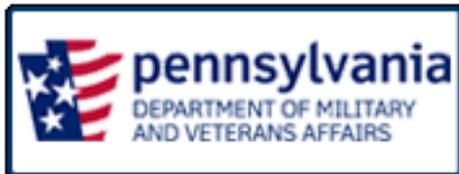


Needs Assessment of Pennsylvania Veterans
Volume VIII: Summary Report of Findings

Conducted for
Pennsylvania Department of Military and Veterans Affairs

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About the Needs Assessment of Pennsylvania Veterans

The Pennsylvania Department of Military and Veterans Affairs engaged a research team at Penn State Harrisburg to conduct a needs assessment of Pennsylvania veterans. The goal of this initiative is to develop a comprehensive understanding of unmet needs and service gaps through the perspectives of both service providers and veterans. By documenting this information, the results of the project will increase the stature of veterans' needs, help to ensure statewide access to core services, and provide guidance on how funding can best be utilized to meet the needs of Pennsylvania veterans.

The activities undertaken by the Institute of State and Regional Affairs are documented individually in specific stand-alone reports (listed below) and culminate in a *Summary Report of Findings (Volume VIII)*.

The individual reports include:

Volume I: Veteran Needs: Insights from Research

Volume II: Focus Groups of Veterans

Volume III: In-Depth Interviews of Veteran Service Organization Administrators

Volume IV: Administrative Web Survey of Veteran Service Organization Administrators

Volume V: Statewide Telephone Survey of Veterans

Volume VI: Statewide Web Survey of Veterans

Volume VII: Demographic Background Research

Volume VIII: Summary Report of Findings

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Table of Contents

INTRODUCTION 1

 Target Population and Services 1

 Methods 2

 Term Clarification..... 4

PRELIMINARY OBSERVATIONS 5

PROPOSED ACTION ITEMS 6

BEHAVIORAL HEALTH..... 18

 Background 18

 Findings: General..... 20

 VSOs and Behavioral Health for Veterans 20

 Findings: PTSD..... 22

 Findings: TBI..... 24

 Findings: Substance Abuse 25

 Findings: VSOs’ Perspectives on Reasons Veterans Do Not Seek Treatment 25

 Findings: VSOs’ Suggestions for Improving Access and Utilization of Behavioral Health Services 26

 Recommendations..... 27

CLAIMS and BENEFITS 29

 Introduction..... 29

 Awareness and Information Flow 30

 Background 30

 Findings: General..... 31

 Findings: Older Veterans 32

 Findings: Younger Veterans 34

 VSOs and Access to Benefits..... 35

 The Burial, State and Local Benefits Example 36

 Veteran Utilization of Benefits 37

 The Transition Assistance Program (TAPs) Example 37

 The Altruism Issue 39

 Stigma 39

 Other 39

 Findings: Access and Utilization 42

Table of Contents (Continued)

Claim Maintenance 45

 Background 45

 Findings: Claim Maintenance 45

 Findings: Assistance with Filing Claims 46

 Findings: Difficulties with Claims Processing..... 48

 Background: Claims Maintenance and VSOs..... 51

 VSOs and the Claims Process..... 51

 Findings: Problems with Powers of Attorney 53

 Findings: Specific Benefits 56

Claim Disputes..... 67

 Recommendations..... 68

COMMUNICATION AND OUTREACH 72

 Background 72

 Findings: General..... 74

 Findings: Internet Access..... 75

 Findings: Younger Veterans 75

 Findings: Observations from VSOs 77

 Recommendations..... 78

CRIMINAL JUSTICE 81

 Background: Arrest Data 81

 Background: Pennsylvania Arrest Data 83

 Background: Incarceration Data 83

 Background: Probation and Parole Data..... 85

Veterans Treatment Court Programs..... 87

 Background: Veterans Treatment Court Programs 87

 VTCs and the OVA 2012 Strategic Plan 88

 Findings: Veterans Treatment Courts 89

 Findings: Incarcerated Veterans..... 92

 Recommendations..... 93

Table of Contents (Continued)

EDUCATION AND TRAINING 94

 Background 94

 Findings: General 96

 Findings: Usage of GI Benefits 96

 Findings: Frustrations with Using GI Benefits 99

 Recommendations 102

EMPLOYMENT 104

 Background 104

 Background: Employment Assistance 105

 Findings: General 106

 Findings: VSOs and Employment 110

 Findings: Transportation and Employment 111

 Recommendations 113

HEALTH CARE 116

 Accessing VA Health Care in VA Facilities 116

 Background 116

 Findings 117

 Veterans’ Homes and Long-Term Care 121

 Background 121

 Findings 121

 Recommendations 122

HOUSING 123

 Background: Population 123

 Background: Resources and Initiatives 124

 Findings: Homelessness among Veterans 125

 Findings: Utilization of Housing Assistance/Homelessness Remediation 126

 Findings: Observations and Recommendations from VSOs 129

 VA Home Loan Program 129

SUB-POPULATIONS OF VETERANS 131

 Background 131

 Findings: Subpopulations Generally 131

Table of Contents (Continued)

Female Veterans..... 133

 Background 133

 Findings: Gender..... 137

Minority Veterans 139

 Background 139

 Findings..... 141

LGBTQ Veterans 142

 Background 142

 Findings..... 143

Rural Veterans 143

 Background 143

 Findings..... 144

Recommendations..... 145

VETERANS SERVICE OFFICERS (VSOs) and VSO PROGRAM MANAGEMENT 146

 Background 146

 Fiscal Context 146

 The Pennsylvania Department of Military and Veterans Affairs (DMVA)..... 148

 Background: State Funding and Services 149

 Findings: General..... 150

 Veteran Awareness of VSOs..... 152

 Challenges Facing VSOs 154

 VSO Training..... 156

 Internet Access..... 157

REFERENCES 159

List of Figures

Figure 1. Behavioral Health Assistance Provided by VSOs 21

Figure 2. Behavioral Health Assistance Provided by VSO Organizational Affiliation 22

Figure 3. Reasons Veterans May Not Seek Behavioral Health Assistance 26

Figure 4. Older Veterans’ Rating of Knowledge of Benefits..... 32

Figure 5. Older Veterans: In-Person/Media Resources Used to Learn About Benefits..... 33

Figure 6. Older Veterans: Internet Resources Used to Learn About Benefits 34

Figure 7. Reasons Veterans Did Not Seek or Claim Benefits..... 40

Table of Contents (Continued)

Figure 8. Reasons Younger Veterans Did Not Seek or Claim Benefits.....	41
Figure 9. Reasons Older Veterans Did Not Seek or Claim Benefits	41
Figure 10. Older Veterans’ Utilization of Assistance with Filing Claims	47
Figure 11. Younger Veterans’ Utilization of Assistance with Filing Claims	47
Figure 12. Problems Veterans Faced Submitting Claims	50
Figure 13. VSOs Reporting “Stolen” Claims by Organizational Affiliation	56
Figure 14. Mean Score Ratings of Effectiveness of Programs for Veterans.....	57
Figure 15. Effectiveness Rating for eBenefits Program.....	60
Figure 16. Effectiveness Rating for the Military Family Relief Assistance Program.....	61
Figure 17. Effectiveness Rating for the Mobile Outreach Van Program	62
Figure 18. Effectiveness Rating for the State Persian Gulf Bonus Program.....	63
Figure 19. Effectiveness Rating for the State Veterans Emergency Assistance Program	64
Figure 20. Effectiveness Rating for Telemedicine.....	65
Figure 21. Effectiveness Rating for Welcome Home Packets	66
Figure 22. Types of Assistance with Access to Veterans’ Treatment Courts	90
Figure 23. Education/Training Benefits Used by Younger Veterans.....	97
Figure 24. Education Benefits Used by Older Veterans	98
Figure 25. Employment Efforts by VSOs	110
Figure 26. Types of Transportation Services Offered by VSOs	112
Figure 27. Types of Transportation Services Offered by Organizational Affiliation	112
Figure 28. Housing Benefits Used by Younger Veterans since Separating from the Military	126
Figure 29. Housing Efforts by Veteran Service Officers	127
Figure 30. Housing Efforts by Organizational Affiliation	128
Figure 31. VSOs’ Populations Most Served by Number of VSOs Reporting	132
Figure 32. Federal Expenditures per Veteran for States Served by a DMVA	149
Figure 33. Veteran Populations Most-Served on a Daily Basis by Service Officers.....	151
Figure 34. Older Veterans’ Awareness of Available Assistance	153
Figure 35. Younger Veterans’ Awareness of Available Assistance	153
Figure 36. Younger Veterans’ Membership in Independent Veteran Organization	154
Figure 37. Internet Access by Organizational Affiliation	158

List of Tables

Table 1. Younger Veterans: In-Person/Media Resources Used to Learn About Benefits	35
Table 2. Younger Veterans: Internet Resources Used to Learn About Benefits.....	35
Table 3. Older Veterans: Awareness of Burial, State and Local Benefits	36
Table 4. Younger Veterans: Awareness of Burial, State and Local Benefits	37
Table 5. Difficulties Veterans Experienced Filing Claims	48
Table 6. Mean Scores of Veteran’s Programs by Organizational Affiliation	58
Table 7. Older Veterans’ Reasons for Not Using VA Education or Training Benefits	99
Table 8. Employment Services Used By Younger Veterans since Separating from the Military	107
Table 9. Employment Services Used By Older Veterans since Separating from the Military	108
Table 10. Employment Efforts by Organizational Affiliation	110
Table 11. Reasons Younger Veterans Did Not Use VA Health Care	118

Table of Contents (Continued)

Table 12. Reasons Older Veterans Did Not Use VA Health Care 118
Table 13. Housing Benefits Used by Older Veterans since Separating from the Military 127
Table 14. States with the Highest Veteran Populations 147
Table 15. States with the Highest Federal Expenditure Spent Per Veteran 148
Table 16. Mean Ranking of the Most Challenging Issues Facing VSOs by Organizational Affiliation .. 155
Table 17. Most-Requested Improvements by Organizational Affiliation..... 156

INTRODUCTION

The Pennsylvania Department of Military and Veteran Affairs (DMVA) undertook this needs assessment (“Study”) of Pennsylvania veterans in order to understand where gaps in information, communication, and service delivery might exist among veterans and those who provide and coordinate services for them. Based upon prior research, including the findings from a 2011 study among veterans that was funded by The Center for Rural Pennsylvania, the DMVA suspected that veterans’ needs were not being met to the fullest extent possible and that differences existed among counties’ practices (Behney *et al.*, 2012). The DMVA intends to use the data from this Study to refine its strategic plan and improve Pennsylvania veterans’ access to benefits and services.

Target Population and Services

Although all persons who served in the Armed Forces may self-identify as a veteran, only those persons who meet the statutory definition of “veteran” are entitled to local, state, and federal veterans’ benefits and services. A “statutory veteran” is “one who served in the active military, naval, or air service, and who was discharged or released from the military under conditions other than dishonorable” (38 U.S. Code 101, 1975). National Guard and reservists are not recognized statutorily as veterans unless they served in an active duty capacity for a defined amount of time. Persons who were dishonorably discharged are not considered to be veterans under the United States Code.

As of 2012, the United States Census identified 21.2 million veterans in the United States, 19.6 million of whom are men and 17.7 million of whom are white (U.S. Census, 2012a). According to Veterans Administration data from 2014, there are 939,069 veterans living in

Pennsylvania, 697,433 of whom served during a time of war (U.S. Department of Veterans Affairs: National Center for Veterans Analysis and Statistics, 2014).

Veterans' benefits and services include, among other things, medical care; behavioral health services; social services; community-based support groups and counseling; housing assistance; employment and re-training assistance; education assistance; burial and funeral services; and benefits for survivors and dependents. These benefits and services are provided federally through one of three Veterans Affairs entities; at the state level through the DMVA and its affiliated State departments and agency partners; and at the local level through County Veterans Affairs offices, County Assistance Offices, and a variety of veteran-friendly community partners and independent charitable organizations. DMVA describes itself as having a "high priority mission to provide education, increase awareness and facilitate access for veterans and their eligible family members" (Hamp, 2014). As such, DMVA assumes the role of the "lead advocate" for veterans within the Commonwealth and "aggressively pursues a leadership role to consolidate and disseminate information from resources that span federal, state and local government, as well as Veteran Friendly Community Partners and independent charitable organizations" (Hamp, 2014). As advocates, DMVA understands its responsibilities to honor veterans' choices on when and what benefits to utilize, and to ensure that veterans receive the full measure of all eligible benefits, services, and programs.

Methods

To explore the extent to which Pennsylvania veterans access available benefits and services, the DMVA contracted with the Penn State Harrisburg and the Institute of State and Regional Affairs (the Research Team) to conduct a four-stage study among Pennsylvania veterans. First, the Research Team conducted a literature review on eight categories of veteran

benefits and services; correlates of veteran utilization of those benefits and services; and specific veteran populations, which included current conflict, female, minority, LGBTQ, and rural veterans. Additionally, the Research Team identified literature on legislative, cultural, and political considerations relevant to the manner in which service providers and veterans interact. The findings from that literature review are contained in full as a stand-alone report: ***Volume I: Veteran Needs: Insights from Research*** and are incorporated, in part, throughout this Report so as to provide context for findings and recommendations.

Next, the Research Team facilitated six focus group sessions among self-selected veterans from throughout the Commonwealth. These focus group sessions allowed the Research Team to explore issues broadly and identify themes for additional study. Following preliminary analysis of the data garnered from this qualitative stage of the study, the Research Team re-interviewed some veterans and sought input from additional veterans' services officers (VSOs) in order to clarify any points that required additional explanation. Then, the Research Team conducted three focus groups with individuals representing veteran service organizations in order to better understand the needs of Pennsylvania veterans, gaps in service, and best practices of service organizations.

The Research Team then developed two surveys to capture data points relevant to each of the themes identified from the literature review and the focus groups. A survey to identify veterans' needs and gaps in service from the perspectives of those who work directly with veterans to file for benefits and services was distributed to 165 veteran service officers via a web survey link, fax, and/or email; a total of 78 surveys were completed as part of this data collection effort. Also, the research team conducted a statewide random telephone survey and a web-based

version of the same survey instrument. These efforts yielded 286 telephone interviews and 136 completed web surveys with Pennsylvania veterans.

Throughout the study, the Research Team consulted with the DMVA and a 12-person Advisory Group comprised of veterans and stakeholders from throughout the Commonwealth. The Research Team collected and analyzed all of the data from these efforts and made the following findings. All data and observations contained in subsections entitled “Background” are derived from prior research conducted by researchers other than the Research Team. All data and observations in the subsections entitled “Findings” derive from data collected during this Study by the Research Team. All information contained in the subsections entitled “Recommendations” reflects the evidence-based opinions of the Research Team. Finally, all of the Study’s recommendations are included in the section below, “Proposed Action Items”.

Term Clarification

The terms “veteran’s service office” and “veteran’s service officer” are abbreviated into the collective acronym “VSO” to refer to all veteran services professionals who were involved in this Study (focus groups: $n = 26$; web survey: $n = 78$). The following terms identify subsets of VSOs:

ODAGVA VSOs: VSOs employed by the Office of the Deputy Adjutant General of Veterans Affairs;

CVSOs: VSOs employed by a county and working either as a County Director or for a County Director; and

IVSOs: Independent Veterans Service Organization service officers, such as the Veterans of Foreign Wars (VFW) and the American Legion. These are non-governmental, non-profit or not-for-profit, organizations.

PRELIMINARY OBSERVATIONS

The following sets forth a preview of the Research Team’s generalized impressions and observations. First, the Commonwealth of Pennsylvania generally has the capacity, programming, and personnel necessary to provide for the majority of the needs of its veterans. Some programs need refinement, but the bulk of the services are substantively solid. The challenges in meeting veterans’ needs lay not with what is available, but how it is available. The flow of information to veterans about available services, benefits, and programs is overwhelming in both volume and presentation. Moreover, the manner in which assistance is provided to veterans is disjointed and discordant. Pennsylvania needs to reduce the cacophony of information to a simple, streamlined melody of support to Pennsylvania veterans.

Communication and integration are the biggest weaknesses at all levels of veteran service delivery. The human element is the greatest strength within the Pennsylvania veterans’ service community. The professionals and volunteers who work in veterans’ services in the Commonwealth are dedicated, impassioned, and motivated to do good. Individual veterans generally are receptive to receiving services and are motivated to self-advocate for those services. They need to be equipped with resources and aided in that advocacy to a much greater extent. In short, Pennsylvania veterans’ needs are not being met to the maximum extent possible due to poor communication with veterans, poor integration of processes and services across and along service delivery streams, and poor communication among the stakeholders who are tasked with obtaining and coordinating benefits and services for veterans.

A simple, yet comprehensive, “one-stop shop” for veterans to access VSOs, programs, claims processes, and programming at all governmental levels, would be invaluable. Specifically, Pennsylvania could develop a sophisticated veteran’s website, app, or other

Internet-based interface, to house links to federal, state, and community resources. Portals could link to county-specific pages of information and interaction. Moreover, the culture within the veterans' service community needs to evolve into a more collegial, cooperative environment. Putting the bottom line up front, the DMVA should implement a strategic plan to improve communication, integrate advocacy and service delivery, and encourage a culture of cooperation across agencies and the non-profit community.

At the outset, the DMVA indicated that it knew what Pennsylvania veterans needed and desired information on how to better meet those needs. The Research Team concurs that the DMVA and the veteran community have a strong grasp on what Pennsylvania veterans need. Some stakeholders are under-informed in a few key areas, but overall, the knowledge-base among veterans and VSOs is robust. Therefore, the focuses of this research, and of this Report, are the present state of knowledge and information among veterans and VSOs; *what* can be done to better meet those needs; and preliminary recommendations on *how* those objectives can be accomplished.

PROPOSED ACTION ITEMS

The following reflects a compilation of the Research Team's professional opinions and recommendations for specific courses of action that will improve veterans' services in the Commonwealth of Pennsylvania. Comments in quotations marks are drawn from statements made by respondents in this Study:

COMMUNICATION

- Create one, central website to serve as a portal, or conduit, for all matters related to veterans' benefits and services. Do market research (through a professional or academic

marketing entity) to create a catchy name that resonates with veterans. Recommendations from the field included “The Virtual Veteran,” “The PA VA,” “PA Veterans Resources,” and “PAVE—Paving the Way for Pennsylvania Veterans.” This proposed website is referred to as The Website for the remainder of these proposed Action Items.

