

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

JoAnn E. Kirchner, MD;^{1,3,4} Mary Sue Farmer, MS, PhD;² Valorie M. Shue, BA;³ Dean Blevins, PhD;^{2,3,4} & Greer Sullivan, MD^{2,3,4}

¹ United States Department of Veterans Affairs Mental Health Quality Enhancement Research Initiative, North Little Rock, Arkansas

² United States Department of Veterans Affairs South Central Mental Illness Research Education Clinical Center, North Little Rock, Arkansas

³ University of Arkansas for Medical Sciences, Little Rock, Arkansas

⁴ United States Department of Veterans Affairs Health Services Research and Development Center for Mental Healthcare and Outcomes Research, North Little Rock, Arkansas

Abstract

We would like to thank the clinicians, OEF/OIF Veterans, and clinical teams who made this work possible. Specifically, we would like to acknowledge Michael T. Lambert, LCSW; Bridgett Larkin, MBA (OEF/OIF Veteran); William M. Moore, PhD; Jamie Mucciarelli, MA (OEF/OIF Veteran); Vince Roca, PhD; Steve Sullivan, M.Div, Th.M; Elizabeth White, LMSW; and Linda Worley, MD. This project was supported by the United States Department of Veterans Affairs Office of Rural Health and South Central Mental Illness Research Education Clinical Center. The views expressed in this article are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs. For further information contact: JoAnn E. Kirchner, MD, VA HSR & D Center for Mental Healthcare and Outcomes Research, 2200 Fort Roots Drive, Bldg 58, North Little Rock, AR 72114; e-mail kirchnerjoanne@uams.edu.

doi: 10.1111/j.1748-0361.2011.00362.x

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.

Key words clergy, criminal justice, education, mental health, rural veterans.

Many persons who live with mental illness in rural areas have difficulty finding appropriate care locally. Even though the prevalence of mental illness is similar in rural and nonrural areas,¹ mental health (MH) specialists tend to be disproportionately located in nonrural, or urban, areas.² This is reflected in findings from large US epidemiological studies,^{1,3-5} which show that rural persons with mental illness are much less likely to receive MH care and

typically obtain it from their primary care provider (PCP) rather than from a MH specialist.⁶ Furthermore, the treatment in primary care tends to be medication alone rather than medication plus psychotherapy, which is generally the optimal combination for effective treatment.⁷⁻⁹

Other reasons for no or inadequate MH care follow. Rural individuals tend to be older,^{10,11} less educated,^{10,12} and poorer^{10,12} than those living in nonrural areas. They

also are less likely to have employer-based health insurance.¹³ Older and less-educated persons often resist using MH care, and those with fewer resources and no insurance face daunting access barriers.

Rural culture appears to value self-reliance and independence.¹⁴⁻¹⁶ Some studies have found that the stigma of having a mental illness and receiving treatment is greater in rural areas than it is in nonrural areas.^{17,18} Rural social networks are smaller, denser, and of greater duration than nonrural social networks and may be far more influential to persons living in rural areas where anonymity is difficult to achieve.^{17,19,20} This lack of anonymity combined with the shortage of MH specialists decreases the chance that persons who live with mental illness in rural areas will receive MH care.¹⁶⁻¹⁸

The US military has a history of recruiting individuals from the rural South, one of the poorest regions of the United States.²¹ Consequently, one-third of Operations Enduring and Iraqi Freedom (OEF/OIF) veterans return to rural or highly rural areas, according to the rural-urban classification system developed by the Veterans Affairs (VA) Planning Systems Support Group in collaboration with the Census Bureau.²¹ Rural residents are defined as not living in an urbanized area that consists of a core census block group or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile. Highly rural residents are defined as living in counties with a population of fewer than 7 persons per square mile.²¹

The Veterans Health Administration (VHA) has worked diligently over the last decade to open community-based outpatient clinics (CBOCs) in rural areas and ensure that they include providers with MH expertise.^{22,23} In addition, the VHA uses telemental health programs to provide specialty medication management and psychotherapy via interactive televideo conferencing (personal communication, John Peters, Care Coordination services, November 5, 2007).²⁴

