell" (DADT), that the harassment of LGB service members became prohibited. Of note, transgender military members were not included in the policy since it covered only sexual orientation and not gender identity. Homosexuality in the military was still not legalized and military personnel were expected to conform to gender norms. The DADT policy was repealed in 2011 and there has since been increased awareness and openness for LGBT people in the military (Wise 2019). Nevertheless, LGBT individuals continue to experience greater frequency of harassment and assault as compared to their heterosexual and cisgender counterparts in the military.

The VA now recognizes LGBT veterans as individuals with "unique healthcare needs" (Sherman et al. 2014). There has been an increase in research examining the mental health impact of discrimination and harassment in the military. LGBT veterans are at an increased risk of suicide, depression, and substance abuse (Cochran et al. 2013). Furthermore, transgender veterans incur a risk of suicide that is 20 times higher than that for the veteran population (Blosnich et al. 2013). In order to better address the needs of the LGBT veterans, VA hospitals have supported a number of interventions and programs. Many of the VA hospitals have LGBT care coordinators and support outreach initiatives. Transgender Education Workgroup within the larger Office of Patient Care Services has been tasked with developing online resources as well as delivering webinars about the transgender healthcare resources. As of 2011, clinical services available to LGBT veterans include medical and mental health care, hormone therapy, preoperative evaluation for sex reassignment surgery, and medically necessary postoperative care (Mattocks et al. 2014).

Clinical Services: Post-traumatic Stress Disorder Programs

The relationship between psychological trauma and military service was first documented in 490 B.C, with early warriors reporting symptoms similar to those noted in recent history (Swartz 2014; Abdul-Hamid and Hughes 2014). In the United States, the American Civil War (1861–1865) had the first documented efforts to provide formal medical treatment for the psychological effects of war (Da Costa 1871). Shortness of breath, rapid pulse, and fatigue were given the

name "irritable heart" or "Da Costa's syndrome"—named after the physician who researched the PTSD-like disorder—which was noted in soldiers during times of fear and stress. Though over the years additional names were given to describe the disorder (i.e., "shell shock," "battle fatigue," "post-Vietnam syndrome"), the diagnosis of PTSD was not adopted until the 1970s and officially in 1980 in the DSM III (APA 1980; Reisman 2016).

Prevalence of PTSD varies among veterans across wars. Estimates of lifetime prevalence of combat-related PTSD across all US veterans ranges between 6% and 31%. Estimates of point prevalence rates ranges from 2.2% to 15.2% during the Vietnam War, 1.9% to 13.2% during the Persian Gulf War, and 4% to17% during the Afghanistan/Iraq War (Richardson et al. 2010). Often PTSD is comorbid with other conditions, and high rates of comorbidity are seen in military veterans. Most commonly, major depression is noted to be three to five times more likely in individuals with PTSD (Rytwinski et al. 2013). Anxiety and substance use disorders are also commonly co-occurring (Hoge et al. 2006; Milliken et al. 2007; Richardson et al. 2010). Estimates of comorbid PTSD and substance or alcohol use are as high as 76% (Seal et al. 2011; McCauley et al. 2012).

To address the long-lasting wounds of service, in 1989, the National Center for PTSD—consisting of seven VA academic centers of excellence—was created within the Department of Veterans Affairs. The center provides leadership in research and development of evidence-based treatments, dissemination of best practices, and consultative services for the treatment of PTSD. The center has become a leader in research and education on PTSD as it exists in all forms—civilian and military assault, rape, child abuse, disaster, etc. (National Center of PTSD, 2020a). Access to evidence-based PTSD treatment including cognitive processing therapy (CPT) or prolonged exposure therapy is widely available at VA sites throughout the United States. These services are offered in person or via telehealth modalities to reach veterans throughout the country. Similarly, PTSD with comorbid substance use disorders, pain, or other psychiatric conditions are provided evidence-based and validated treatments such as seeking safety, psychopharmacology, etc. Levels of care can vary from individual outpatient treatment, PTSD groups, and inpatient or residential treatment services. To augment PTSD care and allow for reentry into the community, veterans are also provided psychosocial supports such as help with housing, vocational support, and programs for veterans leaving state or federal prisons (Department of Veterans Affairs VHA Handbook 2008). The VHA also provides funding for innovative and leading PTSD research. Some of the most impactful strides made in PTSD care are promoted and transmitted by the veterans themselves who are each other's greatest supports as comrades in service.

Clinical Services: Military Sexual Trauma Treatment

Military sexual trauma (MST) refers to sexual assault or harassment that occurs during military service. VA offers a wide range of services for victims of MST as part of their treatment and recovery (Johnson et al. 2015). Veterans who have suffered MST can receive medical and mental health care related to their experience at no cost. VA's national screening program revealed that 1 in 3 women and 1 in 50 men reported experiencing MST during the screening (Military Sexual Trauma 2020). MST is not in itself a diagnosis and can affect veterans in different ways. It is often associated with poor medical and mental health care, increased chronic health issues, and a decreased quality of life. Women veterans who experienced MST are more likely to be diagnosed with PTSD compared with male veteran survivors of MST. Male survivors are more likely to present with somatic symptoms and medical conditions as well as depression and PTSD as compared to male veterans who did not experience sexual assault.