- Hire external consultants with expertise in intergenerational communication and marketing to develop The Website. Incorporate dropdown menus for all major issues/benefits/services, and include a portal to each CVS0 and IVSO. Ensure that The Website has touchscreen capabilities and is compatible with multiple electronic devices.
- Consult with web design experts to make DMVA’s, CVS0s’ and IVSOs’ webpages more uniform, more user-friendly, and linked with a central benefits website. Link these websites with The Website and ensure that web designs are complimentary.
- Dramatically rework the DMVA website and segregate all veteran materials. The DMVA website, in its current form, is cumbersome and irritating to many users. Ensure that the new DMVA website is linked to, and complimentary to, The Website.
- Train VSOs on The Website prior to launch, and then conduct community-level seminars for veterans.
- Create a secure, HIPAA-compliant site for storing military and medical records, where veterans and VSOs can access documents needed for claims. Link this records lockbox with The Website.
- Develop methods of communicating the availability of benefits through means other than word-of-mouth. While paper resources, such as brochures, flyers, and pamphlets, are appealing to older veterans, tech-savvy and younger veterans need different forms of communication. Again, consult with external professionals.

- Assign dedicated professional email addresses to all VSOs and provide mobile Internet access for VSOs.
- Equip mobile outreach vans with tablet computers and mobile Internet access for veterans to use either while working with a VSO or on their own.
- Analyze the cost-per-capita benefit of producing printed materials and make decisions on what types of print materials should be retained and which should be replaced with electronic media.
- Train VSOs on social media. Consult with communications experts to identify all appropriate social media outlets, and then train VSOs in hands-on training sessions on how to incorporate these social media resources into their daily professional practices.
- Consult with marketing or academic professionals to improve the visibility of the DMVA and improve the public image of the DMVA. Consider a name change because the acronym, “DMVA,” is confusing and misleading to many veterans who think it relates to motor vehicles.
- Add more Mobile Outreach Vans, particularly in rural communities. Equip the vans with appropriate paperwork and electronic resources for claims processing and information distribution. Ask VSOs to travel with the Vans. Incorporate service delivery into the Vans. Create a standardized schedule for when the Vans will travel to which locations, publish that schedule, and abide by that schedule. Promote and market the Vans more effectively.
- Reconsider the cost-benefit of Welcome Home Packets and consider making them electronic. Incorporate them into the new website.

- Create a subscription service through opt-in email delivery for all veterans. Link it to the new website.
- Develop an outreach plan to identify and contact veterans as they separate from the Armed Services.
- Use the coffee hours described in the section on Behavioral Health (below) to distribute information and post social media contacts at those locations.
- Sponsor in-person information sessions in all counties on a regularly scheduled basis so that they become ingrained in the communities' planning and calendars.
- Require VSOs to visit college campuses periodically to share information.
- Identify veteran liaisons on all college campuses and develop relationships with those liaisons to share information and manage GI Bill issues.
- Develop a matrix for improving outreach efforts on a case-specific basis. Tailor information flow based on the target audience. For example, deliver information on transition to civilian life in formats more compatible with younger veterans and information on estate planning in more traditional formats.
- Establish a hotline linked by telephone number to the appropriate regional VA office for initial inquiries and a hotline linked by telephone-client number to the appropriate VSO or advocate.
- Schedule biannual reassessments of communications strategies to account for advances in technology and changing communication trends among veterans.
- Create an annual reminder system for benefits review, contact information for VSOs, and any other information stakeholders want to impart. The annual reminder system is

familiar to veterans who are accustomed to having a variety of responsibilities attached to their birthdates and annual physicals.

CLAIMS FOR BENEFITS

- Educate VSOs on the definitions of all terms used in the claims process, with particular emphasis on what an informal claim is, when it is created, what appeals are, and how to navigate the informal and formal appeals processes for claims.
- Work with the VA to provide periodic training in online and paper-copy claims management.
- Provide all VSOs with a simple flow chart and a one-hour tutorial on the claims appeals process.
- Develop interactive, online tools for monitoring claims, preferably with touchscreen capabilities, and provide training to veterans on how to use them in locations accessible to veterans. Also, provide transportation to these training sessions.
- Develop and host how-to webinars and seminars for veterans who want to pursue claims without using a VSO for assistance.
- Develop and host how-to webinars and seminars for VSOs to ensure that they understand the claims processes for federal, state, and local claims. These could be conducted over a three-month period as continuing education for all VSOs, and consideration needs to be given to what kinds of incentives for participation would be most enticing for VSOs. Perhaps continuing education could be a mandatory component of annual accreditation.
- Provide tablet computers for VSOs to allow for mobile connectivity for claims processing.

- Make VA accreditation a condition of employment, so as to ensure uniformity and quality of training on claims processing.

BEHAVIORAL HEALTH

- Acknowledge that fellowship, a sense of belonging, and a sense of being among people who “get it” are critical to veterans’ overall health, including their behavioral health.
- Develop partnerships with local-level community service organizations, independent veteran service organizations, colleges, places of worship, community and non-profit recreation centers such as the YMCA, libraries, and local restaurants to initiate veteran-centric events.
- Establish cost-free weekly, standing coffee hours or social hours. Examples include “Military Monday” or “Reverie,” a morning coffee hour at a local diner with a designated “veterans corner.” Serve free coffee and donuts sponsored by a local donor(s) or solicit the location to provide discounts to veterans. Situate these drop-ins close to the entrance of the establishment so veterans do not have to hunt for the location or traverse the establishment to join. Make them weekly, and designate a VSO or volunteer to attend each week (perhaps rotating responsibility for attending among several volunteers). Even if attendance is low, the existence of the event fosters a sense of community support among veterans and promotes the sense that there “are others out there who care.”
- Consider weekly or monthly events in the evening, such as “Taps,” at a local pub, and provide free soft drinks. Model these events on the coffee hours described above.
- Work with local veteran organizations to create and promote drop-in support groups (but do not call them support groups), on an established basis so that veterans can count on those events recurring, regardless of whether they attend once, sporadically, or regularly.

Again, knowing that these events are occurring in the community has value independent of whatever occurs during these meetings. For example, host a weekly meeting in the local library called “Veterans Swapping Stories.”

- Consult with marketing experts to consider how best to name services. Consideration needs to be given to how to identify veteran-oriented programming in a vernacular comfortable to veterans.
- Educate and train VSOs on “what a brain injury looks like.” Stakeholders could partner with VA medical facilities, universities, and/or medical organizations throughout the Commonwealth to develop educational materials and a half-day training session on TBI and secondary consequences of brain injuries.

CRIMINAL JUSTICE

- Partner with researchers to collect data on arrest rates among Pennsylvania veterans.
- Work with police departments and prosecutors’ offices to develop systems for early identification of veterans who encounter law enforcement.
- Train law enforcement on issues facing veterans, where to obtain resources for them, and how to access Veterans Treatment Courts (VTCs).
- Educate the judiciary in rural communities on VTCs.
- Engage research partners to empirically evaluate the value of VTCs and veterans wings in prisons.
- Expand existing resources for incarcerated veterans and their families.

- Expand training for incarcerated veterans and their families on disability compensation during times of incarceration, how to reassign incarcerated veterans' benefits to family members, and how to restore benefits after release from incarceration.
- Educate incarcerated veterans on how to petition for changes to their discharge status and arrange for education on benefits upon release from prison.

EDUCATION

- Coordinate with university and college registrars to flag veterans who are using the GI Bill and allow those veterans to sustain their registration, without penalty, when tuition payments are delayed due to circumstances beyond the veterans' control.
- Provide VSOs with periodic updates on developments in GI claims processing.
- Establish a GI Bill hotline for veteran/students, perhaps specific to Pennsylvania.
- Develop credit-granting programs within colleges and universities to provide veterans with academic credit for externships, on-the-job training, and credentialing they obtained in connection with their military occupational specialties (MOSs)
- Relatedly, establish standardized protocols for translating MOS certifications into civilian academic credits.
- Incorporate standardized lag times into payment processing by registrars and bursars offices within universities for students paying with GI benefits.
- Identify a GI Bill liaison within each college and university who would serve as the point of contact for all veterans in that institution.
- Encourage academic institutions to institute a veterans coffee hour or "happy hour" with discounted soft drink and coffee prices at a predetermined location on a weekly basis.

- Encourage VSOs to attend weekly student coffee hours.
- Identify faculty members within each academic community who are veterans to serve as informal advisers or points of contact for student veterans and/or require VSOs to visit college campuses periodically to share information.

EMPLOYMENT

- Expand on existing matrices and crosswalks to translate military occupational specialties (MOSs) to civilian job descriptions. Include the letter and number rank designation next to the title for that rank (based on branch of service), followed by a column that lists the civil service job title equivalent and another column that lists traditional definitions for that job. For example, an E-5, Sergeant or Petty Officer First Class, would be described as an upper-level enlisted rank with supervisory responsibilities for X number of subordinates.
- Create and distribute a list of MOSs and provide sample, equivalent civilian job descriptions for veterans to use on their resumes and employers to use as they review applicants. Also provide these lists to VSOs and local-level employment services to provide to veterans as they create resumes and complete job applications.
- Explore means of improving awareness among employers about the professional experiences veterans gain during their military service and how those experiences translate into civilian professions. For example, civilians often do not understand that an ordnanceman has safety, security, and inventory experience.
- Expand transportation options and encourage local bus and shuttle lines to add bus stops at or near veteran service offices and VA facilities.

- Catalog the modes of transportation available to county residents, including veterans. In light of the significant communication issues identified above, it is possible that transportation infrastructure exists in some areas, but is not being promoted among veterans.
- Work with existing employment infrastructure to incorporate veteran-specific services within the state's workforce development organizations.
- Investigate the allegations about veterans' preferences described in this Report.

HEALTH CARE

- Increase transportation through IVSOs.
- Include more volunteer drivers and work with IVSOs to identify volunteers within communities.
- Improve handicapped-accessible transportation.
- Offer free parking "like they do at Walter Reed."
- Increase availability and awareness of Disabled American Veteran vans.
- Increase awareness of available transportation services in general, and post lists of transportation services at all medical facilities, in libraries, and at local coffee hours.
- Analyze why My HealthVet and telemedicine are popular among younger veterans and apply lessons learned to development of The Website and other forms of health delivery.
- Consult with marketing experts to heighten awareness about Veterans' Homes.
- Consider on-call private driver services, such as Uber and Lyft, and consider how such entities could become transportation partners, particularly in more urban areas where these services currently operate.

HOUSING AND HOMELESSNESS

- Improve transportation services to and from temporary housing facilities.
- Promote awareness of available housing funds and housing programs.
- Identify potential partnerships with faith-based and non-profit organizations to provide shelter and emergency services at the local level.

SUBPOPULATIONS

- Education. Education. Education.
- Determine the best means of disavowing VSOs of the “one size fits all” preconception about veteran subpopulations.
- Work with academic partners to develop research briefs on subpopulations. Consider developing partnerships with top-level schools, such as the Army War College, whereby masters-level officer/students can provide research briefs on subpopulation issues as part of their thesis work.

VSO TRAINING

- Develop uniform training protocols for all VSOs, regardless of affiliation.
- Promote professional cohesiveness with team-building and culture-building activities.
For example, sponsor an annual VSO conference or retreat.
- Develop a VSO information website, linked to The Website, with discussion forums and Q&A options to promote information sharing among VSOs.
- Develop standardized performance measures to better assess the performance of all VSOs and consider how to mitigate the alleged “claim-stealing” issue by assessing VSOs on quality of service delivery, not number of claims processed.

- Offer hands-on training on filing claims, perhaps using mock cases, real time, in an online and/or webinar environment.
- Provide tablet computers and Internet access to improve VSO mobility and facilitate online assistance with claims during in-person meetings with veterans.
- Implement quarterly, issue-specific, lunch-hour webinars.
- Consider whether VSOs should be certified and what benefits would be attached to certification in order to incentivize VSOs.
- Offer quarterly webinars for VSOs.
- Send letters to all separating military personnel to inform them of the location of their County VA Office and the identities of local VSOs.

BEHAVIORAL HEALTH

The behavioral health implications of military service reach across all veteran subpopulations and present challenges to health and legal professionals who assist veterans with reintegration following military service (Tanielian & Jaycox, 2008). Depending on which study one reads, approximately 14% to 23% of returning troops display one or more signs of mental health distress (Hoge *et al.*, 2004; Kuehn, 2009; Pew, 2013). Multiple studies indicate that many veterans are at risk of engaging in aggressive, high-risk behaviors, particularly in the weeks and months following deployments (Kilgore *et al.*, 2008; Jacupcak *et al.*, 2007). A subset of veterans who have behavioral issues also suffer from PTSD and/or TBI. All of these conditions often co-occur with depression, anxiety, aggression, suicide, substance abuse, unemployment, domestic violence, and antisocial behavior (Green *et al.*, 2003; Seal *et al.*, 2007; Tuerk *et al.*, 2010). Behavioral health remediation cuts across all of the areas of need contained in this Report and should be considered in relation to all other efforts undertaken by the Commonwealth as it works to improve veterans' services.

Background

To develop background data for the purposes of this Study, the Research Team reviewed veterans and VSO needs assessments from California, Connecticut, New York, Rhode Island, North Carolina, and Virginia. Three themes concerning behavioral health issues emerged as common among these studies; they are outlined below:

(1) There are perceptions that certain behavioral health professionals overprescribe pharmacological interventions. For example, participants in a Connecticut veterans focus group reported, "there are too many meds and not enough therapy" and "they want to medicate you, but you want to talk" (Southwick *et al.*, 2008, p. 6). Compounding the problem, many veterans,

particularly younger veterans, do not trust the efficacy of pharmacological interventions. Forty-five percent of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans in one study were concerned about negative side effects from drugs therapies, and about one-quarter of those veterans did not think that mental health care was effective (Tanielian & Jaycox, 2008).

(2) There are also perceptions that certain behavioral health professionals do not have the time or the skills necessary to promote non-pharmacological interventions among veterans, such as individual therapy, cognitive behavioral therapy, group therapy, or reconditioning therapy. Studies in both Virginia and North Carolina noted that community collaborations are important for improving the quality of behavioral care (Dunkenberger et al., 2010; Morris, 2012). Some researchers recommended a community-based continuum of mental health care that stressed indigenous community support systems. In Connecticut, this multi-staged approach included state colleges and universities and a Military Support Program 24/7 toll-free number (Southwick et al., 2008). Another study found that peer-to-peer support groups would enhance existing services (Dunkenberger et al., 2010).

(3) Behavioral health remains a significant source of perceived stigmatization and embarrassment for certain veterans (Dunkenberger et al., 2010; Morris, 2012; Schell & Tanielian, 2011; Southwick et al., 2008). Many OEF and OIF veterans hold negative beliefs about mental health care and psychotherapy (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009), and many veterans are concerned about medical confidentiality issues. They fear that if they seek treatment, their chain-of-command or future employers will be critical of any record of behavioral health treatment (Stecker, Fortney, Hamilton, & Ajzen, 2007; Tanielian & Jaycox,

2008). A recent study of U.S. Army Combat Medics noted similar concerns (Elnitsky *et al.*, 2013).

Veterans also fear more generalized stigmatization. They fear that they will be perceived as “weak” or “crazy,” which presents a significant barrier to seeking assistance for mental health issues (Mittal *et al.*, 2013; Pietrzak *et al.*, 2009; Stecker *et al.*, 2007). As one focus group participant in the Mittal study explained, “I was scared of the hospitals. I didn’t know what they were going to tell me, you know. Somebody thinks you’re crazy, and they call you crazy. You’re going to end up in a crazy house, right. That’s the last thing I wanted to do” (Mittal *et al.*, 2013, p.90).

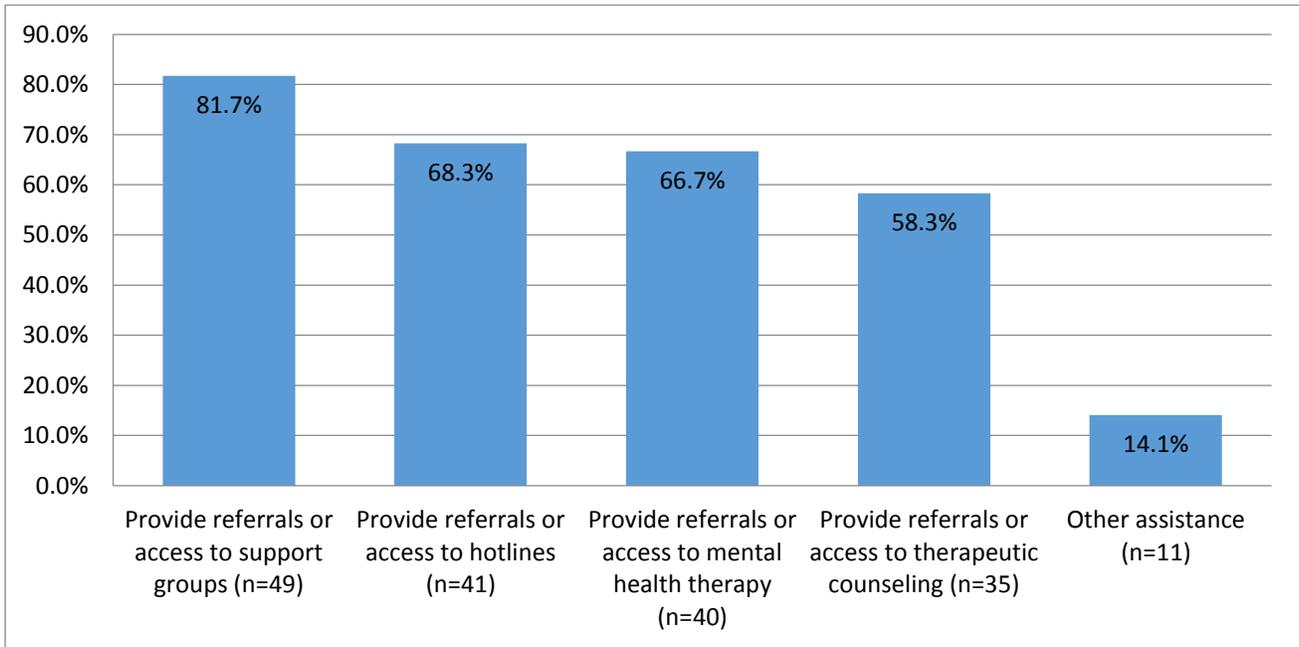
Findings: General

The scope of this Study did not allow for conclusions about state-wide remedies to complex problems of access to behavioral health care. However, it can be concluded from these data that behavioral health remains a pressing concern for Pennsylvania veterans and the VSOs who assist them. Moreover, it can be concluded that, while there is an awareness of the need to improve services, there are deficits of information and resources among these same groups. Finally, the Research Team identified some low-tech interventions that can be promoted throughout the Commonwealth, including weekly coffee hours for veterans.