Still, many rural veterans never obtain the MH care they need.^{4,25-27} Untreated mental illness can result in "self-medication" with drugs or alcohol,^{28,29} relationship difficulties,^{30,31} and job performance issues.³² Therefore, it is critical to develop strategies that engage rural veterans with mental illness as early as possible after their return from combat duty to optimize their chances for a successful recovery. Research indicates that about 1 in every 4 or 5 veterans will return from war with some serious mental illness, most commonly depression (14%), posttraumatic stress disorder (PTSD) (14%), or traumatic brain injury (TBI) (19%), and these illnesses are often complicated by substance abuse.²⁵ The return of these veterans with mental illness to rural areas where

so little help is available can be seen as a public health crisis.³³

To address the needs of rural OEF/OIF veterans who have not formally presented for VA care despite MH and substance use treatment needs, it is important to connect with community stakeholders who are likely to interact with these veterans. Community stakeholders, alternatively called community facilitators or early responders, are key participants in early responses to disasters and public health campaigns to address chronic conditions such as depression and asthma.³⁴⁻³⁶

Fox et al describe a "Rural De Facto Mental Health Services Model" to understand help-seeking behavior, which requires an examination of culture and the health care structure together at the local level. Help seeking by rural residents and ultimate intake into care are facilitated by self, family and friends, ministers, and the criminal justice system.³⁷ Forming a link between these "informal care networks" and the formal care system is essential for providing care in rural areas.³⁷ Building upon this conceptual framework, we identified 3 community stakeholder groups—clergy, postsecondary educators, and criminal justice personnel—as particularly important for OEF/OIF veterans in rural areas.

Local clergy frequently provide frontline spiritual and emotional support for returning soldiers and their families.³³ A national epidemiological study showed that persons with MH problems are more likely to seek help from clergy than from formal sources of care and this practice is more common in rural areas.³⁸ Furthermore, local clergy may be more accessible to the broad population not only because of the numbers (there are more ministers than MH providers), but also because of trust^{33,39} and the lack of stigma associated with counseling from the clergy. In addition, research shows that clergy are eager to help but feel that they lack adequate training to detect and manage mental illness, and they often refer persons with MH problems.⁴⁰

Many soldiers entered the Guard or Reserve to receive educational benefits.⁴¹ Upon returning from OEF/OIF deployment, they enter postsecondary education programs. Approximately 523,000 military veterans are drawing VA education benefits,⁴² and nearly 3 of 5 attend 2-year community colleges, commonly located in rural areas.⁴³

Many soldiers returning to rural areas have difficult transitions to civilian life following deployment and attempt to deal with combat experiences through drugs and alcohol,^{27,44} which can lead to job loss,^{28,45} family alienation,⁴⁵ homelessness,⁴⁶ and criminal charges.⁴⁶ The US Department of Justice Bureau of Justice Statistics indicates that almost 10% of people incarcerated are veterans. A fairly new development in the justice system is veterans' courts of which 11 currently exist,

although few are located in rural areas, and 30-40 are in the planning stage.⁴⁷ Comprehensive “Veterans-Helping-Veterans” service programs and drug court programs have reduced the rate of recidivism. A recent study indicated that only 15% of drug court participants were rearrested compared to more than 75% of nonparticipants.⁴⁸

Early responders have been used in other settings to facilitate access to care. For example, in Australia, rural financial counselors were an important link to mental and general health care services for farmers during a prolonged drought.^{49,50} A recent survey found that almost half of financial counselors responded that more than 20% of their clients needed MH assistance. Subsequent analysis of multiple agencies that served the farming population indicated that these “early responders” served as access points to MH service networks for farming families by providing referrals and information about available MH services.⁵⁰ The financial counselors reported that networking with MH workers, training, and the provision of a referral guide were critical components to improving access to care for this population.⁴⁹

Similarly, the 3 groups of rural community stakeholders we identified—clergy, postsecondary educators, and criminal justice personnel—may be more likely to encounter rural veterans with mental illness or substance abuse or both than the formal health care system.³³ Indeed, these groups might be seen as “early responders” to those with mental illness. As a result, we created a program to develop partnerships with these groups to promote and encourage engagement in MH care for veterans.

Methods/Results

We developed this pilot program in the southern state of Arkansas. According to the US Bureau of the Census, the state ranks 32nd in the nation for total population and has 56 persons per square mile compared to 87 persons per square mile in the United States. A third of the state’s population lives in rural areas. Only Mississippi has a larger percentage of persons living below the poverty level than Arkansas, which ranks first in the nation for the lowest percentage of people 25 year and over with a bachelor’s degree. The percentage of African Americans is 15.5% for Arkansas compared to 12.3% for the United States. Arkansas is among the top 10 states for church attendance in the United States; only 1 of the 10 is outside the South.⁵¹

Veterans in the South are among the poorest and sickest²¹ nationwide, with the lowest per capita income and the lowest percentage of college graduates. Over half (53%) live in rural areas, and approximately 1 in 4 is from an ethnic minority, primarily African American.