MST-related services include outpatient clinic-based therapy as well as inpatient and residential programs for those veterans who require

more intense treatment. There are mixed-gender inpatient and residential programs that provide separate sleeping areas for their women and men veterans. Residential programs available specifically to women veterans are also offered. A crucial component of MST treatment is risk-reduction interventions and an integrated treatment approach that considers co-occurring disorders such as PTSD, depression, or substance use disorders. The first stage of treatment is focused on coping skills followed by the second stage which then involves trauma processing. Dialectical behavior therapy is used to help develop distress tolerance and emotion regulation skills in order to prepare the patient for the second stage of treatment. Acceptance and commitment therapy (ACT) is also often implemented for the treatment of PTSD symptoms. Many VA centers will deliberately place their MST clinics within primary care in order to offer privacy and an environment of safety and support. Increased efforts to identify MST survivors, diagnose associated mental health conditions, and offer evidence-based treatment continue on local and national levels (Vantage Point 2016).

Clinical Services: Suicide Prevention Programs

Since 2001, veteran suicides increased 32 percent compared with a 23 percent for the US adult population. Veteran suicide rate is 1.5 times higher than rate of suicide for the civilian population. Furthermore, approximately two-thirds of veterans who died by suicide had not utilized VA services (Vantage Point 2016; Warren and Smithkors 2020). Factors such as mental health conditions, substance use conditions, and access to lethal means increase the likelihood of suicide.

Suicide prevention strategies mandated by the VA include decreasing access to or securing firearms, increasing suicide risk screening, and further enhancement of the suicide prevention program. One such program is the Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH-VET) which is a novel predictive model that analyzes veterans' health records in order to identify them at an elevated risk for adverse outcomes such as suicide. Upon identification, the veteran then is closely followed by VA mental health specialists and clinicians. REACH-VET initiative was fully implemented in 2017 and at the time of this writing data analysis remains ongoing. However the data from the initial 6 months, from March to May 2017, indicated that the REACH-VET program helped facilitate more healthcare appointments, increased suicide prevention safety plans, and decreased all-cause mortality (US Department of Veterans Affairs 2020b).

Each VA hospital has designated suicide prevention coordinators (SPC) whose responsibilities include working with the identified High Risk for Suicide List (HRL) patients. Veterans on the high-risk list have a "flag" placed in their medical chart to increase awareness of the elevated suicide risk, thus prompting suicide risk assessments during their appointments. Furthermore, HRL patients are required to have increased contact with their mental health providers (Warren and Smithkors 2020). Another suicide prevention resource is the Veterans Crisis Line (988 PRESS 1), a free and confidential support offered to veterans in crisis adding another layer of assistance and access to care. Of course, no amount of available resources will be enough without ongoing efforts to address stigma of mental illness and suicide. Together with Veterans (TWV) is one such initiative which supports efforts to decrease stigma in rural communities in order to prevent suicide (Warren and Smithkors 2020). There are numerous ongoing efforts to provide education, support, and resources to ultimately prevent veteran suicide.

Clinical Services: Substance Use Treatment Programs

Alcohol, nicotine, and illicit substance use are associated with numerous social and health consequences. Despite progress, the use of these substances remains a leading cause of preventable death in the United States (Wilson et al. 2020). The 2018 National Survey on Drug Use

and Health found that among veterans, 300,000 had a substance use disorder, 800,000 had alcohol use disorder, and 78,000 had both an alcohol and substance use disorder (SAMSHA 2020). Substance use disorder among veterans is complicated by high rates of co-occurring mental health conditions, pain, traumatic brain injuries, and suicide (Hankin et al. 1999; Kaplan et al. 2007; Hoge et al. 2008; Tanielian and Jaycox 2008). VA's approach to treating alcohol, nicotine, and substance-related disorders is multilayered and involves both innovations in research, clinical care, and management of co-occurring psychiatric conditions and psychosocial supports. Veterans have access to substance use treatments in a variety of settings at VA including telehealth, outpatient, 12-step group, motivational enhanced treatment, intensive outpatient, residential treatment, and inpatient levels of care. If services are not accessible at a VA facility closest to the veteran, arrangements are made for community care access. As a result of implementation of specialized, evidence-based treatments in VA, rates of treatment response are considerably higher in veterans compared with the general population. Though the need to reach more veterans is apparent, initiatives and goals of VA are to continually expand and develop new ways for addressing these diseases (Dalton et al. 2012).