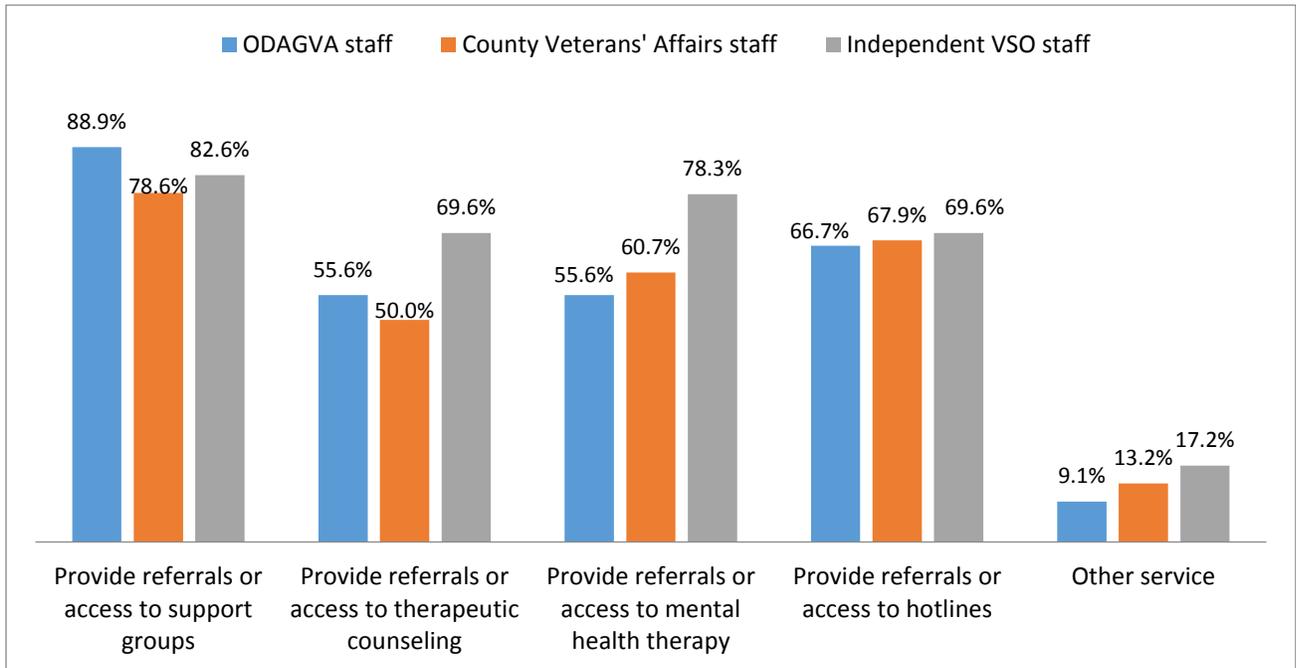
VSOs and Behavioral Health for Veterans

The majority of VSOs reported that they had assisted veterans with “mental health needs” (84.5%; $n = 60$). The following figure outlines the types of behavioral assistance provided by VSOs.

Figure 1. Behavioral Health Assistance Provided by VSOs



ODAGVA VSOs were most likely to report providing referrals or access to support groups for veterans with mental health needs (88.9%; $n = 8$). IVSOs were most likely to provide referrals or access to the following: Support groups (82.6%; $n = 20$), mental health therapy (78.3%; $n = 18$), therapeutic counseling (69.6%; $n = 16$), and hotlines (69.6%; $n = 16$).

Figure 2. Behavioral Health Assistance Provided by VSO Organizational Affiliation**Findings: PTSD**

One-quarter of younger veterans reported that they had received some form of PTSD diagnosis ($n = 99$), and an additional 17% reported that they believed they had experienced PTSD. In contrast, only five percent ($n = 14$) of older veterans had received some form of PTSD diagnosis, and an additional five percent ($n = 14$) perceived that they had experienced PTSD related to their time of military service. Almost all VSOs perceived that the number of veterans suffering from PTSD or mental health conditions far exceeds the numbers who seek assistance or treatment. Many VSOs reported that veterans often say things such as “I’m not crazy, I just get nervous” (or something similar), which many VSOs interpreted as indicative of PTSD.

Veterans and VSOs concurred that ever-higher survival rates, combined with unprecedented operational and personnel tempo rates, means that more service members are returning from longer deployment periods with more serious physical and psychological injuries than ever before.

According to the web survey of VSOs, there appeared to be robust coordination occurring among VSOs, with as many as 82% referring veterans for PTSD support groups; 67% referring for other, specific therapies and hotlines; and 58% referring to counseling.

Based on their experiences interacting with veterans, the VSOs reported that veterans often do not seek PTSD assistance because veterans do not perceive that they have a problem, they fear stigmatization or complications with their jobs, and they do not know where to go for the type of treatment they need. VSOs explained that these veterans do not seek treatment because they believe that treatment is reserved for “mentally ill” people. Many of the veterans were not aware of the gradations of mental health issues, community-based support groups for “nerves,” and relatively short-term programming that is available.

Younger veterans shared strong opinions on how to improve VA services for PTSD, and several recently separated veterans described negative experiences with traditional mental health services. One participant who sought inpatient treatment for PTSD at a VA hospital stated that it, “Felt like [I was] in a prison. [There were] no services to help.” Another veteran described an interaction at a Pennsylvania facility:

“The doctor trivializes things.
He said ‘we’ve all been through some shit.’
I told him to get out of the room.”

This same veteran described receiving alternative therapies at the National Intrepid Center of Excellence in Bethesda, Maryland, and said, “Rather than just eating pills until my liver fails – there is an alternative.” Other veterans also said that VA hospitals “just gave out pills like candy” rather than provide other therapeutic options. However, one veteran shared that he used the Military One Source website to connect with counselors and psychiatrists for free

services. Lastly, Vietnam veterans in one group described providing regular “stand downs” for veterans so that they have a place to go to decompress, rest, and recuperate.

Pennsylvania veterans specifically referenced the stigmatization of PTSD in relation to employment and gun ownership. As one younger veteran said, seeking therapy, “Could cause problems with getting jobs or firearms down the road.” He said the VA attitude is, “That they tell you [to] get help, but we’re going to punish you for getting the help” and he cautioned others in his focus group that they, “Need to be careful on what you claim.” Another veteran seized on what many VSOs explained – language and clinical descriptors matter to veterans and those who treat them. This young man described the stigma attached to the actual language used to describe this mental health condition by explaining, “D is disorder – something is wrong with you. PTS wouldn’t carry as much of a stigma. Adding the disorder is ‘there is something wrong with you’.”

Findings: TBI

Just over two percent of younger veterans had been diagnosed with a traumatic brain injury (TBI) in relation to their military service. Of those not diagnosed, 9.3% ($n = 10$) felt they had experienced a brain injury during military service. One older veteran indicated that he had been diagnosed with TBI. Among older veterans who were not diagnosed with TBI, 2.8% ($n = 8$) felt that they had experienced a brain injury during their time of military service. Neither the veterans nor the VSOs in this study offered insights into TBI treatment, therapies, or programming.

Although most VSOs framed their behavioral health recommendations in general terms, a few made suggestions specific to TBI. Citing a Texas program through the Texas Office of Acquired Brain Injury and the Texas Traumatic Brain Injury Advisory Council (Palladino,

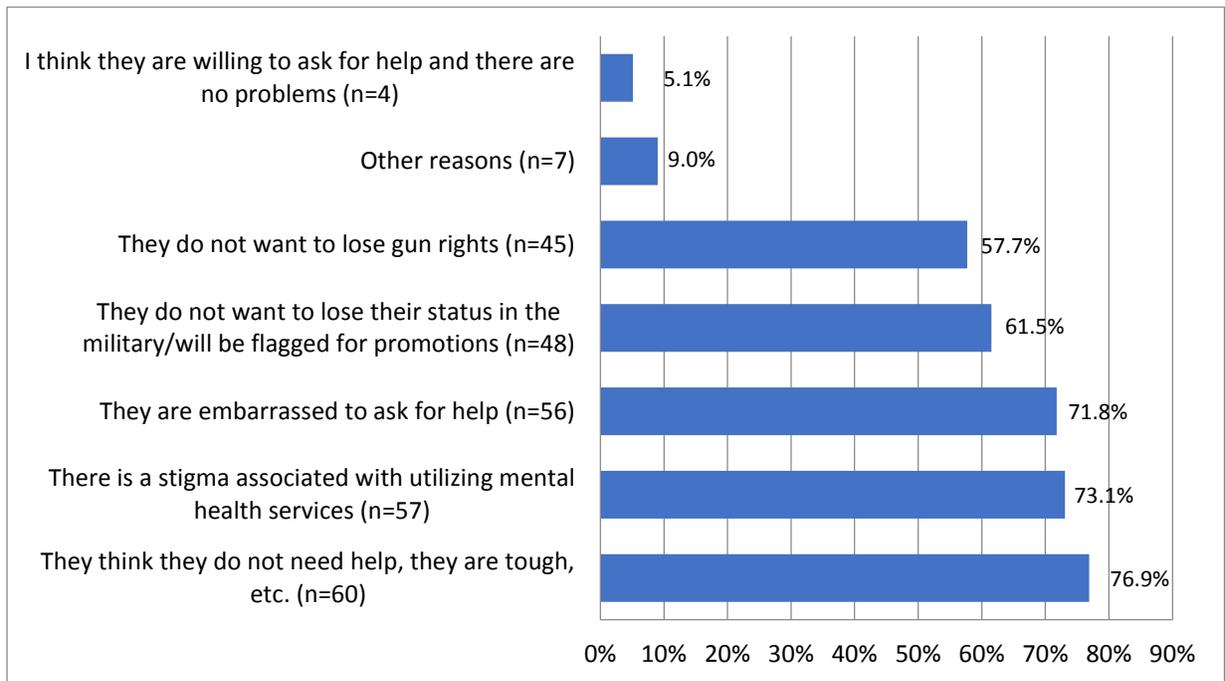
2012), VSOs recommended education and training for state and local agencies on veterans dealing with brain injuries and allocation of additional state resources to issues related to brain injuries.

Findings: Substance Abuse

There were very little data specific to substance abuse in this Study. Many of the veterans and VSOs included substance abuse in their more generalized responses concerning behavioral health. Six percent of veterans in this study had sought drug or alcohol counseling since separating from the military. Almost two-thirds of VSOs referred veterans to drug and alcohol counseling (65.8%; $n = 48$). ODAGVA VSOs were most likely to make drug and alcohol referrals and IVSOs were least likely to make these referrals (72.7%; $n = 8$ versus 64.3%; $n = 18$). Almost two-thirds of CVSOs referred to drug and alcohol counseling (64.7%; $n = 22$).

Findings: VSOs' Perspectives on Reasons Veterans Do Not Seek Treatment

VSOs' observations aligned with the veterans' comments. In a section of the survey that requested optional feedback, VSOs reported a variety of reasons why veterans in their region do not seek behavioral health assistance, including: Veterans think they are "tough" and do not need help (76.9%; $n = 60$); stigma (73.1%; $n = 57$); embarrassment (71.8%; $n = 56$); reluctance to deal with the past or with doctors ($n = 2$); and lack of knowledge of available services ($n = 1$).

Figure 3. Reasons Veterans May Not Seek Behavioral Health Assistance

Findings: VSOs' Suggestions for Improving Access and Utilization of Behavioral Health Services

VSOs universally said that the best approach for dealing with mental health issues is to “eliminate the stigma of seeking treatment.” They shared approaches that have worked in their communities and among their colleagues. Several try to manage stigma by calling programs “transitional programming” to deal with “mental health issues without actually calling them mental health issues.” Others tutor veterans on what to expect in the civilian world rather than how to act or think – counseling that is externally focused. Both of these local-level efforts could be extrapolated to statewide practice.

With respect to drug and alcohol counseling, VSOs said that they needed to improve their abilities to refer veterans to appropriate places for assistance (*e.g.*, VA clinics or medical centers, outside agencies) (26.7%; $n = 8$); to access local resources (13.3%; $n = 4$); and to provide better information on drug and alcohol treatment services (10.0%; $n = 3$).

Please see Volumes III: Focus Groups of Veteran Service Organizations and IV: Administrative Web Survey of Veteran Service Organization Administrators for all suggestions offered by VSOs.

Recommendations

Based on the foregoing, the Research Team makes the following recommendations.

Comments in quotations marks are drawn from statements made by veterans in this Study:

- Fellowship, a sense of “belonging” and a sense of being among people who “get it,” are critical to veterans’ overall health, including their behavioral health. Stakeholders should develop partnerships with local-level community service organizations, independent veteran service organizations, colleges, places of worship, community and non-profit recreation centers such as the YMCA, libraries, and local restaurants to initiate veteran-centric events
- Cost-free weekly, standing coffee hours or social hours. Examples include “Military Monday” or “Reverie,” a morning coffee hour at a local diner with a designated “veterans corner.” Serve free coffee and donuts sponsored by a local donor(s) or solicit the location to provide discounts to veterans. Situate these drop-ins close to the entrance of the establishment so veterans do not have to hunt for the location or traverse the establishment to join. Make them weekly, and designate a VSO or volunteer to attend each week (perhaps rotating responsibility for attending among several volunteers). Even if attendance is low, the existence of the event fosters a sense of community support among veterans and promotes the sense that there “are others out there who care.”
- Consider weekly or monthly events in the evening, such as “Taps,” at a local pub, and provide free soft drinks. Model these events on the coffee hours described above.

- Work with local veteran organizations to create and promote drop-in support groups (but do not call them support groups), on an established basis so that veterans can count on those events recurring, regardless of whether they attend once, sporadically, or regularly. Again, knowing that these events are occurring in the community has value independent of what occurs during these meetings. For example, host a weekly meeting in the local library called “Veterans Swapping Stories.”
- Consult with marketing experts to consider how best to name services. For example, Alcoholics Anonymous has a distinct brand. Consideration needs to be given to how to identify veteran-oriented programming.
- Educate and train VSOs on “what a brain injury looks like.” Stakeholders could partner with VA medical facilities, universities, and/or medical organizations throughout the Commonwealth to develop educational materials and a half-day training session on TBI and secondary consequences of brain injuries.

CLAIMS and BENEFITS

Introduction

Veterans are entitled to myriad benefits (direct or indirect financial or asset assistance) and services (direct or indirect non-financial assistance). For purposes of this Report, the term “benefits” is used to describe generally all benefits and services available to veterans from local, state, and federal resources. Veterans in this Study reported substantial frustrations with accessing benefits. Among the veterans who used local and state resources, there did not appear to be a problem with availability. Instead, it appeared that many Pennsylvania veterans were not aware of a host of local and state benefits that are available to them, and they had trouble with logistics surrounding access.

Stories abound from the Battle of Gettysburg through the present about veterans being unaware of the benefits that they should be receiving and are unable to obtain prostheses, pain management, or long term care (Blanck & Song, 2003; Ford, 2013; Phillips, 2014). But the enduring universality of the problem does not mitigate the pressing need for the Commonwealth to respond more rapidly, more readily, and more thoroughly to veterans’ claims processing needs. The hurdles to effective claims processing should be analyzed in three stages: (1) claim initiation (making veterans aware of their rights and encouraging them to seek benefits through better information flow); (2) claim maintenance (assisting veterans with the filing and processing of claims); and (3) claim dispute (disagreeing informally with a claims’ officer finding through formal appellate process). The following analysis describes challenges at each of these stages, makes observations about the current status of these issues within Pennsylvania, and offers insights into potential responses to these issues.

Awareness and Information Flow

Background

This Study and its predecessor research establish that veterans need more information on benefits, eligibility requirements, application procedures, and appeals procedures. For example, one-third of veterans in the California Veterans Needs Assessment Survey reported that knowing more information about veteran benefits was critical (California Department of Veterans Affairs, 2011). Further, this same survey also found that younger veterans (those under 30) were one of the least knowledgeable groups of veterans regarding benefits (California Department of Veterans Affairs, 2011). While 80% of all California veterans reported their knowledge of benefits as average or better, the survey showed that younger veterans were less likely to know how to file a benefit claim or where to go to receive assistance with their claims (California Department of Veterans Affairs, 2011).

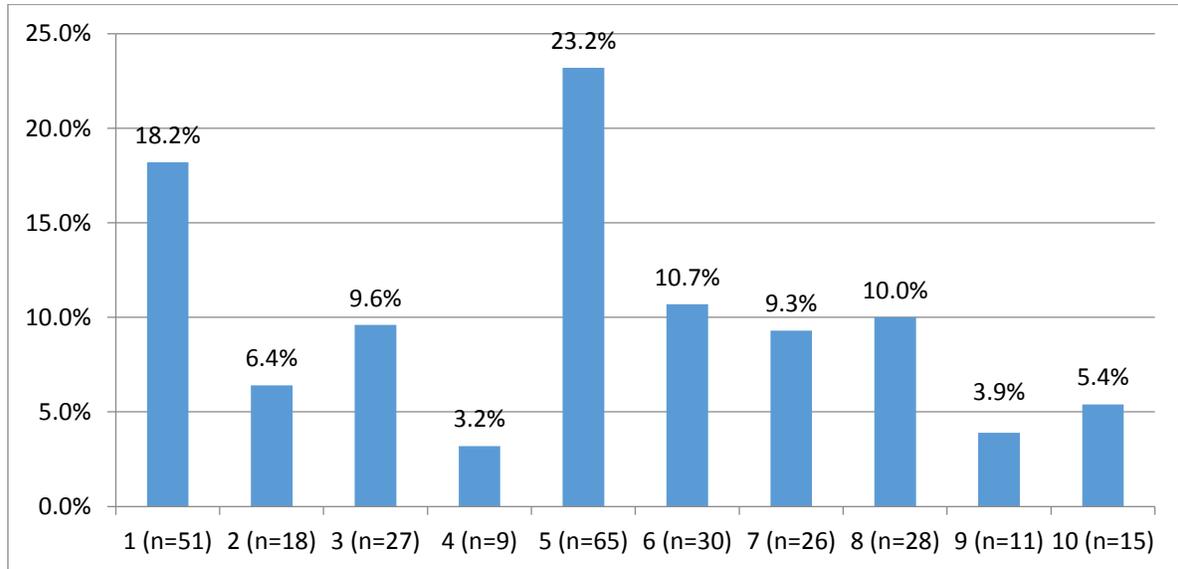
Similarly, a 2011 Rhode Island needs assessment of veterans found that misinformation about services offered by the VA and questions about eligibility were top reasons why veterans did not use services (Dan Cahill and Associates, 2011). Veterans in North Carolina also reported that navigating the complex network of veteran benefits was a major challenge (Morris, 2012). Finally, focus groups of veterans and veteran service providers in Virginia found that outreach using many modes of communication, with comprehensive information on benefits and services, was a critical need (Dunkenberger *et al.*, 2010).