This region has one of the largest numbers of OEF/OIF veterans in the United States.⁵²

The governor of Arkansas established a Yellow Ribbon Task Force to address veterans’ needs. This allowed for collaboration between members of the National Guard, State Health Department, criminal justice system, postsecondary education system, VA medical centers, public MH and substance use treatment programs, and the community at large. The task force provided input from key stakeholders concerned with the needs of returning veterans and identified access to health care, whether provided by the VA or others, as an important issue. Not surprisingly, early responders were identified as key facilitators of veterans’ entry into health care.

Program Goals

The program was embedded within and staffed by the Central Arkansas Veterans Healthcare System (CAVHS). The purpose of the program was to create and implement initiatives that would enhance access to MH and substance use care for returning OEF/OIF veterans through community collaborations and stakeholder education/training. Work with these 3 early responder groups (clergy, postsecondary educators, and criminal justice personnel) resulted in core products that could be used across all 3 groups as well as specific components designed for each group individually. Four primary goals guided the development and early implementation phase of the program. The first was to create a resource toolkit that outreach personnel across all 3 program arms could use to educate early responders on the mental and behavioral health needs of OEF/OIF veterans as well as services to address these needs within VA and non-VA settings. The second goal was to create and use a standardized educational curriculum for clergy on the physical, psychosocial, and spiritual health issues of OEF/OIF veterans and their families in at least 1 rural county. The third goal was to create a student veteran outreach project for rural 2-year colleges on at least 2 separate college campuses, and the fourth goal was to establish a Veterans Treatment Court (VTC) to support veterans involved with the criminal justice system in at least 1 rural county.

Program Description

Below, we describe the process used to establish a program Advisory Board, select the locations for the work, engage community partners, develop the details of the program, implement its early stages, and conduct a preliminary evaluation. The program is described in 3 separate arms: the clergy, college, and criminal justice arms. The VA Office of Rural Health funded the project through

a program to improve services to veterans in rural and highly rural areas.

Program Advisory Board

While the Governor's Task Force was critical to the conceptualization of the program, it was important to establish an advisory board specific to the program. The board ensured that the opinions of returning veterans and community stakeholders were incorporated into the development and implementation of the program's 3 arms and provided recommendations to overcome barriers during this process. Meeting quarterly, this board consists of representatives from the military, VA, state government, criminal justice system, clergy, higher education system, and advocacy groups.

Clergy Arm

Persons who live in rural areas and seek help for mental illness are more likely to contact clergy than they are to turn to formal MH care.^{38,53-55} Even though clergy often have little training in MH issues,³⁹ clergy would like additional training.⁴⁰ We sought to develop a local partnership with clergy in 1 rural county. Within this partnership, we hoped to learn more about the needs of the local community and work together to tailor a training program for local clergy to address the MH needs of veterans and their families.

We sought to find a rural county with: (1) a VA CBOC employing an interested MH provider, (2) a high concentration of veterans, and (3) racial diversity. Union County, Arkansas, met these criteria. We recruited 3 VA employees to provide part-time support. A chaplain (40% time) worked primarily with the clergy and faith community and provided resources for the spiritual aspects of veterans' health. A psychiatrist (10% time) worked primarily with the MH providers, both in the VA and local community, and provided resources and training for the clergy on PTSD, TBI, depression, and suicide. An administrative assistant (20% time) helped find and organize resources and assisted with publicity and communication.

We made a number of site visits to identify interested clergy and additional health and MH resources locally and to obtain the support of the local National Guard/Reserve and veteran leadership. Once we identified key stakeholders, we formed a local advisory group that had knowledge of the community and the kinds of training programs that would be appropriate. Numerous informal meetings with group members occurred prior to setting the agenda for the partnership to ensure that plans were relevant to the community and that the community

would take ownership of the agenda and program from the beginning.

We offered 2 training workshops. The first provided general information on military culture, veteran experiences, introduction to MH issues, veteran spiritual health, family deployment struggles, ideas for church involvement, and local MH resources. The second training workshop was more intensive, involving an overnight retreat for motivated clergy.

College Arm

We based the development of a rural student veteran project on similar initiatives at 4-year universities.⁴² In general, we felt that the project should develop a veteran-friendly campus, provide education on veterans' needs for faculty and staff, offer access to timely MH and substance use evaluation, and supply referral options that included VA and community care.

We identified a network of community colleges affiliated with Arkansas State University (ASU), a 4-year institution with a student veteran outreach program.⁵⁶ In addition, ASU leaders participated on the Governor's Task Force and facilitated engagement with their affiliated community-college leadership. Following an introductory e-mail by the ASU chancellor, we contacted each community college dean by telephone to discuss potential collaboration.