VA addresses alcohol use disorders by integrating screening and treatment in primary care and specialty care settings (Hagedorn et al. 2016). The use of FDA-approved medications for alcohol use disorder, such as naltrexone and acamprosate, is published in VA Department of Defense Clinical Practice Guidelines for Management of Substance Use disorders updated in 2015 and recommended for use across setting for the treatment of alcohol use disorder (Department of Veterans Affairs, Department of Defense 2015).

Innovation in addressing nicotine use disorders has been spearheaded in VA by programs and research that focus on improving delivery and access to treatments. Services include 24-hour access to an on-call counselor, individual counseling, and use of FDA-approved medications (Sherman et al. 2007; Sherman 2008; Rogers et al. 2018). Referrals are facilitated through a telephone care coordination program, with resultant increased cessation rates (18% versus 11% in control group) (Sherman et al. 2018).

Efforts to prevent and reduce opioid related harms among veterans are a priority for VHA and have been a focus of policy initiatives and research (Frank et al. 2020). Major comorbidities that contribute to opioid addiction and overdose are acute and chronic pain and co-occurring mental health illness. In 2019, the VA hosted a state-of-the-art conference to address management of pain and addiction. Consensus was reached in three areas: (1) managing opioid use disorders, (2) long-term opioid therapy and opioid tapering, and (3) managing co-occurring pain and substance use disorders. Some key recommendations from the conference included increasing access to medication for opioid use disorders (MOUD)—such as buprenorphine, naltrexone, and methadone—improving fidelity to evidence-based models of MOUD, increasing provider comfort with MOUD prescribing, providing wide access to team-based care, and improving access to evidence-based non-pharmacologic treatments for pain (Frank et al. 2020).

Clinical Services: Social Determinants of Mental Health

The VA has numerous programs that provide wrap-around veteran services that enable veterans to reintegrate into the workplace and adjust back into their families after military service, including caregiver and family supports, vocational training, homelessness programs, and legal services. In order to be eligible for many of the services, the veteran must be within 12 years from the date of separation from active military service. While in the program, veterans may qualify for a monthly payment or a monthly subsistence allowance. The payments are based on attendance rates, number of dependents, and type of training. In this section we discuss vocational support, homelessness programs, and incarcerated veteran programs.

Vocation Support: The Veteran Readiness and Employment (VR&E) program provides job training, employment accommodations, resumé development, job coaching, and personalized counseling to help guide veterans through their career paths. Additional services help veterans start their own careers or provide independent living services for those who are severely disabled and unable to work (US Department of Veterans Affairs 2020c).

Homelessness Programs: On a single night in January 2018, nearly 38,000 veterans were found experiencing homelessness according to a report by the Department of Housing and Urban Development (HUD). In 2010, that number was 74,000 (The US Department of Housing and Urban Development 2018). Though the overall trend shows declines in homelessness, housing remains a significant concern for many veterans. The National Center on Homelessness among veterans conducts and supports research assessing the effectiveness of programs, identifies and disseminates best practices, and integrates these practices into policies, programs, and services for homeless veterans or veterans at risk. Currently there are over 30 researchers affiliated with the center and are investigating issues related to veteran homelessness in four areas: population-based studies, physical and mental health, program evaluation, and function and flourishing. These four areas identify the contributing causes of veteran homelessness, focus on mental and physical illnesses that disproportionately affect homeless veteran populations, determine how to help veterans flourish beyond housing and into vocational supports, and investigate existing or new models to improve care for veterans (VA National Center on Homeless Among Veternas 2020). A notable program is HUD's VA Supportive Housing (HUD-VASH) program. This provides housing vouchers with VA supportive services to help veterans and their families find and sustain permanent housing. VA case managers, as part of the program, connect veterans to heath care, mental health treatment, substance use counseling, and vocational training. Nationwide, HUD-VASH currently works with 90,000 veterans.

Incarcerated Veterans: Evidence supports specialty treatment courts for individuals at risk for incarceration with co-occurring substance or mental health issues for their reduction in recidivism (Huddleston III et al. 2008; Marlowe 2010; Sarteschi et al. 2011). In 2007, 10% of the people incarcerated in the United States were military veterans, with the highest percentage being from Vietnam War era service (36% state and 39% federal prison) (Noonan and Mumola 2007). Of those veterans incarcerated, 87% are reported to have experienced traumatic events and 31% have been formally diagnosed with PTSD (Saxon et al. 2001). The Veterans Justice Outreach (VJO) program connects veterans in jails, courts, or in contact with law enforcement to mental health and substance use treatment (Finlay et al. 2016). Veteran treatment courts operate independently of the VA but are supported by the VJO. They are modeled after mental health or drug treatment courts (US Department of Veterans Affairs 2015). They supervise veterans with charges to ensure adherence to treatment and can result in reduced or expunged charges following completion of treatment (Cavanaugh 2010; Clark et al. 2010). Veterans who completed the program have been found to have reduced recidivism, improved mental health outcomes, and improved employment and housing relative to those veterans who did not complete the program (Tsai and Rosenheck 2016; Knudsen and Wingenfeld 2016; Tsai et al. 2018). Of those rearrested, substance use, property offenses, and probation violence were noted (Tsai et al. 2018). Those who committed property offenses and probation have been speculated to have greater financial hardship post-incarceration (Motivans 2015). Those rearrested due to addiction illustrate both the psychosocial challenges and consequences of substance use disorders among veterans and underscore the importance of mandated addiction treatment.