Findings: General

In this Study, participants expressed that lack of information is a major reason why many veterans do not seek services or benefits. Pennsylvania VSOs consistently reported that lack of awareness and lack of initiative on the part of the veterans is a pernicious problem. Several common themes emerged concerning the manner in which veterans receive information about benefits. These data should be used to develop more comprehensive outreach programming.

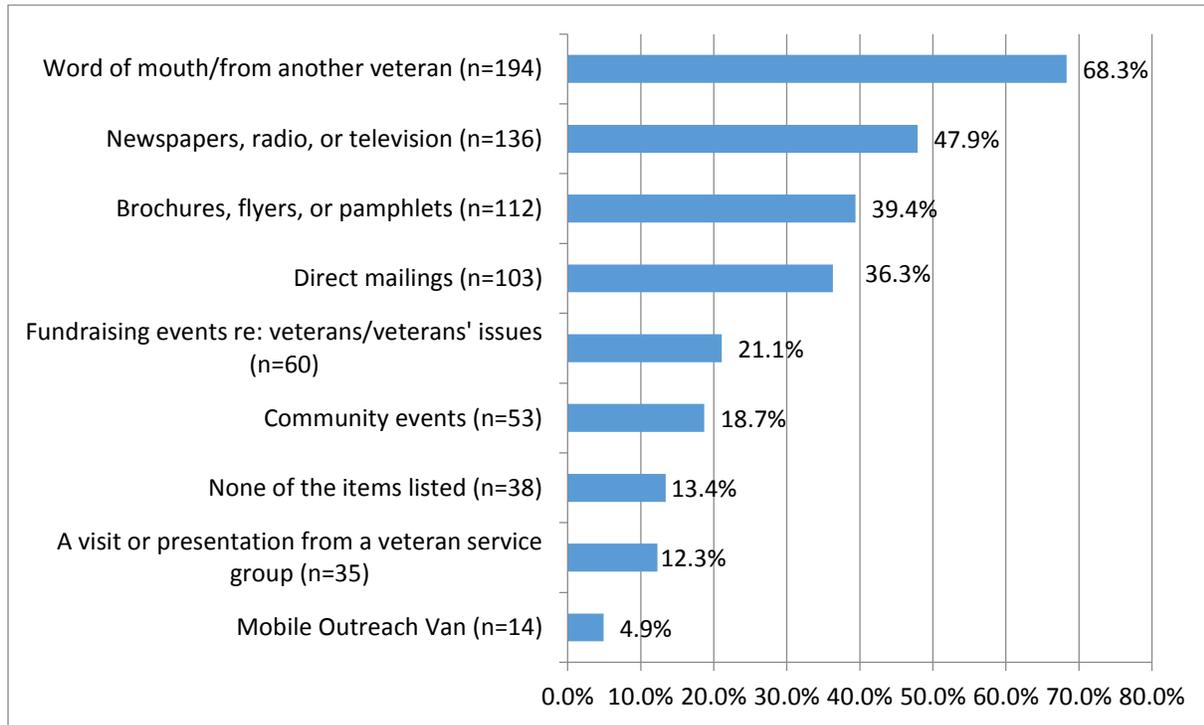
Pennsylvania veterans as a whole perceived themselves to be informed, but not well-informed, about available benefits. On a scale of one to ten, more than half of younger veterans reported that they were “knowledgeable” about veterans’ benefits, with a mean score of 6.07. Older veterans were less confident in their knowledge level, reporting a mean score of 4.87. More than a quarter of older veterans described themselves as “extremely” lacking in knowledge of what benefits are available to them. Nearly two-thirds of all veterans (62.7%; $n = 178$) indicated that they know how to get information about veterans’ benefits that they may be eligible to receive based on their military service. However, this means that more than one-third of the veterans surveyed were unaware of how to get this information (37.3%; $n = 106$).

These data are useful only to speak to whether veterans perceive themselves as knowledgeable of benefits, which suggests a subjective level of comfort rather than an objective measure of actual information-uptake. These data are encouraging to the extent that they indicate that more than half of veterans feel confident in their level of knowledge of benefits available to them. Unfortunately, it is not known whether this level of comfort is justified by the actual uptake of information among these veterans.

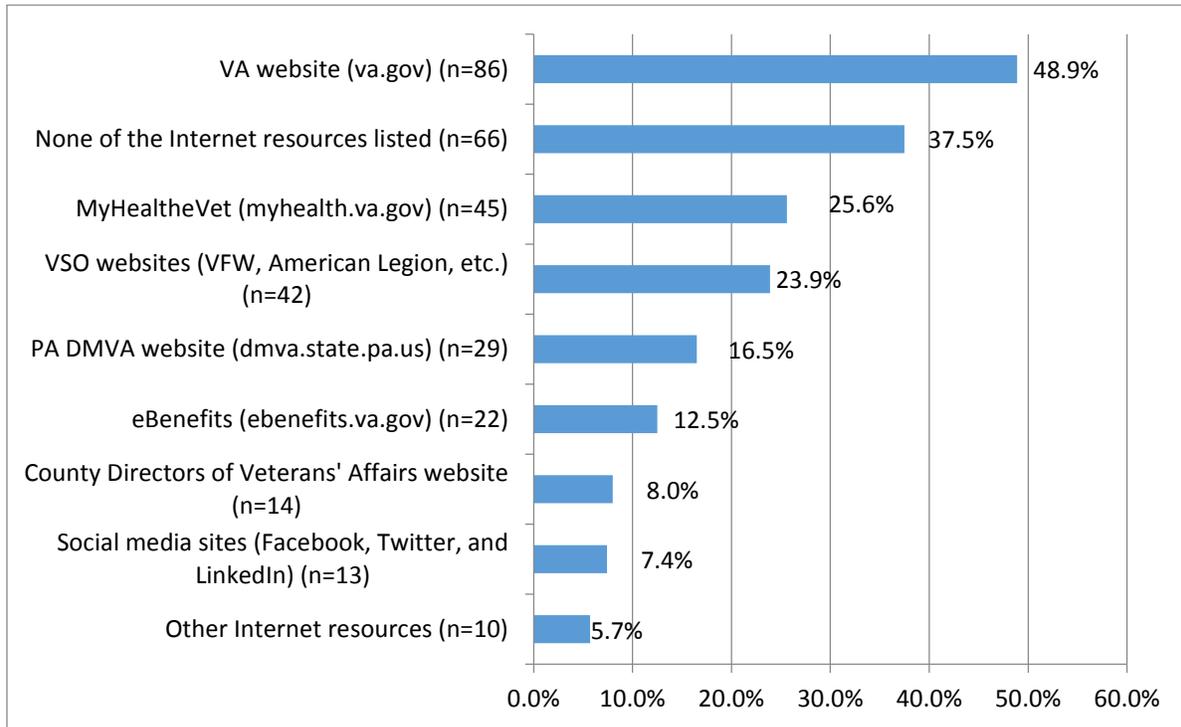
Findings: Older Veterans**Figure 4. Older Veterans' Rating of Knowledge of Benefits**

Veterans in Pennsylvania received information on benefits in a variety of ways, most often by word-of-mouth. For example, older veterans obtained benefits information most commonly from word-of-mouth from another veteran (68.3%; $n = 194$). The next-most common resources utilized by older veterans were newspapers, radio, or television (47.9%; $n = 136$), and then brochures, flyers, or pamphlets (39.4%; $n = 112$).

Figure 5. Older Veterans: In-Person/Media Resources Used to Learn About Benefits



Over one-third of older veterans did not use the Internet (38.2%; $n = 109$). Among those who worked online, they most frequently cited the VA website (www.va.gov) (48.9%; $n = 86$). The following figure displays all of the Internet resources utilized by older veterans.

Figure 6. Older Veterans: Internet Resources Used to Learn About Benefits

Older veterans also received information from government representatives, VA hospitals and clinics, college counseling offices, and veteran service organizations.

Findings: Younger Veterans

Younger veterans similarly reported that they most commonly received information on benefits through word-of-mouth. However, their Internet usage was, not surprisingly, much higher than that of older veterans. Only one young respondent reported that he did not use the Internet to obtain benefits information. Moreover, the overwhelming majority of younger veterans expressed a desire to have more electronic and social media resources.

Table 1. Younger Veterans: In-Person/Media Resources Used to Learn About Benefits

Resources	Number	Percent
Word of mouth/from another veteran	110	80.9%
Brochures, flyers, or pamphlets	47	34.6%
A visit or presentation from a veteran service group	39	28.7%
Direct mailings	31	22.8%
Newspapers, radio, or television	23	16.9%
Community events	19	14.0%
Fundraising events targeted towards veterans/veteran's issues	10	7.4%
Mobile Outreach Van	8	5.9%

Table 2. Younger Veterans: Internet Resources Used to Learn About Benefits

Internet Resources	Number	Percent
VA website (va.gov)	98	72.1%
eBenefits (ebenefits.va.gov)	55	40.4%
MyHealtheVet (myhealth.va.gov)	53	39.0%
Veteran service organization websites (VFW, American Legion, etc.)	42	30.9%
PA Department of Military & Veterans Affairs website (dmva.state.pa.us)	28	20.6%
Social media sites such as: Facebook, Twitter, and LinkedIn	22	16.2%
County Directors of Veterans Affairs website	16	11.8%

Several younger veterans accessed resources through colleges and universities, including: VA certifying officials, recruiters, human resources/student advisors, and student veterans clubs. Other veterans mentioned resources such as smaller veteran support groups, mortgage lenders, realtors, or their state representatives.

VSOs and Access to Benefits

Pennsylvania VSOs perceived that many veterans were not self-advocating. VSOs in this Study reported a “taking a horse to water” problem whereby they make the information available as best they can, but veterans do not help themselves or proactively seek information. The VSOs also cited lack of information as a primary reason that veterans do not take advantage of certain

benefits. The following provides details on several programs that the Research Team discussed specifically with veterans and VSOs.

The Burial, State and Local Benefits Example

Many Pennsylvania veterans were not aware of certain federal, state and local benefits outside of the health care system. Generally, older veterans were unaware of state and local benefits programs. The most well-known program was the VA cemetery burial (53.1%, $n = 152$ for older veterans; and 61.6%, $n = 77$ for younger veterans), but just over a quarter of veterans are familiar with county burial benefits (18.5%, $n = 53$ for older veterans; and 29.3%, $n = 36$ for younger veterans). This was followed by the Pennsylvania Department of Education's educational assistance programs (24.9%; $n = 71$) and county burial benefits (18.5%; $n = 53$). The programs with the least awareness were the DMVA Educational Gratuity Program (5.9%; $n = 17$) and the DMVA Blinded Veterans Pension Program (5.6%; $n = 16$). The following tables display the number and percent of older and younger veterans (respectively) who were aware of the state and local benefits listed in the survey.

Table 3. Older Veterans: Awareness of Burial, State and Local Benefits

Program	Number	Percent
VA cemetery burial	152	53.1%
PA Department of Education's educational assistance programs	71	24.9%
County burial benefits	53	18.5%
DMVA Paralyzed Veterans Pension Program	33	11.5%
DMVA Emergency Assistance Program	32	11.2%
VA special adaptive vehicle equipment grant (must have a qualifying injury)	31	10.9%
DMVA Military Family Relief Assistance Program (MFRAP)	26	9.1%
DMVA Persian Gulf War Bonus Program	25	8.7%
DMVA Real Estate Tax Exemption Program	22	7.7%
VA vehicle purchase grant (must have a qualifying injury)	22	7.7%
VA special clothing allowance (must have a qualifying injury)	20	7.0%
Personal Financial Planning and Financial Management	20	7.0%
DMVA Educational Gratuity Program	17	5.9%
DMVA Blinded Veterans Pension Program	16	5.6%

Table 4. Younger Veterans: Awareness of Burial, State and Local Benefits

Program	Number	Percent
VA cemetery burial	77	61.6%
PA Department of Education's educational assistance programs	45	36.9%
County burial benefits	36	29.3%
DMVA Real Estate Tax Exemption Program	31	25.4%
DMVA Military Family Relief Assistance Program (MFRAP)	29	24.2%
DMVA Persian Gulf War Bonus Program	28	23.7%
DMVA Blinded Veterans Pension Program	25	20.8%
DMVA Paralyzed Veterans Pension Program	24	20.0%
DMVA Emergency Assistance Program	23	19.2%
VA special adaptive vehicle equipment grant	22	19.3%
DMVA Educational Gratuity Program	20	16.7%
Personal Financial Planning and Financial Management	19	16.5%
VA vehicle purchase grant	17	15.2%
VA special clothing allowance	17	15.0%

Veteran Utilization of Benefits

Nearly three-quarters of veterans did not seek or claim benefits (70.5%; $n = 201$), and they described the reasons that they did not do so. Over one-half of veterans noted that they did not feel like they needed benefits or services (55.4%; $n = 107$). Further, over one-third of veterans surveyed did not think they were entitled to or eligible for benefits (34.7%; $n = 67$). Other reasons included being denied benefits in the past, denials due to income limits, and not wanting to lose other benefits. Language barriers and childcare issues were the least frequently cited (both 1.0%; $n = 2$).

The Transition Assistance Program (TAPs) Example

During TAPs, military personnel receive information on benefits, and veterans indicated that the content of the TAPs program was useful. The results of this study indicate that the “taking a horse to water” problems as interpreted by VSOs exists with respect to TAPs. A small portion of veterans in this study reported that they took advantage of TAPs when they separated from the military. It should be noted that there was a concern among some VSOs that National

Guard members and Reservists are not receiving information on services and benefits since they do not go through a TAP program. Only one-third of younger veterans and eight percent of older veterans reported that they participated in the TAPs program when they transitioned out of military service. This is not surprising, given the fact that the TAP program started in 1990, after many respondents had concluded their military service. Many declined to pursue TAPs opportunities when they re-entered civilian life because they were more focused on going home to family and friends. They perceived that they did not need the services “any time soon.” One VSO noted that younger veterans will “eventually realize they need us.”

On the other hand, some veterans wanted more from TAPs and suggested that it needs to be more responsive to the realities of the reintegration process. While veterans were satisfied with the material covered in TAPs, many felt overwhelmed by the amount of information covered in a short period of time. Veterans indicated that TAPs’ duration ranges from a few days to several weeks. For example, one younger veteran noted, “There is so much information when transitioning – you can’t remember it all. How can I recall all that?” Veterans also suggested that information should be introduced earlier when they are not preoccupied with thoughts of family, friends, and exiting the military. One participant summed it up by stating, “It’s like trying to share important information in the last five minutes of class – you are ready to go.” Additionally, several participants discussed that benefits-related information and contacts provided during the TAPs program were not relevant when they returned to their home state or needed services “down the road.” Therefore, they felt that it was important to have access to an up-to-date list of local contacts and resources for veterans no matter where they are located. Lastly, when asked how to improve the TAPs program, one veteran bluntly stated, “However

you do it, dumb it down.” He went on to say, “It’s a good program, but it needs to be stretched out longer.”

The data collected concerning awareness and the TAPs program are emblematic of problems with promoting awareness across all veteran populations and all benefit programs. Often, the lack of awareness arises from a confluence of events, as it does with TAPs, where the mode of communication is not sufficiently tailored to an overwhelmed and marginally receptive audience.

The Altruism Issue

VSO veterans explained that many veterans often are hesitant to seek benefits because they “feel that they are taking away from the next veteran.” This is especially true among older veterans. One VSO summarized this observation by saying, “They think there is only a certain amount of money available for all vets. But it’s an endless pit. They just don’t understand.”

Stigma

Fear is another barrier to veterans seeking services. Specifically, VSOs reported that some veterans believe that they will lose the legal right to carry a gun or suffer adverse consequences at work if they pursue mental health services. For many veterans, carrying a gun is a precondition of their employment in law enforcement, security services, or the National Guard. Therefore, regardless of the veracity of this fear, it is a real barrier to veterans seeking counseling and community support for PTSD, TBI, and other mental health issues.

Other

Finally, participants across all respondent groups noted several other miscellaneous reasons why veterans do not seek benefits. These included:

- Veterans have good benefits with their jobs and do not need veteran benefits.
- Vietnam veterans do not have a good opinion of the VA.
- Depression era veterans do not want handouts and are too embarrassed to file.
- Some veterans are just not interested in receiving benefits.

While most VSOs (89.3%; $n = 67$) explained veterans’ failures to pursue claims as a consequence of a lack of information, an overwhelming majority of VSOs reported that some veterans willfully do not pursue benefits or services available to them (97.4%; $n = 75$). The VSOs attribute that refusal to pursue benefits predominantly to veterans’ negative opinion of the VA (88.0%; $n = 66$). The following figures display the reasons why VSOs think veterans do not seek benefits. Veterans could select all of the reasons that applied.