The community college network had 104 full-time faculty members and 4,453 students across the 4 campuses where enrollments ranged from 255 students at an Air Force base to 3,127 students at the largest, most established college. The largest campus operated a counseling center staffed by a master's-level licensed professional counselor, and the 3 smaller campuses operated academic counseling centers. In addition, the college coordinator of student recruitment served in the National Guard and recently had returned from OIF deployment. Each campus was located within 30 minutes driving time to CAVHS or a CBOC that provided primary and specialty MH care through televideo.

We staffed the college arm with a full-time licensed clinical social worker (LCSW), half-time psychologist, and quarter-time psychiatrist. Each was associated with CAVHS. The LCSW triaged student veterans referred by faculty, counselors, or self and assessed them for mental illness and substance use problems with a comprehensive assessment program developed by VA researchers and used in VA primary-care-based MH programs.^{56,57} Additional interactions, if indicated, occurred on campus with the LCSW through telemedicine delivered by the psychologist or psychiatrist or in person at CAVHS. Also, student veterans who did not want

VA-based care could attend the local community MH center.

A memorandum of understanding between the community college network and CAVHS details the responsibility of each organization. In the first year of funding, we conducted a focus group with faculty and student veterans to identify the needs of the student veterans. The findings, along with existing literature on the needs of student veterans,^{41,58} informed the development of the educational program for faculty and presentations at student orientation. These training events focused on the unique skills and talents of veteran students and available resources to address potential educational, physical, and emotional needs. In addition, program staff focused on establishing a student veterans group at each participating campus.

Criminal Justice Arm

The criminal justice arm attempted to support and address the needs of veterans who were involved with the criminal justice system in rural communities. The implementation strategy was informed by the program advisory board in collaboration with the Arkansas National Guard and from a visit to an established VTC in Tulsa, Oklahoma.

An alternative to standard courts, VTCs combine the structure and accountability of court with a strong emphasis on treatment.⁵⁹ Treatment courts use an interdisciplinary, nonadversarial judicial process for diverting an (alleged) offender who has a qualifying charge into a strenuous treatment program that addresses the treatment needs of the offender and requires regular court appearances to monitor program compliance. A team consisting of the judge and court staff, a prosecutor, a public defender or private attorney representing the offender, a probation or parole officer, and a counselor typically staff the treatment court. Community providers perform treatment services. Most treatment programs last an average of 18 months.⁶⁰

Working in partnership with the Arkansas Drug Court Coordinator, we considered several locations for the VTC. After advice from community partners, we selected the 23rd Judicial District in Lonoke County, Arkansas. The judge and team had proven expertise and motivation to run a model treatment court and were willing to assist in the development and revision of the VTC over time.

Simultaneously, we added a full-time VTC liaison, an LCSW supported by CAVHS, to coordinate services and assure that full utilization of CAVHS resources would be available to participating veterans. If the veterans' needs extend beyond the scope of CAVHS practice/services, then the VTC liaison coordinates engagement in other

services. The VTC liaison continues to provide follow-up services after the participant exits the VTC to ensure that the veteran maintains progress over time.

Once we selected the site and the VTC liaison, we focused on building working relationships between the court, the prosecuting attorneys, the Department of Community Corrections, and CAVHS. Communication strategies were discussed to allow each component of the justice system to notify the VTC liaison of a veteran involved in the criminal justice system. To facilitate notification, we provided training to the various police departments in the district. Memorandums of understanding were developed to solidify expectations from all involved community partners and court participants. The VTC had its first docket on March 5, 2010.

Another vital component of the VTC is the mentor program composed of veteran volunteers who work directly with the VTC participants. They observe participants and help them to set goals and action plans. Most importantly, mentors act as a support for veterans in a way that only other veterans can.

Evaluation

The program had 4 goals. The first spanned all 3 arms and focused on the development of a toolkit and its use with stakeholders to assist in reaching the remaining 3 goals. The remaining 3 goals included establishing collaborative relationships with clergy in a rural county, establishing veteran outreach projects on at least 2 rural college campuses, and the establishment of a VTC in 1 rural county. Evaluation results for each goal of the program after the first year of funding follow.