Medical Research

The Office of Research and Development (ORD) is the research and development branch of VA. It was established in 1947 and is a congressionally mandated research program focused on veteran health. It is the only federally funded research program that is directly tied to a fully integrated healthcare system. In 2019, the ORD budget was 1.3 billion dollars with 119.1 million and 33 million allocated to mental health and substance use research, respectively (Congressional Research Service 2020). ORD has been a leader in veteran and American healthcare innovation for over 60 years. VA investigators have been awarded Nobel Prizes, Lasker Awards, and other distinctions. All the while VA research remains closely tied to clinical work, with 70 percent of researchers providing direct patient care. ORD promotes programs for veterans via ties to federal agencies, nonprofit organizations, and private industries (US Department of Veterans Affairs, 2020).

Within ORD there are several research services. Clinical sciences R&D involves clinical trials, comparing existing therapies, and improving clinical practice. The clinical sciences section also oversees VA's Cooperative Studies Program, which is responsible for multisite clinical trials and epidemiological research on health issues in veteran populations. Rehabilitation R&D supports research focusing on restoring limbs lost due to traumatic amputations, central nervous system injuries, loss of sight or hearing, and restoring other physical and cognitive impairments. Health sciences R&D supports healthcare system and patient outcomes level research. This includes quality improvement, increasing access, measuring outcomes, and reducing wasteful healthcare spending.

The VA launched a major restructuring effort in the 1990s (1995–2000) in which the VA transitioned from a tertiary/specialty and inpatient-based care system delivering care in a traditional model to one that focuses on primary, outpatient-based, team, and evidence-based management practice. The goals of providing industry-leading quality and performance measured services subsequently led to multiple systematic evaluations affirming the high quality of care in VA (Jha et al. 2003; Ashton et al. 2003; Committee on Quality of Health Care in America 2001; McQueen et al. 2004). In an effort to further systematically study and enhance VA clinical programs, the VA Quality Enhancement Research Initiative (QUERI) was created in 1998.

QUERI is a large-scale, multidisciplinary, quality improvement initiative that spans clinical services including inpatient, outpatient, and long-term care settings (McQueen et al. 2004). QUERI coordinating centers are staffed by teams of researchers and clinical leaders who conduct research and evaluation activities that identify practices with strong evidence base in clinical care and work to implement these practices across the VA. QUERI centers exist for mental health and substance use disorder analysis, as well as medical conditions such as colorectal cancers, HIV/AIDS, diabetes, etc. (McQueen et al. 2004). In 1 year QUERI-funded programs implemented 50 evidence-based practices for a wide range of conditions across VAs nationally.

Some of the successful outcomes and findings of QUERI initiatives have concerned antipsychotic medication management and use of opioid agonist therapies (McQueen et al. 2004). In both, there have been measurable improvements in clinician adherence to best practice recommendations (Willenbring et al. 2004).

Education

> To educate for VA and for the Nation (Mission of the Office of Academic Affiliations 2019).

In accordance with its mission to uphold the educational efforts for the benefit of veterans, DVA supports education and training programs for medical, nursing, and allied health professionals (Mission of the Office of Academic Affiliations 2019). Many VA hospitals are affiliated with academic medical centers and coordinate training as part of their training efforts. This unique collaboration was implemented following World War II under the leadership of General Omar Bradley, Administrator of VA at the time, in order to

address the national shortage of physicians. VA strives to support and train new health professionals in order to continue to provide hig-quality health care to the veterans and the nation.

VA works in collaboration with 144 out of 152 accredited medical schools and is affiliated with more than 40 other health professional institutions. It is estimated that over 60% of medical trainees and about 50% of psychologists spend a portion of their training at VA hospitals (Mission of the Office of Academic Affiliations 2019). Nationally recognized specialties such as geriatrics, spinal cord injury medicine, and addiction psychiatry have grown and continue to develop in part due to the VA's educational efforts. As a result of VA-led initiatives and training programs, pain management is now accepted as a significant healthcare concern. Consequently, the VA is a valuable resource in the national educational efforts of future health professionals.

Disaster Preparedness: "Fourth Mission"

VA's "Fourth Mission" includes humanitarian support and national disaster preparedness in the event of war, national emergencies, and natural disasters (Veterans Affairs Fourth Mission Summary 2020). The Emergency Management Strategic Healthcare Group is tasked with developing comprehensive emergency management plans (Koenig 2003). Its purpose is to ensure continued service to veterans as well as civilians in support of local emergency efforts.