Figure 7. Reasons Veterans Did Not Seek or Claim Benefits

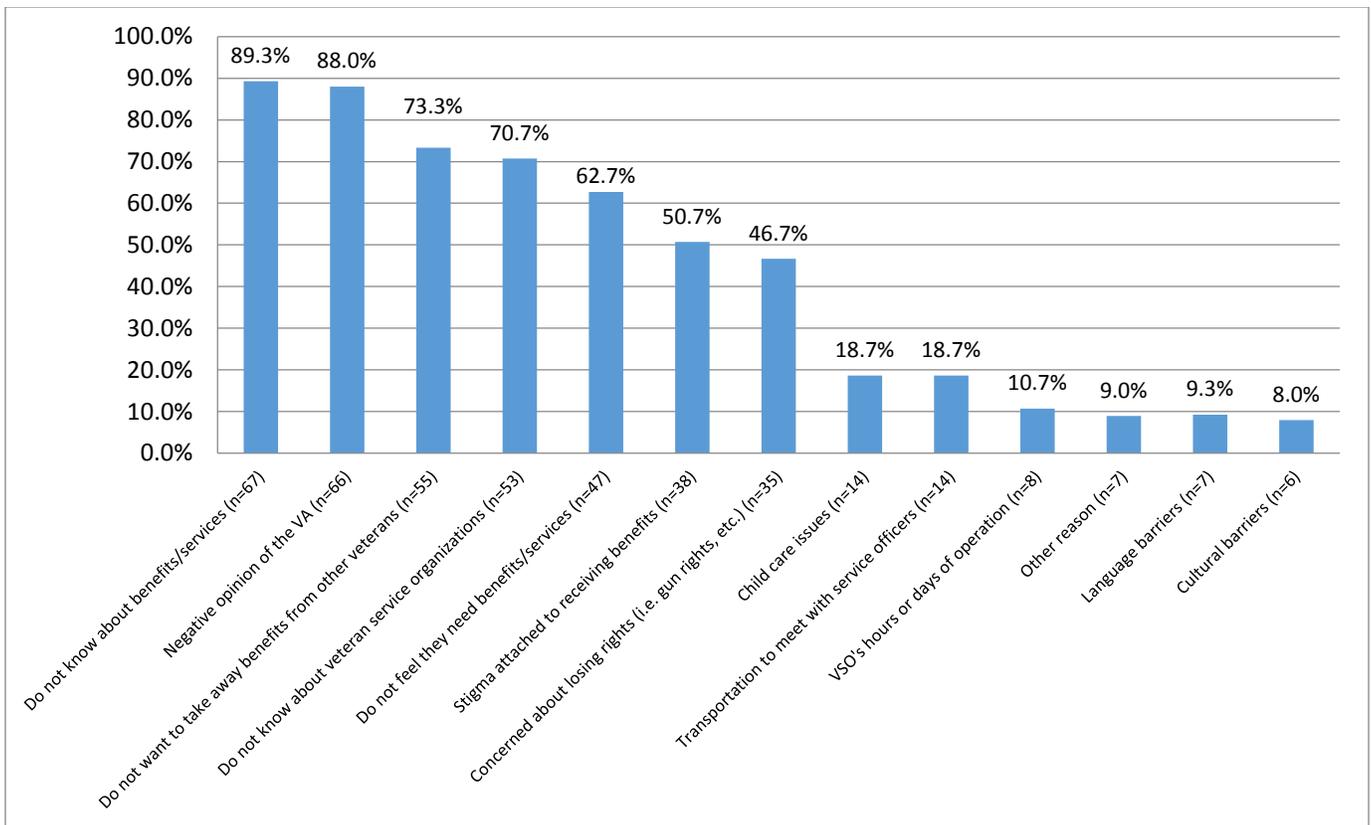


Figure 8. Reasons Younger Veterans Did Not Seek or Claim Benefits

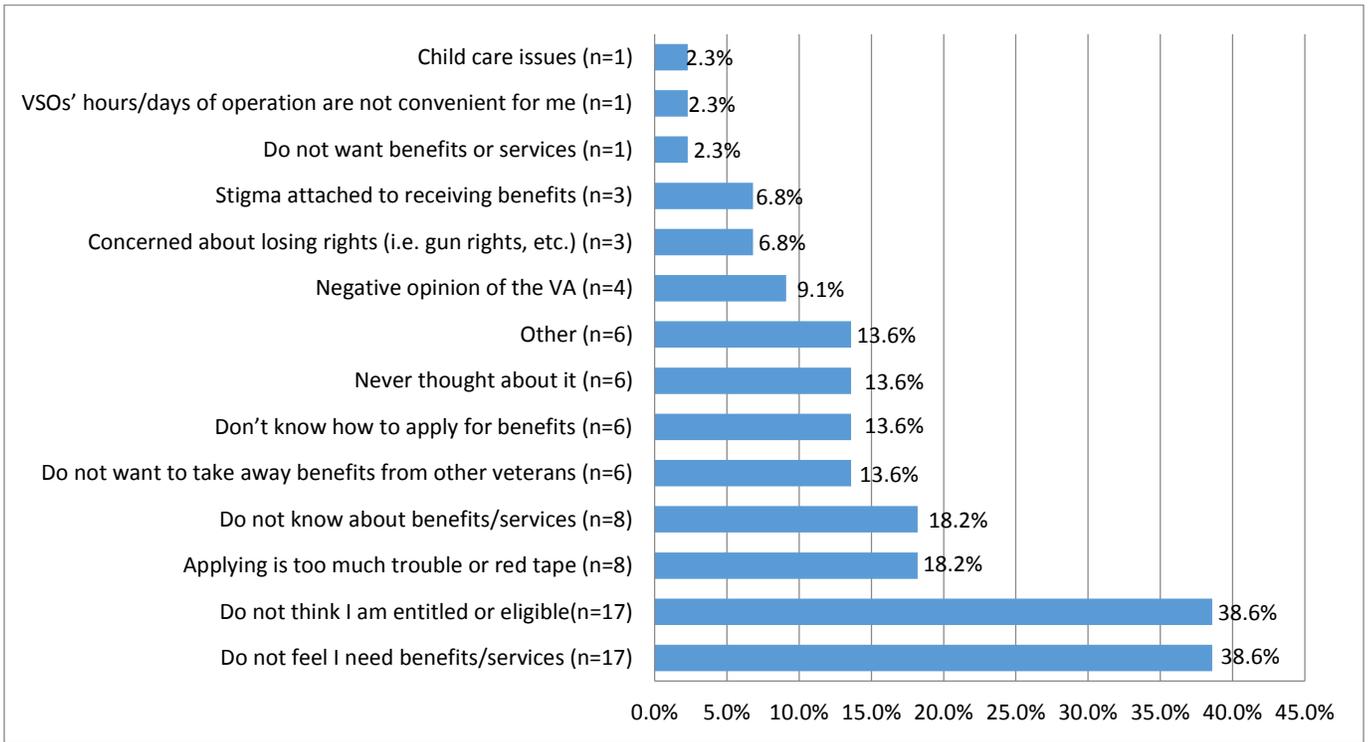
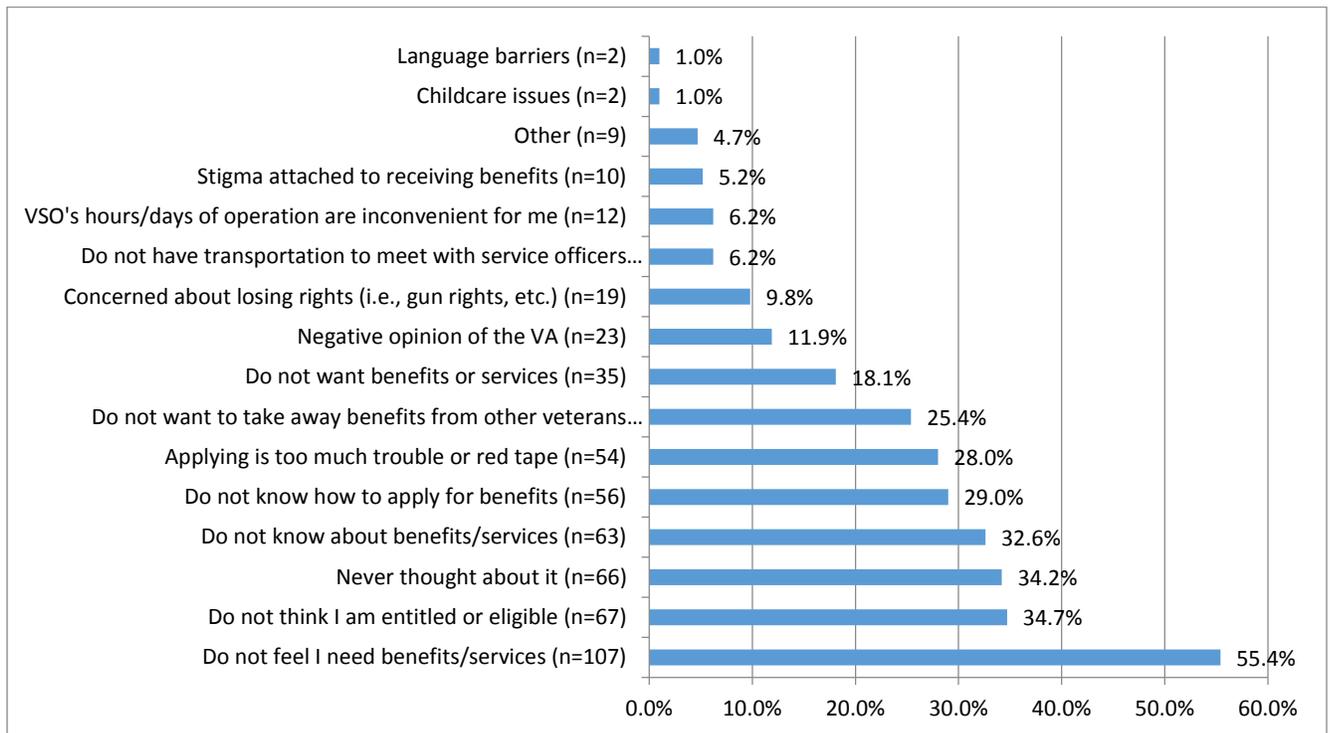


Figure 9. Reasons Older Veterans Did Not Seek or Claim Benefits



Findings: Access and Utilization

Word-of-mouth remains the prevailing conduit for information among Pennsylvania veterans. The veteran community revealed in this study is one that seeks to “take care of its own” and “have each other’s backs,” but effective policy cannot be crafted in reliance on the interpersonal networks, regardless of how robust the culture within the veteran community may be. Therefore, greater consideration needs to be given to developing methods of communicating the availability of benefits through means other than word-of-mouth. According to this study, paper resources, such as brochures, flyers, and pamphlets, are not highly effective in reaching veterans. Only 34% said that they receive information from these types of resources. Further analysis should be given to the cost per capita benefit of producing printed materials. Again, a strategic communications plan is appropriate for increasing awareness of benefits, and such plans should include new and developing means of communicating.

The majority of all veterans in this study relied upon Internet resources for information on veterans’ programs, services, and benefits. Electronic communication is critical to expanding Pennsylvania veterans’ knowledge and awareness. Nearly three-quarters (72%) of younger veterans and 49% of older veterans rely upon the VA website for information, but only 11.8% of younger veterans and 8% of older veterans accessed the County Directors’ web pages for information. Follow-up interviews revealed that the under-utilization of the County and DMVA websites can be attributed to poor website design and lack of awareness of the existence of these websites. A plurality of veterans use multiple websites to stay informed about benefits, including eBenefits (40% younger and 13% older); MyHealthVet (39% younger and 26% older); the DMVA website (21% younger and 17% older); and social media sites such as Facebook (16.2% younger and 7% older). Several veterans in follow-up interviews expressed frustration that

veterans' organizations do not use social media, such as Twitter or Facebook. Other veterans reported that they would appreciate access to automatic feeds, with several mentioning subscription email services as a favorable option.

Finally, veterans from Philadelphia County noted their frustration with not having a county VSO director. The Philadelphia Veterans Advisory Commission currently fills this role, although veterans did not feel that there was sufficient flow of information from this entity. In fact, several veterans identified themselves as members of an organization committed to getting "support at the municipal level" for veterans in Philadelphia.

VSOs provided a number of suggestions to encourage veterans to seek and claim benefits. The top three most-noted comments were: More direct outreach to veterans (21.7%; $n = 10$), better education of veterans about benefits (19.6%; $n = 9$), and mass media communication to veterans (19.6%; $n = 9$). Please see Volumes III: Focus Groups of Veteran Service Organizations and IV: Administrative Web Survey of Veteran Service Organization Administrators for a complete list of ideas offered by VSOs to encourage veterans to seek and claim benefits.

For context, findings from other states' needs assessments informed these observations, including the following information:

- The Ohio Department of Veterans Services created a liaison officer position with the purpose of connecting county veterans service offices to the regional VA office in Ohio in order to monitor claims and identify issues (Moe, 2012). The liaison officer is then able to work with County Veterans Service Officers (CVSOs) to help resolve these issues. In 2012, the CVSO Hot-Line was created to allow accredited County Veteran Service Officers in the state of Ohio to track benefit claims via telephone or via an online component; both of these programs have helped to expedite the claims of Ohio veterans

(Moe, 2012). Pennsylvania's DMVA has created a system similar to Ohio. County Directors of Veterans Affairs in Pennsylvania are able to monitor and track benefit claims with the Regional Field Offices in Philadelphia and Pittsburgh in order to help speed up claims processing for Pennsylvania veterans. VSOs should be trained more fully on how to access information from these databases.

- In Texas, a single source referral service was suggested since the state is so large and resources are dispersed (Palladino, 2012). Pennsylvania's OVA identified a single-source provider as an objective, but nothing has been instituted as of yet. As noted in subsequent sections of this Report, the Research Team regards single-sourcing or streamlining of information as a top priority identified by this Study.
- Some states use an outreach program to attempt to contact veterans who are "at-risk" through phone or mail shortly after their return home. Researchers noted that it is key to have accurate address information on veterans (Southwick *et al.*, 2008). Some preliminary efforts at coordinating this kind of project have been discussed in various forums, but Pennsylvania does not yet have this infrastructure in place.
- Some researchers suggest utilizing a number of channels of communication, including television, social media, texting, flyers, brochures, and posters, to reach veterans (Morris, 2012). Again, the OVA recognizes the need to improve its strategic communications, and efforts are being discussed among DMVA personnel. However, the approach among stakeholders continues to be piecemeal. While the price tag would be high, the Research Team believes that DMVA should hire external consultants with expertise in intergenerational communication and marketing to develop a user-friendly virtual one-stop-shop for accessing information on benefits.

Claim Maintenance

Background

Many veterans become overwhelmed and stymied when filing and processing claims for benefits. Veterans in this and prior research reported confusion about applying for benefits, trouble tracking claims, and lengthy periods of time needed to fulfill claims (Behney *et al.*, 2012; Defense Solutions LLC, 2006). One of the most frequent problems described in Penn State Harrisburg's 2011 study was a lack of ability for veterans to track claims after they had been initiated (Behney *et al.*, 2012). Furthermore, a 2006 study found that some of Pennsylvania's veterans believe there to be gross inconsistency in the claim approval process from region to region. Specifically, there was found to be a perception among some veterans that claim processing times were longer in Philadelphia than in Pittsburgh (Defense Solutions LLC, 2006).

Findings: Claim Maintenance

In this Study, nearly one-quarter of veterans had difficulty gathering evidence needed to file their claims (23.8%; $n = 19$), and one-fifth had difficulty obtaining an appointment at VA facilities (22.5%, $n = 18$). Others reported problems with long delays in processing of claims and difficulty connecting with a VSO to assist with claims. Many veterans who participated in focus groups expressed concerns about the timeliness of claims processing. Several described the filing process as "easy," but said the length of the claims process is unreasonable. For example, one veteran said his claim took two years to process, but that the VA "retro'd" the claim to the date of application. A veteran summarized his frustration with the process as follows: "You have no idea what someone is or is not doing with your claim. Some people may pass away while waiting for their benefits. What is their quality of life while they are waiting?" Another veteran suggested that backlogged claims should automatically be approved after one year because,

“They should be able to get you an answer within a year.” Another veteran said that the claims process is political and that veterans should take their claims to their member of Congress.

Findings: Assistance with Filing Claims

Almost two-thirds of veterans had filed a new claim for benefits or services (63.8%; $n = 83$). Half of these individuals filed the claim themselves (50.0%; $n = 39$). The others used formal assistance from a veteran service organization. Five individuals declined to report how they filed their most recent claim.

Older veterans sought assistance with filing claims from a variety of individuals and organizations. Over one-third (36.8%; $n = 50$) sought assistance from a CVSO, while just under one-third (31.6%; $n = 43$) reported that they had sought assistance from an IVSO. Several veterans did not obtain any assistance (16.9%; $n = 23$). Of those who indicated that they would seek assistance from “someone else,” almost half (45.5%; $n = 5$) identified a VA representative or hospital; while others identified the Internet or representatives at their college or university (both 18.2%; $n = 2$); or a family member or community organization (both 9.1%; $n = 1$).

Over one-third of younger veterans had never filed a claim (36.2%; $n = 47$), and they provided a variety of explanations for this choice. More than one-third did not feel they needed benefits and/or did not think they were not entitled to benefits (38.6%; $n = 17$). Other younger veterans said that they were not eligible for benefits due to their income levels, lack of time, and fear of losing other benefits. The following figures depict utilization of assistance with filing claims for older and younger veterans.