In collaboration with the advisory board, project team, consultants, and stakeholders, a comprehensive 34-page toolkit was created outlining psychosocial issues important for returning OEF/OIF veterans and the community and governmental programs and services available for care and education. Each arm used this toolkit to develop educational curricula for training stakeholders over the project. Ninety stakeholders attended formal training workshops (VTC = 36; college = 31; clergy = 23), with many others consulting in face-to-face meetings. The majority of participants were older (median age = 50-59, range = 20-70+), male (75.6%), white (90.0%), and nonveterans (63.3%). The professional roles of participants varied: police officers (29.4%), MH providers (21.9%), clergy (20.0%), other/administrative personnel (20.0%), educators (16.5%), and firefighters (1.2%). Educational attainment ranged from high school equivalent or less (16.6%), trade school or some college (28.9%), bachelor's degree (18.9%), master's degree (27.8%), to doctoral (7.8%). A slight majority (53.9%) stated that

they knew of veterans having difficulty within their organization, and 40.0% knew family members of veterans having difficulties. On a scale from 1 (little) to 5 (a great deal), participants rated their overall learning high ($M = 4.26$, $SD = 0.61$) and overall experience with the program slightly higher ($M = 4.69$, $SD = 0.53$).

The second goal was to create a standardized curriculum for clergy in 1 rural county. With input from 2 different training formats (a 2-hour workshop or an intensive 2.5-day workshop), a curriculum was developed that included program aims and objectives, group activities, and learning evaluation tools. The program chaplain maintained collaborations established through this arm, which has answered numerous inquiries from clergy to assist in linking parishioners to VA services. Network collaborations have been established in 2 rural counties of the state.

The third goal was to establish veteran outreach projects at 2 rural colleges. Projects were established on 4 college campuses and received 32 referrals for various student services. The most common reason for referral was physical or MH issues (59.4%), followed by family conflict (31.3%). The majority of participants were male (81.3%) and white (93.3%). While all referrals received counseling, only 1 was referred for VA services. Student veteran groups are being established on each campus.

The fourth goal was to establish a VTC in a rural county, which was accomplished through multiple stakeholder collaborations as described above. Sixteen veterans were referred for eligibility assessments, 2 were admitted to the VTC, and 4 were being evaluated. The VA and judicial system each referred about 38% of the veterans. Family, friends, or self referred the remaining veterans. Ten participants were not enrolled in the program. The most common reason was the veteran's decision not to participate (43.8%); only 18.8% were ineligible. Of those referred, all were male with a mean age of 37.5 years ($SD = 11.44$). Only 14.3% were currently married, and 60% were white. Most were OEF/OIF veterans (53.3%) and had served during wartime (73.3%). Nearly all (93.8%) had recorded substance abuse problems, about half (46.7%) had non-PTSD MH diagnoses, and a third (33.3%) had PTSD. Socioeconomically, 40% reported financial problems or stressors, 40% had housing issues, and 53% and 20%, respectively, reported medical or family/work problems.

Evaluating the partnerships across the 3 arms of this project can be difficult, but 2 key factors are bilateral communication and equal power between collaborators.^{61,62} These elements have been a core value of the implementation process and are emphasized in implementation manuals developed for each arm. All 3 arms have maintained regular meetings with stakeholders and have

begun to expand to additional counties, which may include telehealth for veterans enrolled in college and the VTCs.

Discussion

This article described the conceptualization, development, and initial implementation of a pilot program designed to improve engagement in, and access to, MH care for veterans returning to rural areas. While the program specifically targets the veteran population, this type of outreach program could address the needs of rural populations in general. Given the limited availability of formal MH services in rural areas, involving community-based "early responder" stakeholders may increase the chances of meeting MH needs. While this program works directly with early responders, it also incorporates outreach to veteran service organizations, uses veteran peer support, and includes family members.

A strong point of the program is its embedment within a VA medical center providing health care to veterans in Arkansas. This supports the organizational infrastructure to champion and coordinate the program. Personnel within the CAVHS MH service coordinate the college and criminal justice arms, and personnel in the chaplain service coordinate the clergy arm. In addition, this provides a direct linkage of the veterans engaged in the individual arms into VA MH care services. Thus, having the program within a health care system ensures that services are readily available when needed.

The success of this pilot program has encouraged program and clinical leadership in the VA to expand each of the arms into additional rural areas. Veterans Administration medical centers could easily replicate this program in other southern states because of similar religious practices, community college networks, criminal justice systems, and rural designations. Nonrural areas may need to modify the program or target different stakeholder groups, such as service industries, for example, bartending and hairdressing.³³ Since it is not feasible to duplicate VTC personnel in all court systems, further expansion and dissemination of the program may rely heavily on technology such as interactive televideo conferencing.