Over the years, VA has offered support and crucial medical as well as mental health resources in the wake of floods, tornadoes, and hurricanes. During the unprecedented and devastating COVID-19 pandemic, VA pledged to make 1500 medical beds available to non-veteran patients including those living in community nursing homes across the country. VA employees were also reassigned and deployed to COVID-19 hot spots to assist with clinical care (Massarweh et al. 2020). While the VA has traditionally provided care only to veterans, its "Fourth Mission" allows it to extend its resources and personnel for the benefit of the entire nation (Motivans 2015; Tsai et al. 2018).

Conclusion

The overarching mission of the Department of Veterans Affairs has always been to care for and honor military veterans. It is the largest integrated healthcare system in this country with over a thousand healthcare centers, serving close to nine million veterans each year. Overtime, VA has evolved and expanded; however, the spirit of its purpose has not changed: serving those who served remains the very foundation of its mission. Clinical services, education, research, and disaster preparedness are the four missions that inspire its growth and ongoing improvement.

References

Abdul-Hamid, W.K., Hughes, J.H. Nothing new under the sun: post-traumatic stress disorders in the ancient world. Early Sci Med. 2014;19:–557.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 3rd ed. Washington, D.C.: American Psychiatric Association; 1980.

Ashton, C.M., Souchek, J., Petersen, N.J., et al. Hospital use and survival among Veterans Affairs beneficiaries. N Engl J Med 2003; 349:1637–46.

Blosnich, J. R., Brown, G. R., Shipherd, P. J., Kauth, M., Piegari, R. I., & Bossarte, R. M. (2013). Prevalence of Gender Identity Disorder and Suicide Risk Among Transgender Veterans Utilizing Veterans Health Administration Care. *American Journal of Public Health, 103*(10). doi:https://doi.org/10.2105/ajph.2013.301507

Byne, W., & Wise, J. (2020). Toward Optimizing Mental Health Care for Sexual and Gender Minority Veterans. *Focus, 18*(3), 289-295. doi:https://doi.org/10.1176/appi.focus.20200009

Cavanaugh, J.M. (2010). Helping those who serve: Veterans treatment courts foster rehabilitation and reduce recidivism for offending combat veterans. New England Law Review, 45, 463–487.

Clark, S.C., McGuire, J., & Blue-Howells, J. (2010). Development of veterans treatment courts: Local and legislative initiatives. Drug Court Review, 7, 171–208

Cochran, B. N., Balsam, K., Flentje, A., Malte, C. A., & Simpson, T. (2013). Mental Health Characteristics of Sexual Minority Veterans. *Journal of Homosexuality,*

60(2–3), 419-435. doi:https://doi.org/10.1080/00918369.2013.744932

Congressional Research Service. Federal Research and Development (R&D) Funding: FY 2020. Updated March 18th, 2020. Retrieved 11/11/2020 from https://fas.org/sgp/crs/misc/R45715.pdf.

Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press, 2001.

Da Costa, J.M. On irritable heart: A clinical study of a form of functional cardiac disorder and its consequences. Am J Med Sci. 1871;61:17–52.

Dalton, A., Oliva, E., Harris, A., Trafton, J. Health services for VA patients with substance use disorders: comparison of utilization in fiscal years 2011, 2010, and 2002. Palo Alto: Program Evaluation and Resource Center; 2012.

Department of Veterans Affairs, Department of Defense (2015). Clinical Practice Guideline for the Management of Substance Use Disorders. Version 3.0. Retrieved 11/6/2020 from https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf

Department of Veterans Affairs, V.H.A. VHA handbook 1162.02: Mental Health Residential Rehabilitation Treatment Program (MH RRTP) Washington, DC: Author; 2010.

Department of Veterans Affairs, V.H.A. VHA handbook 1160.01: Uniform Mental Health Services in VA Medical Centers and Clinics. Washington, DC: Author; 2008.

Ellerbe, L. S., Manfredi, L., Gupta, S., Phelps, T. E., Bowe, T. R., Rubinsky, A. D., Burden, J. L., & Harris, A. H. (2017). VA residential substance use disorder treatment program providers' perceptions of facilitators and barriers to performance on pre-admission processes. Addiction science & clinical practice, 12(1), 10. https://doi.org/10.1186/s13722-017-0075-z

Frank, J. W., Bohnert, A., Sandbrink, F., McGuire, M., & Drexler, K. (2020). Implementation and Policy Recommendations from the VHA State-of-the-Art Conference on Strategies to Improve Opioid Safety. Journal of general internal medicine, 1–5. Advance online publication. https://doi.org/10.1007/s11606-020-06295-y

Finlay, A. K., Smelson, D., Sawh, L., McGuire, J., Rosenthal, J., Blue-Howells, J., Timko, C., Binswanger, I., Frayne, S. M., Blodgett, J. C., Bowe, T., Clark, S. C., & Harris, A. (2016). U.S. Department of Veterans Affairs Veterans Justice Outreach Program: Connecting Justice-Involved Veterans with Mental Health and Substance Use Disorder Treatment. Criminal justice policy review, 27(2), https://doi.org/10.1177/0887403414562601

Godleski, L., Darkins, A., Peters, J. Outcomes of 98,609 U.S. Department of Veterans Affairs patients enrolled in telemental health services, 2006–2010. Psychiatr Serv. 2012 Apr;63(4):383-5. doi: https://doi.org/10.1176/appi.ps.201100206.