Figure 10. Older Veterans’ Utilization of Assistance with Filing Claims

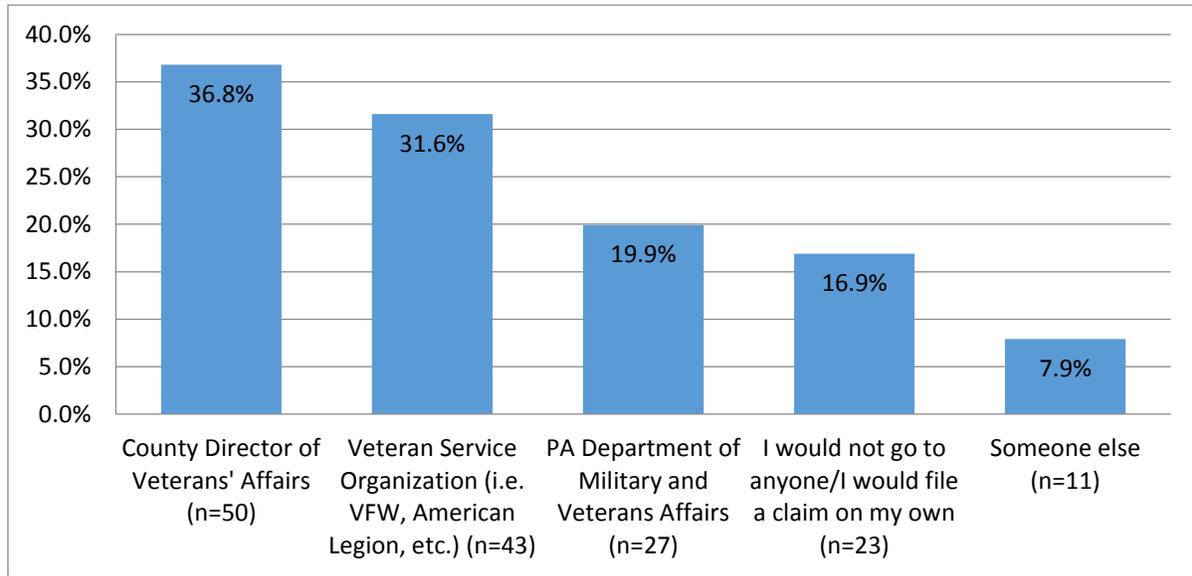
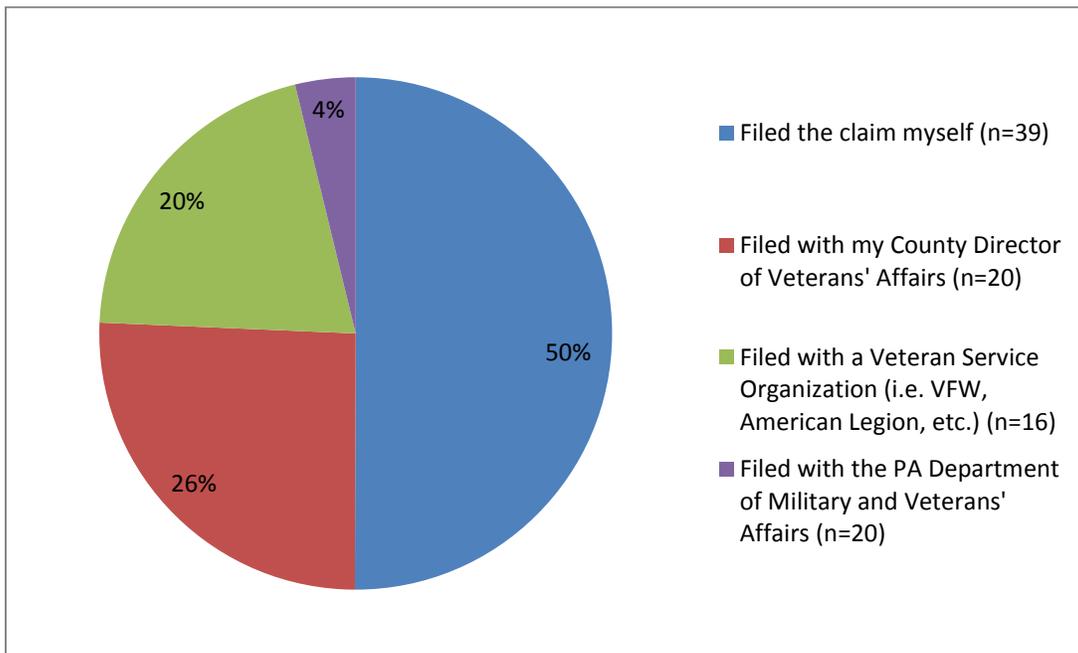


Figure 11. Younger Veterans’ Utilization of Assistance with Filing Claims



Findings: Difficulties with Claims Processing

While half of all veterans reported that they did not encounter problems filing or submitting claims (51.3%; $n = 41$), other veterans shared a number of problems that they had faced. Nearly one quarter of veterans experienced difficulty gathering evidence needed to file their claims (23.8%; $n = 19$), and over one-fifth reported difficulties securing appointments at VA facilities (22.5%; $n = 18$).

Table 5. Difficulties Veterans Experienced Filing Claims

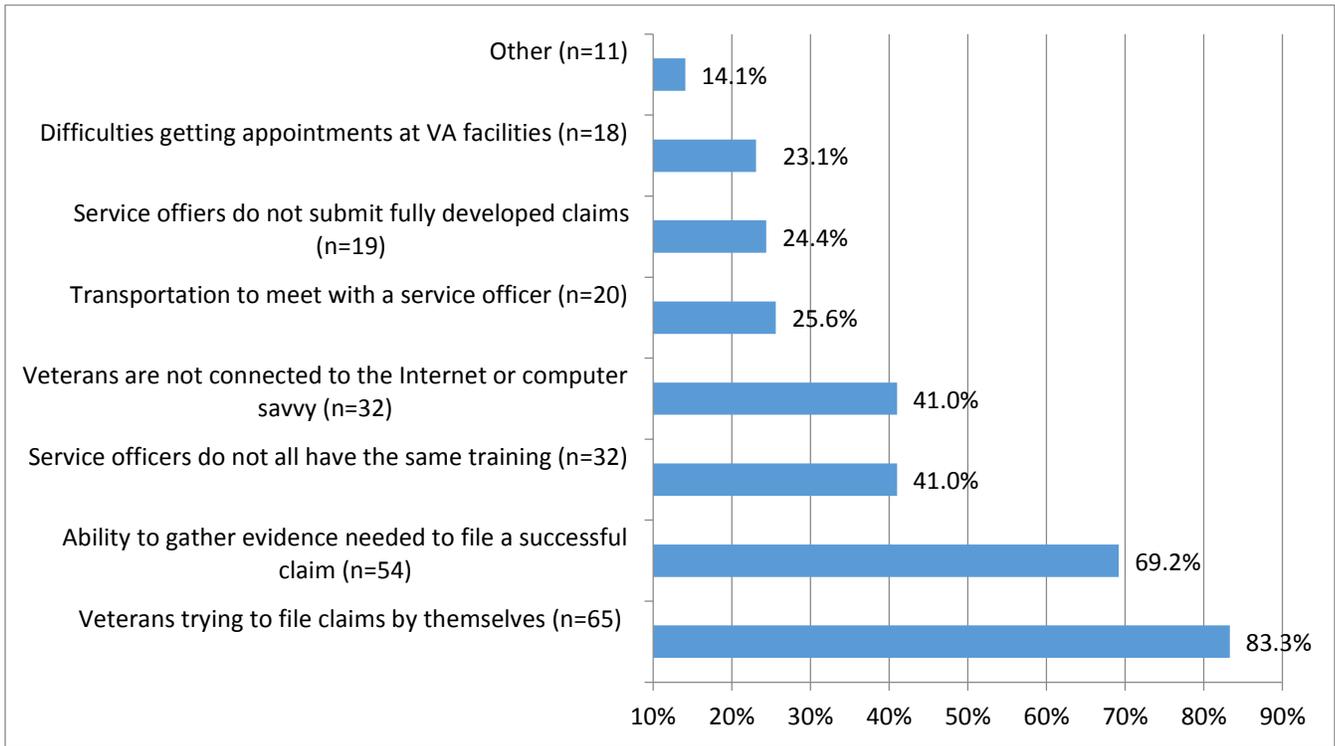
Difficulty	Number	Percent
I did not have any problems filing or submitting claims	41	51.3%
I had difficulty gathering evidence needed to file my claim (i.e. medical records and documentation)	19	23.8%
I experienced difficulties getting appointments at VA facilities	18	22.5%
Other problems: long processing times for VA claims, poor information and direction from service officers, and never enough paperwork to satisfy the VA	9	6.4%
A service officer was not able to submit my claim	4	5.0%
I did not have transportation to meet with a service officer	0	0.0%
I am not connected to the Internet or computer savvy	0	0.0%

Many veterans in this Study reported that they struggled with filing claims, meeting filing deadlines, and pursuing appeals because they did not know where to access or store required documents. Much of the claims process is electronic, which was a challenge for some veterans. Older veterans, in particular, were not comfortable with electronic storage. Younger veterans are capable of creating electronic documents, but they explained that they are not skilled in navigating the complexities of the claims process. Therefore, the Research Team recommends a two-pronged approach whereby veterans have a user-friendly means of following claims, combined with a secure site for storing military and medical records. DMVA and other veterans groups might consider hiring outside consulting services to develop interactive, online tools for monitoring claims, preferably with touchscreen capabilities and other features familiar to

younger veterans. Simultaneously, stakeholders could develop means of training older veterans on how to store documents in secure, easily accessible sites.

Veterans' opinions of the VA were very low in this study. Overwhelmingly, veterans perceived that the VA "does everything it can to reject a claim." Many described the paperwork as a "mechanism just to turn people away from using the VA." In particular, several veterans discussed the difficulty in obtaining a 100% service-connected disability rating. They felt that the VA offers so many benefits for this disability rating because "they know it will never get used . . . they make it too hard."

More broadly, Pennsylvania veterans reported that they often "hit the wall" because they did not know where to go or what to say when seeking benefits. Even when veterans were able to contact the appropriate organization, they said they had difficulty getting past gatekeepers. Every focus group in this study lamented the cumbersome steps required to obtain basic information about benefits and the lack of transparency from point-of-contact staff. In fact, many veterans shared that VSOs' staff were not forthcoming with information, and much of the leg work for receiving benefits fell on the individual veterans. Several observed, "You have to ask the right questions;" "if you don't ask for it, you don't get it;" and "if you don't dig deeper, you won't find out." One participant summed up the lack of assistance when he said the attitude is, "They basically say to us, 'thank you for your service – you're on your own.' They don't speak that last piece, but that's what they mean."

Figure 12. Problems Veterans Faced Submitting Claims

VSOs described other problems veterans face in submitting claims. Several noted a lack of knowledge by veterans on procedures required for claims processing ($n = 3$), while others reported communication issues ($n = 2$); accessibility issues ($n = 1$); difficulties providing documentation ($n = 1$); length of time to adjudicate claims ($n = 1$); problems with the VA ($n = 1$); and “veterans do not read” ($n = 1$). VSOs across all organization types concurred that veterans are ill-equipped to file claims without assistance. Over three-quarters of IVSO and County VSOs, and all of the ODAGVA VSOs, said that these “unassisted claims” are the primary obstacle to successful claims processing (79.3%; $n = 23$; 81.6%; $n = 31$; and 100%, $n = 11$, respectively). All ODAGVA VSOs also said that evidence-gathering was a significant obstacle.

Background: Claims Maintenance and VSOs

Pennsylvania hosts 74 physical federal VA facilities, all of which carry the term “VA” in the title, but serve distinctly different purposes (U.S. Department of Veterans Affairs, 2014(b)). For many veterans, their “claims with the VA” might actually be claims with the Veterans Health Administration (VHA), National Cemetery Administration (NCA), or the Veterans Benefits Administration (VBA). Once inside each of these organizations, there are even more layers of internal complexity, each with their own potentially confusing acronyms. The VSOs in this study most often interacted with facilities associated with the VHA for medical and mental health care and the VBA for pensions and various forms of financial benefits.

While some veterans attempted to represent themselves in claims with the VHA and VBA, the majority of Pennsylvania veterans took advantage of the services of a Veterans Service Officer. These VSOs must be accredited by the VA to assist veterans. The VA accredits non-attorneys and attorneys to serve as advocates. Non-attorneys must submit an application and score 75% or higher on a VA test in order to become accredited as a VSO advocate. It does not appear from this study that all Pennsylvania VSOs are meeting the VA’s accreditation requirements. Instead, there are several work-arounds whereby VSOs can assist veterans without being accredited. For example, accreditation is only required if the VSO is assisting in the actual preparation or prosecution of a claim with the VA, so VSOs can provide “general advice.”

VSOs and the Claims Process

Claims for benefits can take one of many forms, including an “informal claim,” a “formal claim,” and a “fully developed claim.” Each of these types of claims invokes certain deadlines and requirements for veterans, and many Pennsylvania VSOs need to be better educated on the implications of each type of claim.

An “informal claim” arises from any communication in any form that identifies that a benefit is being sought by a veteran. The informal claim can be deemed “initiated” simply by placing a telephone call and requesting information. If a veteran calls a VA facility, identifies himself/herself, and requests information on a particular benefit, the recipient of that call may enter an informal claim into the VA computer system. The VA computer system then begins to track that claim and imposes certain deadlines. It is possible that a VSO working with a veteran will not know about the informal claim unless the VSO specifically asks the veteran whether that veteran has ever communicated with a VA entity about his/her benefits. More troubling, the VSO might not know about the informal claim until prejudicial deadlines have expired, including a one-year limit on “perfecting” the claim.

Pennsylvania VSOs need to be better trained on how to determine whether an informal claim has been filed. It appears from this research that some VSOs are not trained adequately in how to investigate the existence of an informal claim, how to handle informal claims, and what to do if the informal claim needs to be withdrawn. Several VSOs in this study were uninformed in some respects and misinformed in others about the claims process. Anecdotally, the data in this study suggest that some veterans have been inadvertently misled, to their detriment, in the informal claims process by well-intentioned, but uninformed, VSOs.

Formal claims are easier to spot because they require that the veteran or his/her VSO complete certain documents, which are supposed to be maintained electronically and in hard-copy. Forms 21-526 or 21-534 are most-often used for initiating formal claims. It is apparent from this study that not all Pennsylvania VSOs are receiving training on how to complete, file, and track these and other documents. Again, it is imperative that VSOs understand how to

manage these documents and the related deadlines for processing them. Irreversible prejudice to a claim can result if claims are mishandled by VSOs.

Finally, Fully Developed Claims (FDCs) are filed using Form 21-527EZ or 21-534EZ and require that the veteran designate a 21-22 representative. They also require that the application has been completed, with nothing left to amend or clarify, upon initial submission. In other words, the veteran and his designee have one shot at submitting a claim. If they fail to include pertinent information, that failure can impact the claims adversely. Therefore, it is imperative that VSOs assisting with FDCs receive proper training. Mistakes in this process can cause lengthy delays and procedural prejudice to the veteran-claimant. Training also should be provided to VSOs on how to preserve veterans' appellate rights in the FDC process.

Findings: Problems with Powers of Attorney

Finally, issues arose in relation to appointments of VSOs as powers of attorney (POAs) for veterans pursuing claims. The veteran and the surviving spouse are the only ones who can sign the initial claim application. Thereafter, POAs can sign on behalf of the veteran. A veteran-claimant can have only one representative for each claim (*38 Code of Federal Regulations Section 14.629*). The VA recognizes a "VA power of attorney," but not a state power of attorney (U.S. Department of Veterans Affairs Form 21-22).

The POA can sign (in lieu of the veteran) informal notices of claims, notices of disagreement with claims decisions, and substantive appeals. Once a POA is assigned to a veteran-claimant, that POA is the point of contact for that claim. In theory, both the POA and the veteran-claimant receive copies of all documents. In reality, oftentimes only the POA receives the documents.

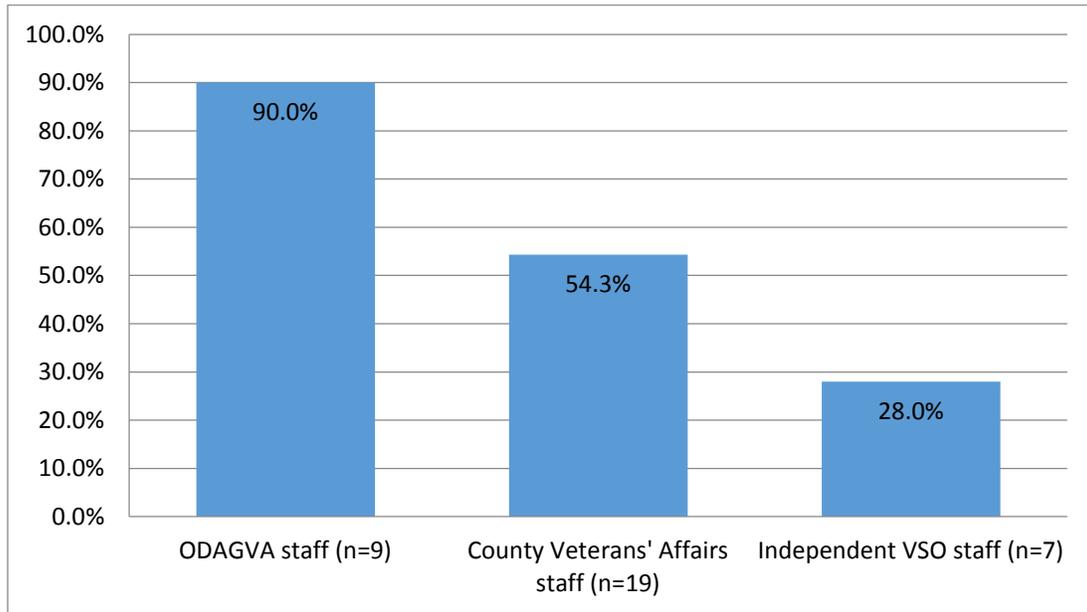
When there is only one POA assigned to a file, then administrative problems appear to be confined to more traditional concerns with timeliness, record-keeping, and documentation of need. However, when the POA is changed during the course of a claim, additional and substantial delays can arise. In many cases, a change in a POA can cause a claim to be rejected or returned to the veteran for amendment. This rejection and/or return for amendment does not toll the underlying deadline for filing a claim, so the delays can be prejudicial.

Although the Research Team did not identify any intentional misconduct or nefarious purposes, several groups of veterans perceived that some VSOs “steal” claims from other VSOs. To illustrate, suppose hypothetically that “Joe” (a CVSO) initiates a claim on behalf of “Bob,” a veteran who has a disability claim. Joe is listed as the POA for Bob. The claim proceeds through the process slowly, and administrative delays frustrate Bob. These delays are not the result of any action Joe has taken or failed to take; they are inherent to the VA system. Nevertheless, Bob decides to take matters into his own hands and visits his local VA center. At the center, Bob meets “Dave,” an IVSO. Dave greets Bob as he enters the building and asks if he can assist Bob. Then Bob proceeds to share his frustrations with Dave. Not knowing that Bob already has Joe as his POA, Dave asks Bob to sign a POA form so that Dave can investigate Bob’s claim status. Bob signs the form, and the records now reflect that Bob has a new POA. That new POA must be added to the file, and all old files that list Joe as the POA are now invalid. The administrator who is processing Bob’s claim might reject the claim due to clerical errors on one or more of the old forms that list Joe, or that administrator might return the papers to Bob for amendment. Either way, the file is delayed and the clock on Bob’s various deadlines for processing his claims continues to run.

Neither Joe nor Dave did anything “wrong.” They both genuinely want to help Bob, and they believe that are working in Bob’s best interest. But their efforts are at cross purposes, and Bob’s claim ultimately may suffer. Pennsylvania VSOs need to be trained on how to identify existing POAs and how to work with veterans who have pending claims; how to explain the significance of POAs to veterans; and how to ensure that they obtain informed consent from veterans who wish to transfer their POAs during the pendency of a claim.

In this study, half of all VSOs reported that another VSO had “stolen” one or more claims from them (50.0%; $n = 35$). ODAGVA VSOs were most likely to report they have had a claim stolen and IVSOs were least likely to say that they had a claim stolen from them. The VSOs who had experience with “stolen” claims said that the situation often arose with veterans making the change “without understanding exactly what it means” (25.9%; $n = 7$); when veterans go to a VA hospital (25.9%; $n = 7$); when veterans speculate that they can get their claim processed faster with another service officer ($n = 2$); when veterans are not asked if they already have representation ($n = 2$); and when VSOs take a near-complete claim “just to boost their numbers” ($n = 2$).