Finally, the needs that inspired the development of this program are not unique to the United States. Forty-five other countries are contributing to the International Security Assistance Force in Afghanistan for a total strength of 119,500 troops.⁶³ In particular, 9,500 United Kingdom, 2,830 Canadian, and 1,550 Australian troops were participating on June 7, 2010.⁶³ Like their US counterparts, veterans from these countries also experience mental illness.⁶⁴⁻⁶⁶ Furthermore, rural populations in Canada and Australia must travel long distances to receive MH care

due to the shortage of MH care professionals.^{67,68} Given that the US Veterans Administration health care system is publicly funded and is a universal health care system for qualified veterans,⁶⁹ its structure is more similar to countries such as Australia and Canada that have universal health care coverage than it is to the US private health care system. Veterans from other countries might benefit from a similar program adapted to their specific cultures and health care organizations.

Across the United States, the VA has started several initiatives that will support the implementation and sustainability of this type of program. The VA leadership recently prioritized addressing the needs of veterans involved in criminal justice systems.⁷⁰ Furthermore, a recent joint VA/Department of Defense meeting on the needs of returning OEF/OIF veterans concluded that liaisons with postsecondary education and faith-based communities are critical for the successful reintegration of veterans. Still, the success of this program will depend largely upon the degree to which the community stakeholder groups “own” and consequently sustain the different arms.

References

- Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62:617-627.
- Ellis AR, Konrad TR, Thomas KC, Morrissey JP. County-level estimates of mental health professional supply in the United States. *Psychiatr Serv*. 2009;60(10):1315-1322.
- Probst JC, Laditka SB, Moore CG, Harun N, Powell MP, Baxley EG. Rural-urban differences in depression prevalence: implications for family medicine. *Fam Med*. 2006;38(9):653-660.
- Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):629-640.
- Larson SL, Fleishman JA. Rural-urban differences in usual source of care and ambulatory service use: analyses of national data using Urban Influence Codes. *Med Care*. 2003;41(Suppl 7):III65-III74.
- Jameson JP, Blank MB. The role of clinical psychology in rural mental health services: defining problems and developing solutions. *Clin Psychol: Sci & Pract*. 2007;14:283-298.
- Jameson JP, Blank MB. Diagnosis and treatment of depression and anxiety in rural and nonrural primary care: national survey results. *Psychiatr Serv*. 2010;61(6):624-627.
- Young AS, Klap R, Sherbourne CD, Wells KB. The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry*. 2001;58:55-61.
- Fortney J, Rost K, Zhang M, Pyne J. The relationship between quality and outcomes in routine depression care. *Psychiatr Serv*. 2001;52(1):56-62.
- Ricketts TC, Johnson-Webb KD, Randolph RK. Populations and places in rural America. In Ricketts TC, ed. *Rural Health in the United States*. New York: Oxford University Press; 1999:7-24.
- Norton CH, McManus MA. Background tables on demographic characteristics, health status, and health services utilization. *Health Serv Res*. 1989;23(6):725-756.
- Baughner E, Lamison-White L. *Poverty in the United States: 1995*. Washington, DC: US Department of Commerce, Bureau of the Census; 1996.
- Larson SL, Hill SC. Rural-urban differences in employment-related health insurance. *J Rural Health*. 2005;21(1):21-30.
- Bachrach LL. Psychiatric services in rural areas: a sociological overview. *Hosp Community Psychiatry*. 1983;34(3):215-226.
- Hauenstein EJ, Petterson S, Rovnyak V, Merwin E, Heise B, Wagner D. Rurality and mental health treatment. *Adm Policy Ment Health*. 2007;34:255-267.
- Philo C, Parr H, Burns N. Rural madness: a geographical reading and critique of the rural mental health literature. *J Rural Stud*. 2003;19:259-281.
- Hoyt DR, Conger RD, Valde JG, Weihs K. Psychological distress and help seeking in rural America. *Am J Community Psychol*. 1997;25(4):449-470.
- Rost K, Smith GR, Taylor JL. Rural-urban differences in stigma and the use of care for depressive disorders. *J Rural Health*. 1993;9(1):57-62.
- Fortney J, Mukherjee S, Curran G, Fortney S, Han X, Booth BM. Factors associated with perceived stigma for alcohol use and treatment among at-risk drinkers. *J Behav Health Serv Res*. 2004;31(4):419-429.
- Rost K, Fortney J, Zhang M, Smith J, Smith GR. Treatment of depression in rural Arkansas: policy implications for improving care. *J Rural Health*. 1999;15(3):308-315.
- Office of Rural Health. *Demographic Characteristics of Rural Veterans*. Washington, DC: Department of Veterans Affairs; 2009.
- Chapko M, Borowsky S, Fortney J, et al. Evaluation of the Department of Veterans Affairs community-based outpatient clinics. *Med Care*. 2002;40(7):555-560.
- Jonk YC, Call KT, Cutting AH, O'Connor H, Bansiya V, Harrison K. Health care coverage and access to care: the status of Minnesota's veterans. *Med Care*. 2005;43(8):769-774.
- Monnier J, Knapp RG, Frueh BC. Recent advances in telepsychiatry: an updated review. *Psychiatr Serv*. 2003;54(12):1604-1609.