Hagedorn, H. J., Brown, R., Dawes, M., Dieperink, E., Myrick, D. H., Oliva, E. M., Wagner, T. H., Wisdom, J. P., & Harris, A. H. (2016). Enhancing access to alcohol use disorder pharmacotherapy and treatment in primary care settings: ADaPT-PC. Implementation science : IS, 11, 64. https://doi.org/10.1186/s13012-016-0431-5

Hankin, C.S., Spiro, A., I II, Miller, D.R., Kazis, L. Mental disorders and mental health treatment among U.S. Department of Veterans Affairs outpatients: The Veterans Health Study. American Journal of Psychiatry. 1999;156:1924–1930.

Hoge, C.W., Auchterlonie, J.L., Milliken, C.S. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA. 2006;295(9):1023–1032.

Hoge, C.W., McGurk, D., Thomas, J.L., Cox, A.L., Engel, C.C., Castro, C.A. Mild traumatic brain injury in U.S. Soldiers returning from Iraq. New England Journal of Medicine. 2008;358:453–463.

Huddleston, C.W. III, Marlowe, D.B., & Casebolt, R. (2008). Painting the current picture: A national report card on drug courts and other problem-solving court programs in the United States Volume II, Number 1. Washington, DC: National Drug Court Institute

Jha, A.K., Perlin, J.B., Kizer, K.W., Dudley, R.A. Effect of the transformation of the Veterans Affairs health care system on the quality of care. N Engl J Med. 2003;348:2218–27.

Johnson, N. L., Robinett, S., Smith, L. M., & Cardin, S. (2015). Establishing a new military sexual trauma treatment program: Issues and recommendations for design and implementation. *Psychological Services, 12*(4), 435-442. doi:https://doi.org/10.1037/ser0000061

Kaplan, M.S., Huguet, N., McFarland, B.H., Newsom, J.T. Suicide among male veterans: A prospective population-based study. Journal of Epidemiological Community Health. 2007;61(7):619–624.

Knudsen, K.J., Wingenfeld, S. A specialized treatment court for veterans with trauma exposure: Implications for the field. Community Mental Health Journal. 2016;52(2):127–135.

Koenig, K. L. (2003). Homeland Security and Public Health: Role of the Department of Veterans Affairs, the US Department of Homeland Security, and Implications for the Public Health Community. *Prehospital and Disaster Medicine, 18*(4), 327-333. doi:https://doi.org/10.1017/s1049023x0000128x

Marcus, S. C., Hermann, R. C., Frankel, M. R., & Cullen, S. W. (2018). Safety of Psychiatric Inpatients at the Veterans Health Administration. *Psychiatric Services, 69*(2), 204-210. doi:https://doi.org/10.1176/appi.ps.201700224

Marlowe, D.B. (2010). Research update on adult drug courts. Alexandria, VA: National Association of Drug Court Professionals.

Massarweh, N. N., Itani, K. M., & Tsai, T. C. (2020). Maximizing the US Department of Veterans Affairs'

Reserve Role in National Health Care Emergency Preparedness—The Fourth Mission. *JAMA Surgery, 155*(10), 913. doi:https://doi.org/10.1001/jamasurg.2020.4153

Mattocks, K. M., Kauth, M. R., Sandfort, T., Matza, A. R., Sullivan, J. C., & Shipherd, J. C. (2014). Understanding Health-Care Needs of Sexual and Gender Minority Veterans: How Targeted Research and Policy Can Improve Health. *LGBT Health, 1*(1), 50-57. doi:https://doi.org/10.1089/lgbt.2013.0003

McCauley, J.L., Killeen, T., Gros, D.F., et al. Posttraumatic stress disorder and co-occurring substance use disorders: advances in assessment and treatment. Clin Psychol Sci Prac. 2012;19:283–304.

McQueen, L., Mittman, B.S., Demakis, J.G. Overview of the Veterans Health Administration (VHA) Quality Enhancement Research Initiative (QUERI), Journal of the American Medical Informatics Association. 2004; 11(5):339-343. https://doi.org/10.1197/jamia.M1499

Military Sexual Trauma (2020). Retrieved 11/22/2020, from https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf

Milliken, C.S., Auchterlonie, J.L., Hoge, C.W.Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. JAMA. 2007;298:2141–2148.