The conventional wisdom among VSOs maintains that claims are most-often reassigned to new POAs by VSOs embedded in VA medical centers. One VSO described it as “a battleground there. We are not numbers-driven or membership-driven. They [the veterans] don’t even understand what they are signing [Power of Attorney form].” Veterans reported 10-20 “stolen” claims per VSO within the past year. At least one VSO from each type of organization acknowledged that he/she had “stolen: at least one claim, with intention, on at least one occasion.”

Figure 13. VSOs Reporting “Stolen” Claims by Organizational Affiliation

In addition to the recommendations from the field, several states have begun implementing a hotline system whereby the state works in conjunction with the federal regional centers to advocate for veterans' claims (Moe, 2012). Within Pennsylvania, some studies have concluded that the creation of a cabinet-level position dedicated to veterans' affairs would provide more streamlined oversight of veteran programs (Behney *et al.*, 2012; Defense Solutions LLC, 2006; Pennsylvania Department of the Auditor General, 2006). Such findings exceed the scope of this Study's research questions.

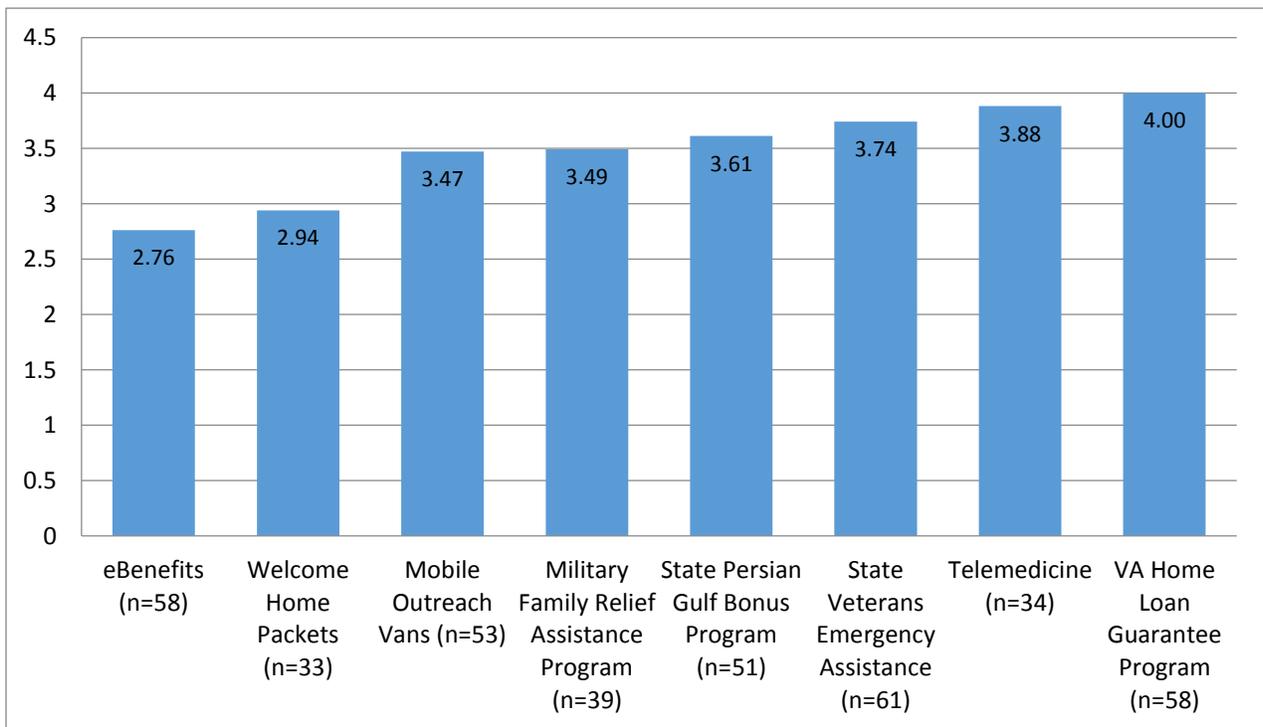
Findings: Specific Benefits

During the focus groups and through surveys, the Research Team asked VSOs to provide their insights into the effectiveness of a variety of specific benefits. These data are useful both as insights into the programs themselves and as larger examples of challenges that all veterans and VSOs face in accessing benefits more generally. VSOs rated the effectiveness of several benefits on a scale of 1 to 5, where 1 was very ineffective and 5 was very effective. For purposes of

analysis, a rating of 1 or 2 was considered ineffective and service officers were asked why they rated the program as ineffective as a follow-up question. Conversely, a rating of 4 or 5 was considered effective and service officers were asked why they rated the program as effective as a follow-up question. Service officers also were able to indicate if they were not familiar or had not used the program.

eBenefits. The eBenefits program was rated least effective by participating service officers, with a mean score of 2.76. In comparison, the VA Home Loan Guarantee program was rated most effective, having a mean score of 4.00. The following figure shows the mean score for each of the rated programs. A smaller number means that the type of program was rated as less effective by VSOs.

Figure 14. Mean Score Ratings of Effectiveness of Programs for Veterans



Comparing the mean scores of effectiveness for each of the benefits by organizational affiliation, ODAGVA VSOs ranked many of the programs highest, while CVSOs ranked many

lowest. The following table shows the mean scores for veterans' benefits by organizational affiliation.

Table 6. Mean Scores of Veteran's Programs by Organizational Affiliation

Program	ODAGVA VSOs	CVSOs	IVSOs
eBenefits	3.18	2.36	3.00
Military Family Relief Assistance Program	3.87	3.44	3.33
Mobile Outreach Vans	3.89	3.57	3.19
State Persian Gulf Bonus Program	3.70	3.69	3.40
State Veterans Emergency Assistance	3.36	4.03	3.41
Telemedicine	4.25	3.42	4.07
VA Home Loan Guarantee Program	4.45	3.76	4.11
Welcome Home Packets	3.00	2.67	3.06

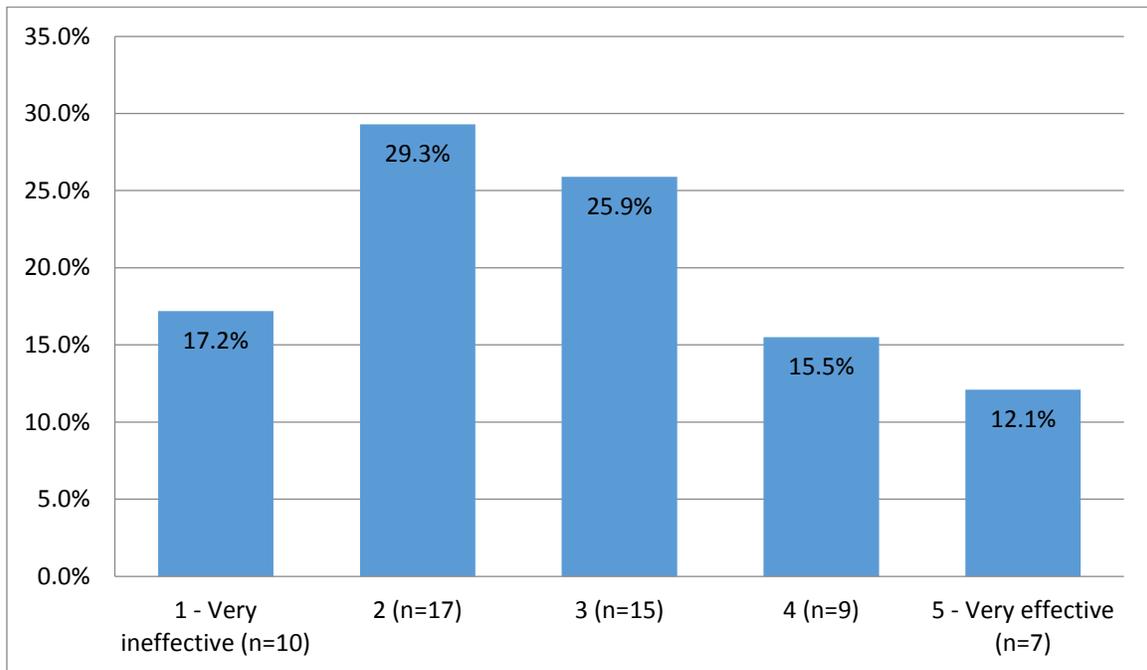
In 2009, the VA and Department of Defense (DoD) began implementing the eBenefits web portal system, which allows veterans and their families to access information related to their benefits, check the status of claims, and perform certain self-service functions (Department of Veterans Affairs and Department of Defense, n.d.). Since the service is relatively new, there has been little evaluation of the program's success or of Pennsylvania veterans' knowledge of the services available.

VSOs recognized eBenefits as, hypothetically, an effective means for tracking claims. Unfortunately, more than half of VSOs perceived the eBenefits system in its present form as ineffective. They complained of inaccurate or out-of-date information being maintained within eBenefits and that there is no means by which a claimant can discuss an eBenefits claim with a VSO.

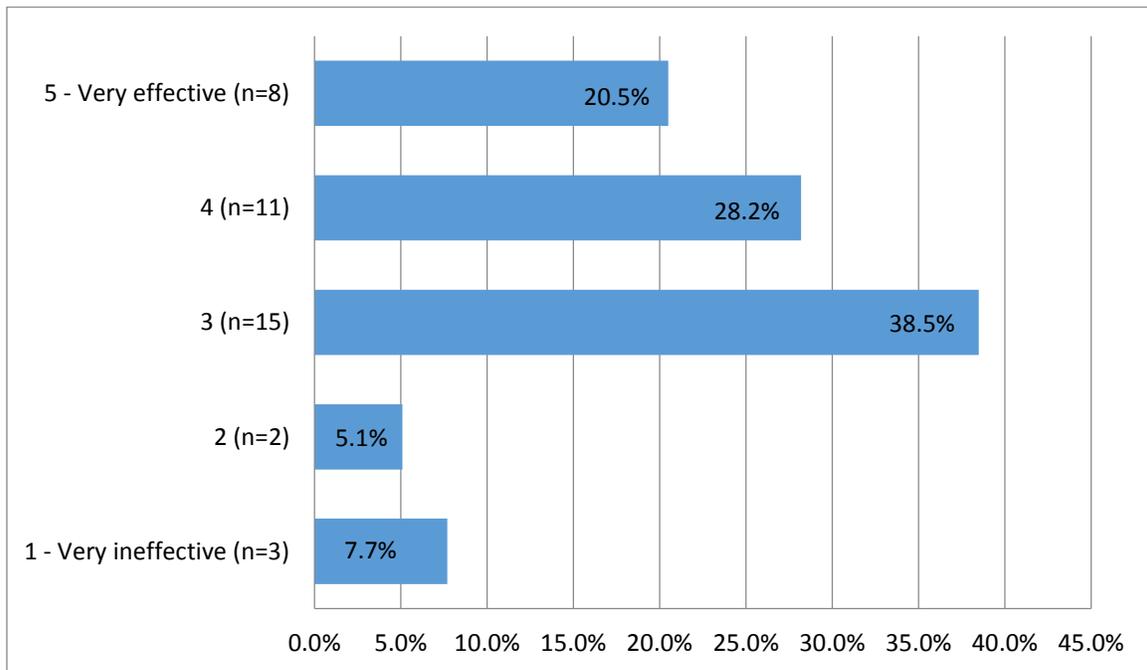
Of the VSOs who assessed the eBenefits program, over one-quarter rated it as effective (27.6%; $n = 16$), explaining that the program improves accessibility for veterans to check on their benefit and claim information ($n = 10$); provides a "one-stop shop" for information ($n = 1$);

and allows an easy way for more technologically savvy veterans to have information right at their fingertips ($n = 2$). On the other hand, nearly half of VSOs rated eBenefits as ineffective (46.5%; $n = 27$). Half of these individuals stated that inaccurate information is provided in eBenefits (50.0%; $n = 12$). Another one-third reported that the program was difficult for veterans who may be less technologically savvy (33.3%; $n = 8$). Other complaints included lack of training on how to use the program ($n=1$); that the program information is too basic ($n = 1$); and the inability for VSOs to interact with the veteran and his/her eBenefits file ($n = 1$). Finally, 14.7% ($n = 10$) did not provide a rating and indicated that they were not familiar with eBenefits or had not used the program.

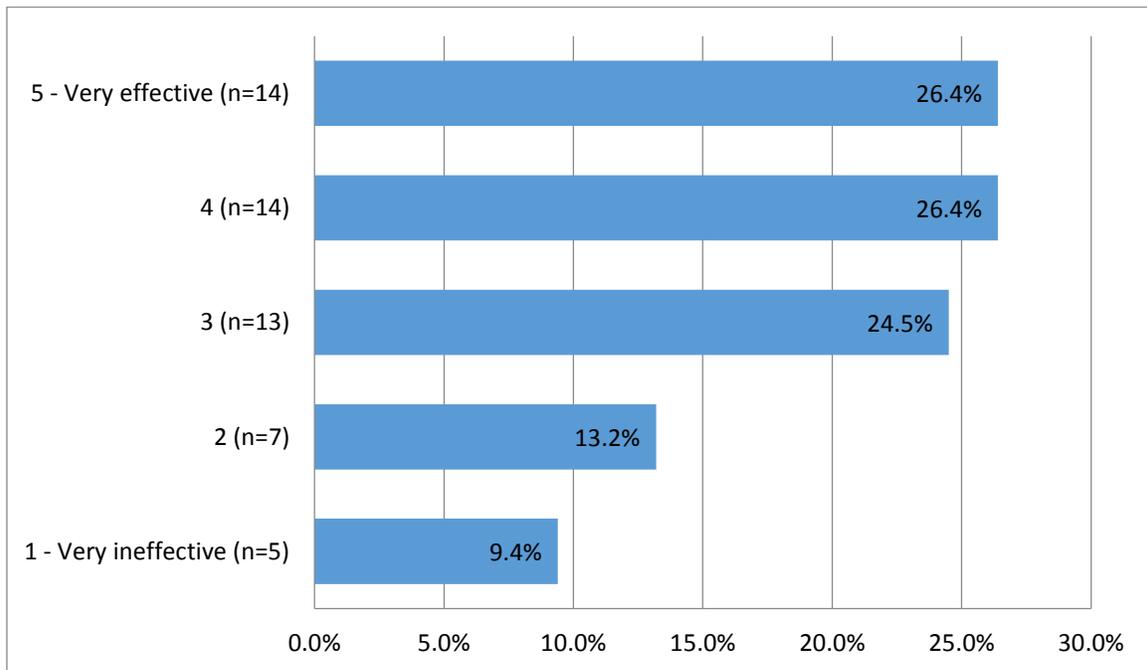
The eBenefits program garnered impassioned feedback, with many VSOs describing it as a “good idea that is badly implemented.” The VSOs explained that, inside the eBenefits database, “veterans can be their own worst enemy” when they try to submit claims. Veterans often lack the necessary documentation or knowledge to put together a fully developed claim (FDC, see above). One county director described it, “Like going to your murder trial without a lawyer.” Although some participants noted that eBenefits has reduced the number of calls to their offices, they spend an excessive amount of time trying to fix errors in the initial claims filed by the veterans. VSOs perceive themselves to be critical to the eBenefits process; one participant expressed the value of service officers to veterans when he stated, “Nothing is more important than a service officer who can talk to someone and try to maximize all types of benefits. There is no magic website or 1-800 number that can help the veterans like a service officer.”

Figure 15. Effectiveness Rating for eBenefits Program

Military Family Relief Assistance Program (MFRAP). The MFRAP provides grants to eligible military service members and their families with an immediate financial need. Of the VSOs who assessed this program, nearly half rated the MFRAP as effective (48.7%; $n = 19$), recognizing that it provides immediate financial assistance to veterans in need (61.5%; $n = 8$); the program's responsiveness (23.1%; $n = 3$); its ability to reach a large number of veterans in need ($n = 1$); and the program's network of people available to help veterans ($n = 1$). Very few of the VSOs who assessed the MFRAP rated it as ineffective (12.8%; $n = 5$), and the only complaints concerned the amount of red tape in the application process ($n = 1$) and poor marketing of the Program ($n = 1$). Finally, almost half of participating service officers did not provide a rating and noted that they were not familiar with or had not used the MFRAP (42.6%; $n = 29$).

Figure 16. Effectiveness Rating for the Military Family Relief Assistance Program

Mobile Outreach Vans. Pursuant to this program, Mobile Outreach Vans travel throughout the Commonwealth and allow VSOs to establish temporary offices in rural and hard-to-access regions. Of the VSOs who assessed this program, over half rated Mobile Outreach Vans as effective (52.8%; $n = 28$). Half of these service officers noted the Mobile Outreach Van's accessibility as the biggest reason the program is effective (50.0%; $n = 12$), explaining that the program allows VSOs to reach isolated areas and individuals (37.5%; $n = 9$). Over one-fifth of VSOs rated the program as ineffective (22.6%; $n = 12$) complaining that not many veterans know about the vans or take advantage of them ($n = 2$); the vans schedule can be spotty and infrequent ($n = 1$); vans do not provide veterans with paperwork or information when they leave, which can cause problems ($n = 1$); and vans need to spend more than just one day at a location ($n = 1$). Finally, one-fifth of VSOs did not provide a rating and indicated that they were not familiar with or had not used Mobile Outreach Vans (20.9%; $n = 14$).