25. RAND Health, RAND National Security Research Division. *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica, CA: Rand Corporation; 2008.
26. Hoge CW, Auchterlonie JL, Milliken CS. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *J Am Med Assoc*. 2006;295(9):1023-1032.
27. Seal KH, Maguen S, Cohen B, et al. VA mental health services utilization in Iraq and Afghanistan veterans in the first year of receiving new mental health diagnoses. *J Trauma Stress*. 2010;23(1):5-16.
28. Becker WC, Fiellin DA, Desai RA. Non-medical use, abuse and dependence on sedatives and tranquilizers among U.S. adults: psychiatric and socio-demographic correlates. *Drug Alcohol Depend*. 2007;90:280-287.
29. Sullivan LE, Fiellin DA, O'Connor PG. The prevalence and impact of alcohol problems in major depression: a systematic review. *Am J Med*. 2005;118(4):330-341.
30. Du Rocher Schudlich TD, Youngstrom EA, Calabrese JR, Findling RL. The role of family functioning in bipolar disorder families. *J Abnorm Child Psychol*. 2008;36(6):849-863.
31. Kessler RC, Walters EE, Forthofer MS. The social consequences of psychiatric disorders, III: probability of marital stability. *Am J Psychiatry*. 1998;155(8):1092-1096.
32. Stewart WF, Ricci JA, Chee E, Hahn SR, Morganstein D. Cost of lost productive work time among US workers with depression. *J Am Med Assoc*. 2003;289(23):3135-3144.
33. Sullivan G. The need for "community cultural competence." *Psychiatr Serv*. 2007;58(9):1145.
34. Dietrich S, Mergl R, Freudenberg P, Althaus D, Hegerl U. Impact of a campaign on the public's attitudes towards depression. *Health Educ Res*. 2010;25(1):135-150.
35. Gillissen A, Wirtz H, Juergens U. Patient and physician factors contributing to poor outcomes in patients with asthma and COPD. *Dis Manag Health Outcomes*. 2007;15(6):355-376.
36. Patterson O, Weil F, Patel K. The role of community in disaster response: conceptual models. *Popul Res Policy Rev*. 2010;29:127-141.
37. Fox J, Merwin E, Blank M. De facto mental health services in the rural south. *J Health Care Poor Underserved*. 1995;6(4):434-468.
38. Wang PS, Berglund PA, Kessler RC. Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Serv Res*. 2003;38(2):647-673.
39. Openshaw L, Harr C. Exploring the relationship between clergy and mental health professionals. *Soc Work Christ*. 2009;36(3):301-325.
40. Kramer TL, Blevins D, Miller TL, Phillips MM, Davis V, Burris B. Ministers' perceptions of depression: a model to understand and improve care. *J Relig Health*. 2007;46(1):123-139.
41. DiRamio D. From combat to campus: voices of student-veterans. *NASPA J*. 2008;45(1):73-102.
42. Veteran Center Handbook for Student Veterans. *Student Veterans of America*. 2009; January 1:1-17. Available at: www.studentveterans.org. Accessed January 10, 2011.
43. Field K. Cost convenience drive veterans' college choices. *Chron High Educ*. 2008;54(46):A1.
44. Eggleston AM, Straits-Tröster K, Kudler H. Substance use treatment needs among recent veterans. *N C Med J*. 2009;70(1):54-58.
45. Peirce JM, Kindbom KA, Waesche MC, Yuscavage ASE, Brooner RK. Posttraumatic stress disorder, gender, and problem profiles in substance dependent patients. *Subst Use Misuse*. 2008;43:596-611.
46. Greenberg GA, Rosenheck RA. Jail incarceration, homelessness, and mental health: a national study. *Psychiatr Serv*. 2008;59(2):170-177.
47. Mikkelson K. Veterans courts offer hope and treatment. *Public Lawyer*. 2010;18(1):2-5.
48. Veterans alternative to incarceration program (VATIP). *Veterans Outreach Center*. 2010. Available at: <http://www.veteransoutreachcenter.org/vatip.html>. Accessed June 30, 2010.
49. Fuller J, Broadbent J. Mental health referral role of rural financial counsellors. *Australian J Rural Health*. 2006;14:79-85.
50. Fuller JD, Kelly B, Law S, Pollard G, Fragar L. Service network analysis for agricultural mental health. *BMC Health Serv Res*. 2009;9(87). Available at: <http://www.biomedcentral.com/1472-6963-9-87>. Accessed October 12, 2010.
51. Newport F. Mississippians go to church the most; Vermonters, least. *Gallup Poll*. 2010; February 17. Available at: <http://www.gallup.com/poll/125999/Mississippians-Go-Church-Most-Vermonters-Least.aspx>. Accessed May 27, 2010.
52. VHA Office of Public Health and Environmental Hazards. *Analysis of VA Health Care Utilization among US Global War on Terrorism (GWOT) Veterans, Operation Enduring Freedom, Operation Iraqi Freedom*. Washington, D.C.: Veterans Health Administration. 2007.
53. Weaver AJ. Has there been a failure to prepare and support parish-based clergy in their role as frontline community mental health workers: a review. *J Pastoral Care*. 1995;49(2):129-147.
54. Weaver AJ, Flannelly KJ, Stone HW. Research on religion and health: the need for a balanced and constructive critique. *J Pastoral Care Counsel*. 2002;56(3):213-219.
55. Weaver AJ, Flannelly KJ, Oppenheimer JE. Religion, spirituality, and chaplains in the biomedical literature: 1965-2000. *Int J Psychiatry Med*. 2003;33(2):155-161.
56. Beck PRIDE Center. *Arkansas State University - Jonesboro*. 2010. Available at: <http://www2.astate.edu/cpi/beckpride/>. Accessed June 30, 2010.