Mission of the Office of Academic Affiliations. (2019). Retrieved 11/22/2020, from https://www.va.gov/oaa/oaa_mission.asp

Mohamed, S., Neale, M. & Rosenheck, R. (2009). VA Intensive Mental Health Case Management in Urban and Rural Areas: Veteran Characteristics and Service Delivery. Psychiatric services (Washington, D.C.). 60. 914-21. https://doi.org/10.1176/appi.ps.60.7.914.

Motivans, M.A. Federal Justice Statistics, 2012-Statistical Tables. 2015 Retrieved 11/6/2020 from Washington, DC: http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5217.

National Center for PTSD (2020a). History of the National Center for PTSD. Retrieved 11/12/2020 from https://www.ptsd.va.gov/about/work/ncptsd_history.asp

Noonan, M.E., & Mumola, C.J. (2007). Veterans in state and federal prison, 2004. Retrieved 11/6/2020 from http://bjs.gov/content/pub/pdf/vsfp04.pdf

Puntasecca, C., Hall, E. A., & Ware, J. (2019). Serving All Who Served: An Analysis of the VA's Visual and Digital Rhetorics for Welcoming Sexual and Gender Minority Veterans into VA Care. *World Medical & Health Policy, 11*(4), 440-463. doi:https://doi.org/10.1002/wmh3.321

Reisman, M. (2016). PTSD Treatment for Veterans: What's Working, What's New, and What's Next. P & T: a peer-reviewed journal for formulary management, 41(10), 623–634. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047000/

Richardson, L.K., Frueh, B.C., Acierno, R. Prevalence estimates of combat-related post-traumatic stress disorder: critical review. Aust N Z J Psychiatry. 2010;44:4-19 https://doi.org/10.3109/00048670903393597

Rogers, E.S., Fu, S.S., Krebs, P., Noorbaloochi, S., Nugent, S.M., Gravely, A., Sherman, S.E. Proactive tobacco treatment for smokers using VA mental health clinics: a randomized controlled trial. Am J Prev Med. 2018 May; 54(5): 620-9.

Runnals, J. J., Garovoy, N., McCutcheon, S. J., Robbins, A. T., Mann-Wrobel, M. C., Elliott, A., & Strauss, J. L. (2014). Systematic Review of Women Veterans' Mental Health. *Women's Health Issues, 24*(5), 485-502. doi:https://doi.org/10.1016/j.whi.2014.06.012

Rytwinski, N.K., Scur, M.D., Feeny, N.C., et al. The co-occurrence of major depressive disorder among individuals with posttraumatic stress disorder: a meta-analysis. J Trauma Stress. 2013;26:299–309.

Saha, S., Freeman, M., Toure, J., Tippens, K. M., Weeks, C., & Ibrahim, S. (2008). Racial and ethnic disparities in the VA health care system: a systematic review. *Journal of general internal medicine*, *23*(5), 654–671. https://doi.org/10.1007/s11606-008-0521-4

SAMSHA (2020). 2018 National Survey on Drug Use and Health: Veterans. Retrieved 11/6/2020 from https://www.samhsa.gov/data/report/2018-nsduh-veterans.

Sarteschi, C.M., Vaughn, M.G., & Kim, K. (2011). Assessing the effectiveness of mental health courts: A quantitative review. Journal of Criminal Justice, 39, 12–20. doi: https://doi.org/10.1016/j.crimjus.2010.11.003

Saxon, A.J., Davis, T.M., Sloan, K.L., McKnight, K.M., McFall, M.E., Kivlahan, D.R. Trauma, symptoms of posttraumatic stress disorder, and associated problems among incarcerated veterans. Psychiatric Services. 2001;52(7):959–964.

Seal, K.H., Cohen, G., Waldrop, A., et al. Substance use disorders in Iraq and Afghanistan veterans in VA healthcare, 2001–2010: implications for screening, diagnosis and treatment. Drug Alcohol Depend. 2011;116:93–101.

Sherman, S.E. A Framework for Tobacco Control: Lessons learnt from Veterans Health Administration. BMJ, 2008; 336: 1016-9. PMCID: PMC2364861

Sherman, S.E., Estrada, M., Lanto, A.B., Farmer, M.M., Aldana, I. Effectiveness of an on-call counselor at increasing smoking treatment. J Gen Intern Med., 2007; 22: 1125-31. PMCID: PMC2305728

Sherman, M. D., Kauth, M. R., Ridener, L., Shipherd, J. C., Bratkovich, K., & Beaulieu, G. (2014). An empirical investigation of challenges and recommendations for welcoming sexual and gender minority veterans into VA care. *Professional Psychology: Research and Practice, 45*(6), 433-442. doi:https://doi.org/10.1037/a0034826

Sherman, S.E., Krebs, P., York, L.S., Cummins, S.E., Kuschner, W., Guvenc-Tuncturk, S., Zhu, S.H. Telephone care co-ordination for tobacco cessation: randomized trials testing proactive versus reactive models. Tob Control. 2018 Jan; 27(1): 78-82.