57. Oslin D, Ross J, Sayers S, Murphy J, Kane V, Katz I. Screening, assessment, and management of depression in VA primary care clinics. The Behavioral Health Laboratory. *J Gen Intern Med.* 2006;21(1):46-50.
58. Herrmann D, Raybeck D, Wilson R, Allen BJ, Hopkins C. College is for veterans, too. *Chron High Educ.* 2008; 55(13): A99.
59. Longshore DL, Turner S, Wenzel SL, et al. Drug courts: a conceptual framework. *J Drug Stud.* 2001;31(1):7-26.
60. Drug Courts Program. *State of Arkansas.* 2010. Available at: <http://courts.state.ar.us/drugcourt/index.cfm>. Accessed July 6, 2010.
61. Blevins D, McGovern R, Morton B. Evaluating a community-based participatory research project for elder mental healthcare in rural America. *Clin Interv Aging.* 2008;3(3):535-545.
62. Wolff T. A practical approach to evaluating coalitions. In: Backer T, ed. *Evaluating Community Collaborations.* New York, NY: Springer Publishing; 2003:95-165.
63. International Security Assistance Force: Troop Contributing Nations. *International Security Assistance Force.* 2010; June 7. Available at: <http://www.afghanistan.gc.ca/canada-afghanistan/assets/pdfs/100607Placement.pdf>. Accessed July 1, 2010.
64. Iversen AC, Van Staden L, Hughes JH, et al. The prevalence of common mental disorders and PTSD in the UK military: using data from a clinical interview-based study. *BMC Psychiatry.* 2009;68(9). Available at <http://www.biomedcentral.com/1471-244x/9/68>. Accessed January 10, 2011.
65. Fikretoglu D, Brunet A, Schmitz N, Guay S, Pedlar D. Posttraumatic stress disorder and treatment seeking in a nationally representative Canadian military sample. *J Trauma Stress.* 2006;19(6):847-858.
66. Forbes D, Lewis V, Parslow R, Hawthorne G, Creamer M. Naturalistic comparison of models of programmatic interventions for combat-related post-traumatic stress disorder. *Aust N Z J Psychiatry.* 2008;42:1051-1059.
67. Bodor R. The future for social work and mental health in rural and northern Canada. *Rural Soc.* 2009;19(4):289-292.
68. Bambling M, Kavanagh D, Lewis G, et al. Challenges faced by general practitioners and allied mental health services in providing mental health services in rural Queensland. *Aust J Rural Health* 2007;15(2):126-130.
69. Oliver A. The Veterans Health Administration: an American success story? *Milbank Quarterly* 2007;85(1):5-35.
70. Shinseki EK. T21 VA Transformative Initiative. *Department of Veterans Affairs* 2010; Available at: <http://www1.va.gov/opa/T21/>. Accessed January 10, 2011.