Sherman, S.E., Takahashi, N., Kalra, P., Gifford, E., Finney, J., Canfield, J., Kelly, J., Joseph, G., Kuschner, W. Care coordination to increase referrals to smoking cessation telephone counseling: A demonstration

project. Am J Managed Care., 2008; 14: 141-8. PMID: 18333706

Swartz, M.H. Textbook of Physical Diagnosis: History and Examination. 7th ed. Philadelphia, Pennsylvania: Elsevier; 2014.

Tanielian, T.L., Jaycox, L. Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery. Santa Monica, CA: Rand Corporation; 2008.

Trafton, J.A., Greenberg, G., Harris, A.H., Tavakoli, S., Kearney, L., McCarthy, J., Blow, F., Hoff, R., Schohn, M. VHA mental health information system: applying health information technology to monitor and facilitate implementation of VHA Uniform Mental Health Services Handbook requirements. Med Care. 2013 Mar;51(3 Suppl 1):S29-36. doi: https://doi.org/10.1097/MLR.0b013e31827da836.

True, G., Frasso, R., Cullen, S. W., Hermann, R. C., & Marcus, S. C. (2017). Adverse events in veterans' affairs inpatient psychiatric units: Staff perspectives on contributing and protective factors. *General Hospital Psychiatry, 48*, 65-71. doi:https://doi.org/10.1016/j.genhosppsych.2017.07.001

Tsai, J., Finlay, A., Flatley, B., Kasprow, W. J., & Clark, S. (2018). A National Study of Veterans Treatment Court Participants: Who Benefits and Who Recidivates. Administration and policy in mental health, 45(2), 236–244. https://doi.org/10.1007/s10488-017-0816-z

Tsai, J., Rosenheck, R.A. Psychosis, lack of job skills, and criminal history: Associations with employment in two samples of homeless men. Psychiatric Services. 2016;67(6):671–675.

The US Department of Housing and Urban Development, Office of Community Planning and Development (2018). The 2018 Annual Homeless Assessment report (AHAR) to Congress. Retrieved 11/11/2020 from https://www.hudexchange.info/resource/5783/2018-ahar-part-1-pit-estimates-of-homelessness-in-the-us/

US Department of Veterans Affairs (2020a). About Veterans Affairs. Retrieved 11/22/2020 from https://www.va.gov/about_va/

U.S. Department of Veterans Affairs (2015). Veterans justice outreach. Retrieved 11/6/2020 from http://www.va.gov/homeless/vjo.asp.

US Department of Veterans Affairs (2015a). Women Veterans Health Care. Retrieved 11/22/2020 from https://www.womenshealth.va.gov/WOMENSHEALTH/healthcare.asp

VAntage Point, July 2016. VA conducts nation's largest analysis of veteran suicide. Retrieved 10/20/20 from https://www.blogs.va.gov/VAntage/28983/va-conductsnations-largest-analysis-veteran-suicide.

US Department of Veterans Affairs (2020). Office of Research and Development. Retrieved 11/11/2020 from https://www.research.va.gov/about/.

US Department of Veterans Affairs (2020b). Office of Research and Development. Retrieved 12/17/2020 from https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/video_archive.cfm?SessionID=3527&Seriesid=78

US Department of Veterans Affairs. Profile of Veteran: 2017 Highlights. Retrieved 11/22/2020 from https://www.va.gov/vetdata/Quick_Facts.asp

US Department of Veterans Affairs (2020c). Veteran Readiness and Employment. Retrieved 11/15/2020 from https://www.benefits.va.gov/vocrehab/

VA National Center on Homelessness Among Veterans (2020). Veterans Experiencing Homelessness. Retrieved 5/15/2020 from https://www.va.gov/homeless/nchav/research/index.asp.

Veterans Affairs Fourth Mission Summary (2020). Retrieved November 22, 2020, from https://www.va.gov/health/coronavirus/statesupport.asp

Warren, M. B., & Smithkors, L. A. (2020). Suicide Prevention in the U.S. Department of Veterans Affairs: Using the Evidence Without Losing the Narrative. *Psychiatric Services, 71*(4), 398-400. doi:https://doi.org/10.1176/appi.ps.201900482

Wise, J. E. (2019). Loss of moral high-ground: The transgender ban, a military psychiatrist's perspective and call to action. *Journal of Gay & Lesbian Mental Health, 23*(2), 114-116. doi:https://doi.org/10.1080/19359705.2019.1579037

Willenbring, M.L., Hagedorn, H., Postier, A., Kenny, M. Variations in evidence-based clinical practices in nine VA opioid agonist therapy clinics. Drug Alcohol Depend. 2004;75:97–106.

Wilson, N., Kariisa, M., Seth, P., Smith, H. IV, Davis, N.L. Drug and Opioid-Involved Overdose Deaths — United States, 2017–2018. MMWR Morb Mortal Wkly Rep 2020;69:290–297.