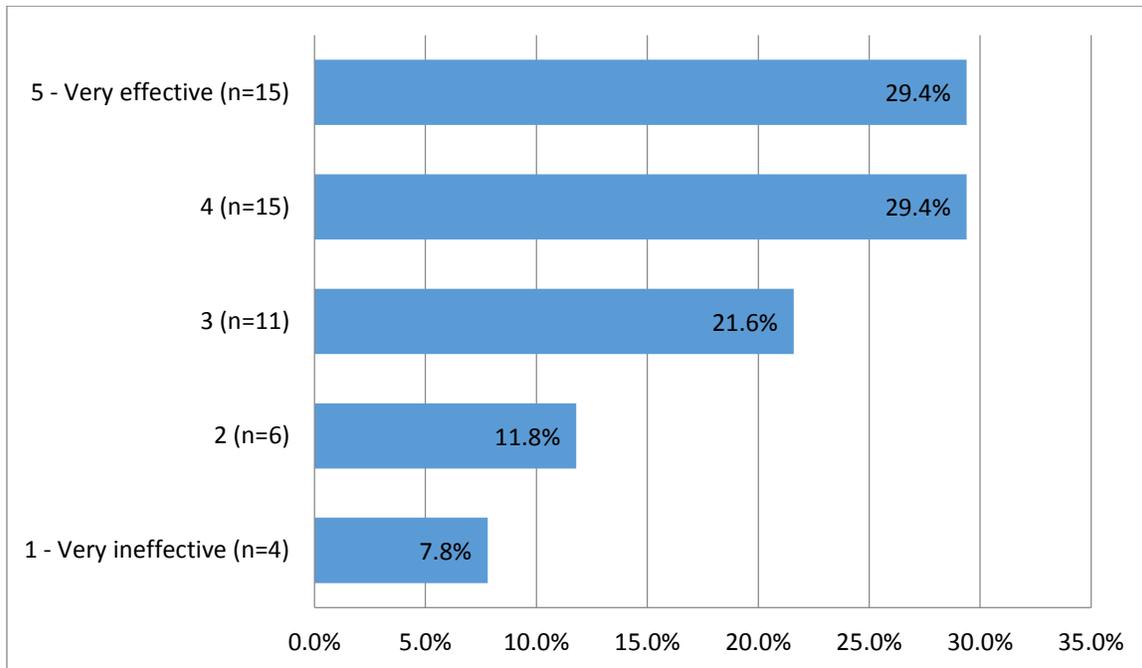
Figure 17. Effectiveness Rating for the Mobile Outreach Van Program

As an aside, several veterans offered specific recommendations for improving the Mobile Outreach Van program, including better promotion and marketing; more consistent drivers who know the routes; paying drivers; defining a consistent calendar for visits several months in advance so veterans can make plans; creating a consistent schedule within communities with an emergency component of extra visit days as the need arises; establishing a hotline for the van to come to people; and equipping the vans with better technology and better Internet access.

State Persian Gulf Bonus Program (SPGB). The SPGB provides compensation for eligible service members who served during the Persian Gulf Conflict. Over half of the VSOs who assessed this program rated it as effective (58.8%; $n = 30$), citing the program's effectiveness in providing funds for veterans and the value of having this period of service honored in this fashion ($n = 12$). Others noted that the program has good administrators in Pennsylvania ($n = 2$). Nearly one-fifth of VSOs who assessed the SPGB rated it as ineffective

(19.6%; $n = 10$), saying that the Program needs to be promoted more ($n = 3$); there is a lack of information on application procedures ($n = 2$); and that there is a tight time constraint of the program ($n = 1$). Finally, one-quarter of participating VSOs did not provide a rating and noted that they were not familiar with or had not used the program (25.0%; $n = 17$).

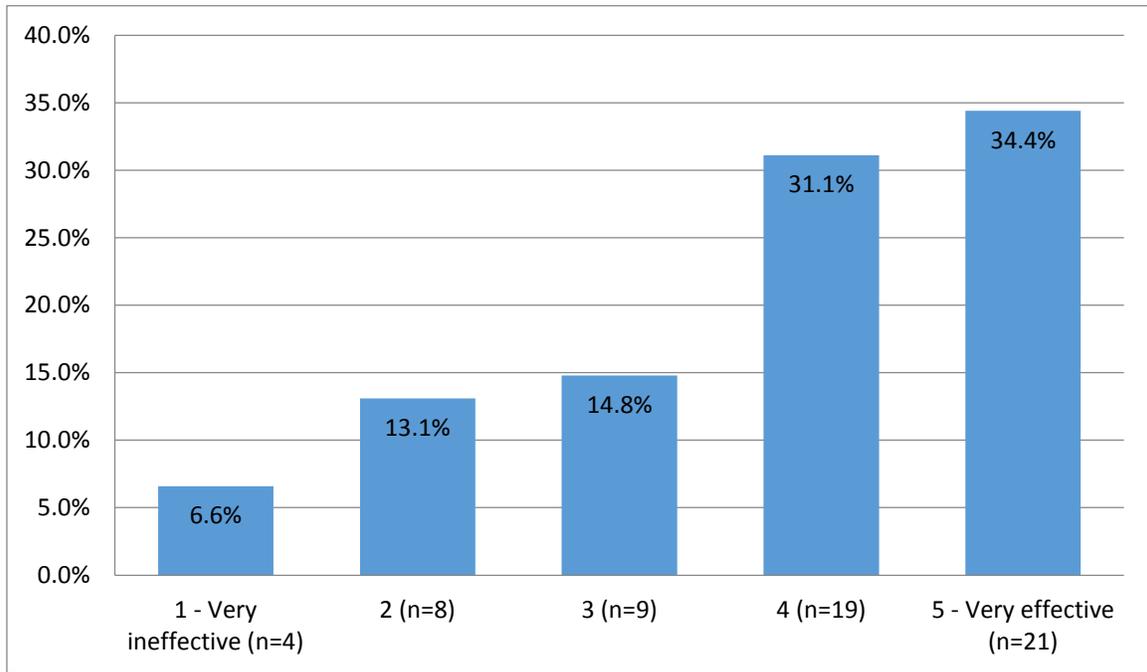
Figure 18. Effectiveness Rating for the State Persian Gulf Bonus Program



State Veterans Emergency Assistance (SVEA). The State Veterans Emergency Assistance Program provides financial aid to veterans and their beneficiaries on a temporary basis or during an emergency. Nearly two-thirds of VSOs who assessed this program rated it as effective (65.5%; $n = 40$), focusing on “the good work the Program does for veterans and their families” (70.4%; $n = 19$); the program’s responsiveness (22.2%; $n = 6$); the ease of access through County Veterans’ Affairs Offices ($n = 1$); and the program’s responsiveness to widows ($n = 1$). Less than one-fifth of VSOs who assessed the program rated it as ineffective (19.7%; $n = 12$), complaining that there are too many stipulations and qualifications for the Program ($n = 4$);

and that the Program has inadequate funding ($n = 3$); a lengthy approval process ($n = 1$); and that the program “is on its way out” ($n = 1$). Finally, 12.9% ($n = 9$) of VSOs did not rate the program and reported that they were not familiar with or had not used the SVEA Program.

Figure 19. Effectiveness Rating for the State Veterans Emergency Assistance Program



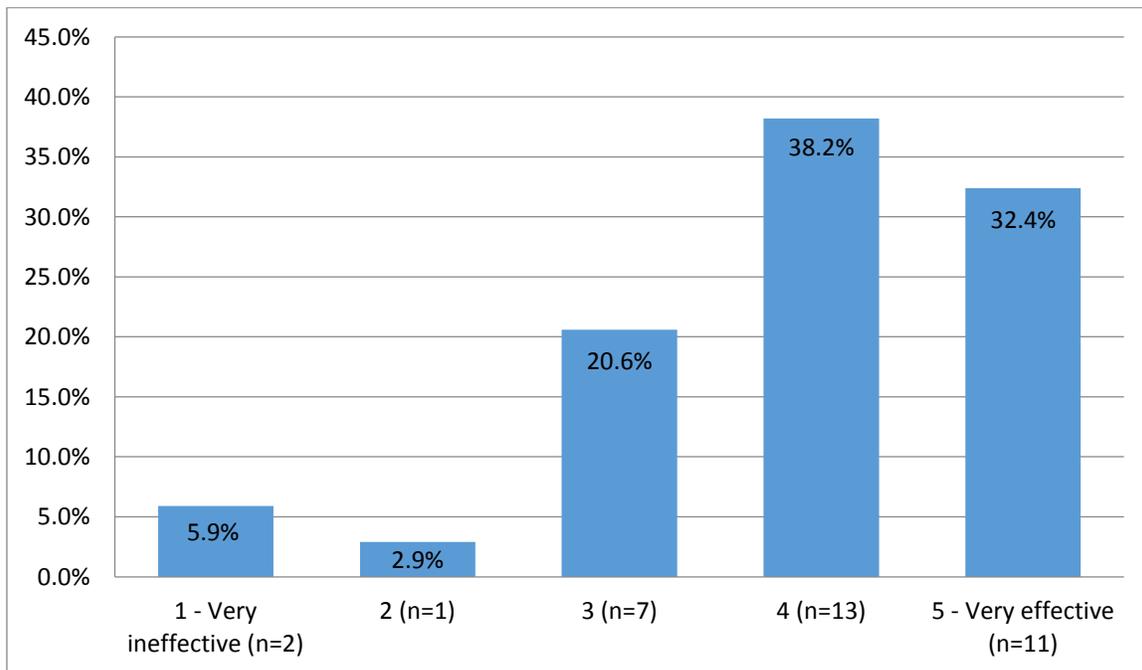
Telemedicine and Telehealth. In July 2003, the Veterans Health Administration launched the Care Coordination/Home Telehealth (CCHT) Program (Darkins *et al.*, 2008). Telehealth uses telecommunication technologies to monitor conditions and deliver certain medical services to veterans remotely. For many conditions, veterans can obtain care and advice from their own homes (Petersen, 2013). This program has been found to be particularly useful for veterans with chronic health conditions such as diabetes, high blood pressure, or PTSD (Broderick, 2013).

In 2012, the VA reported that about 80,000 veterans utilized Telehealth services (Jordan, 2013). Recent studies find that Telehealth lead to reductions in hospital admissions and bed-

days-of-care (Broderick, 2013; Darkins *et al.*, 2008). Telehealth also allows for a considerable cost savings compared to the cost of VHA's home-based primary care and nursing home care (Broderick, 2013; Darkins *et al.*, 2008).

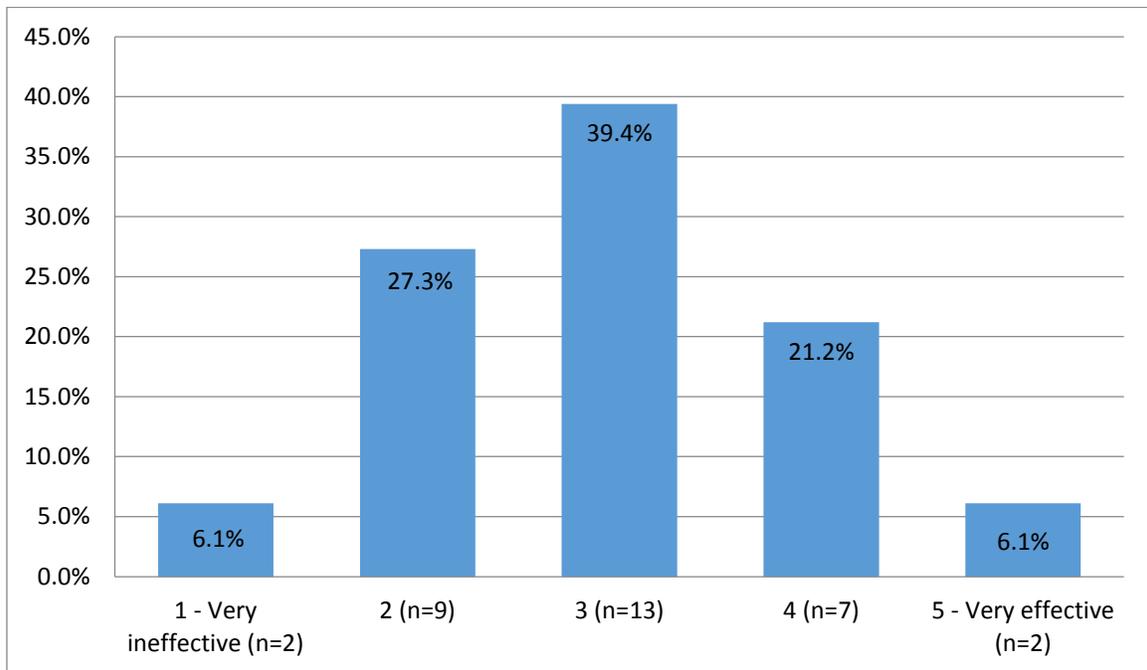
Of the VSOs who assessed this program, over two-thirds rated it as effective (70.6%; $n = 24$), explaining that the program saves money and travel for veterans (33.3%; $n = 6$); allows veterans to stay in their homes longer (16.7%; $n = 3$); provides assistance to veterans when needed ($n = 2$); expands the VA's capacity ($n = 2$); is easy to use ($n = 1$); helps rural veterans get care in a timely manner ($n = 1$); and provides information for veterans to stay on top of their health care needs ($n = 1$). Only 4.7% ($n = 3$) of VSOs rated telemedicine as ineffective, claiming that the program impedes the doctor-patient relationship ($n = 2$) and that it is not widely offered ($n = 1$). Finally, almost half of VSOs did not provide a rating because they were not familiar with or had not used the telemedicine program (46.9%; $n = 30$).

Figure 20. Effectiveness Rating for Telemedicine



Welcome Home Packets. Under this program, recently separated Pennsylvania veterans receive a Welcome Home Packet that contains information on veterans' benefits in Pennsylvania. Interestingly, almost half of participating VSOs did not provide a rating for this program and indicated they were not familiar with or had not used Welcome Home Packets (46.8%; $n = 29$). Of the VSOs who did provide a rating for the program, fewer than a third rated it as effective (27.3%; $n = 9$), acknowledging that it puts resources "at a veteran's fingertips" ($n = 4$), and that the packet provides comprehensive information that can be reviewed on veterans' own time ($n = 2$). One-third of VSOs who assessed the Welcome Home Packet program rated it as ineffective (33.4%; $n = 11$). Over half of the reasons for rating the program as ineffective focused on the perception that veterans "do not look at the packet when they receive it" (60.0%; $n = 3$).

Figure 21. Effectiveness Rating for Welcome Home Packets



Claim Disputes

If a veteran does not agree with the decision made about his/her claim by a VA entity, he/she has the right to seek relief through the VA's Board of Veterans Appeals (BVA) within one year of the adverse claim decision. Nationally, only approximately 11% of claims are appealed each year. The BVA, which is internal to the VA, sits in Washington D.C. By its own description, the appeals process with the BVA is "a complex, multistage, non-linear process set in law that has evolved over decades, with a continuous open record that allows submission of new evidence (medical records, statements, etc.) at any time" (U.S. Department of Veterans Affairs, 2014)¹. Unlike an appeals court in the judicial system, the BVA reviews the entire claim file "de novo," meaning that they reopen it and reassess all of the facts with fresh eyes. They also accept new and additional information from the veteran. Because this BVA process is so complicated, and because it requires the veteran to advocate for his/her claim in a quasi-legal capacity, it is imperative that veterans receive as much assistance as possible at this stage.

If the veteran does not obtain the desired relief from the BVA appeal, then he/she may remove the matter from the VA system and pursue a judicial appeal through the United States Court of Appeals for Veterans Claims (CAVC). The CAVC is an Article III, independent, federal appellate court that receives appeals from the BVA (United States Court of Appeals for Veterans Claims, 2014). The CAVC provides the first level of formal judicial involvement in the otherwise administrative claims process of appealing decisions made about VA claims. Because it is a formal legal forum in which certain legal and evidentiary rules apply, the process of appealing claims to the CAVC can be quite daunting for veterans untrained in the law. Recent efforts have been made to develop legal clinics to assist veterans in these appeals, but those nascent efforts have very little structure or funding (Veterans Law and Disability Benefits Clinic at Harvard,

¹See <http://www.bva.va.gov/docs/Appeals101Briefing.pdf>, for a complete explanation of the BVA appeals process.

2014). Much work remains to be done.

Over one-third of younger veterans reported filing an “appeal” of a claim for benefits or services (36.6%; $n = 30$). While the majority described their “appeal” as occurring at the local level within the VA regional office (70.8%; $n = 17$), 41.7% ($n = 10$) reported filing an appeal with the BVA. No younger veterans had filed an appeal with the CAVC. Finally, 8.3% ($n = 2$) indicated that they had never heard of any of the BVA, the CAVC, or any organizations involved in the appeals process.

From the VSOs’ perspective, the appeals process is under-utilized, in part because it is so daunting. Almost all VSOs have handled at least one appeal within a VA regional office (90.5%; $n = 57$); almost three-quarters (71.4%; $n = 45$) have appealed a claim to the BVA; and 17.5% ($n = 11$) have appealed to the CAVC. A large majority of participating VSOs provided assistance with appeals of claims for service-connected disability claims (88.7%; $n = 63$). Almost two-thirds assisted with appeals of pension claims (63.5%; $n = 40$).

Recommendations

- Develop methods of communicating the availability of benefits through means other than word-of-mouth. While paper resources, such as brochures, flyers, and pamphlets, are appealing to older veterans, tech-savvy and younger veterans need different forms of communication.
- Create one, central website portal for all information and links for Pennsylvania veterans. It needs to have a catchy name that resonates with veterans. Recommendations from the field include “My Virtual VA,” “The PA VA,” or “PA Veterans Resources.” Hire external consultants with expertise in intergenerational communication and marketing to develop a user-friendly virtual one-stop-shop for accessing information on benefits. This

website should have dropdown menus for all major areas of concern and a portal to each county CVA and each IVSO. It should include touchscreen capabilities and compatibility with multiple electronic devices. VSOs need to be trained on this portal prior to launch, and then community-level seminars need to be conducted among veterans.

- Create a secure, HIPAA-compliant site for storing military and medical records where veterans and VSOs can access documents needed for claims.
- Develop and host how-to webinars and seminars for veterans who want to pursue claims without using a VSO for assistance.
- Develop and host how-to webinars and seminars for VSOs to ensure that they understand the claims processes for federal, state, and local claims. These could be conducted over a three-month period as continuing education for all VSOs, and consideration needs to be given to what kinds of incentives for participation would be most enticing for VSOs. Perhaps continuing education could be a mandatory component of annual accreditation.
- Provide tablet computers for VSOs to allow for mobile connectivity and claims processing.
- Assign dedicated professional email addresses and provide mobile Internet access for VSOs.
- Equip mobile outreach vans with tablet computers and mobile Internet access for veterans to use either while working with a VSO or on their own.
- Analyze the cost-per-capita benefit of producing printed materials and make decisions on what types of print materials should be retained and which should be replaced with electronic media.
- Consult with web design experts to make DMVA's, CVSOs' and IVSOs' webpages more

uniform, more user-friendly, and linked with a central benefits website.

- Train VSOs on social media. Consult with communications experts to identify all appropriate social media outlets, and then train VSOs in hands-on training sessions on how to incorporate these social media resources into their daily professional practices.
- Develop interactive, online tools for monitoring claims, preferably with touchscreen capabilities, and provide training to veterans on how to use them, in locations accessible to veterans. Also provide transportation to these training sessions.
- Make VA accreditation a condition of employment so as to ensure uniformity and quality of training on claims processing.
- Educate VSOs on the definition of all terms used in the claims process, with particular emphasis on what an informal claim is, when it is created, what appeals are, and how to navigate the informal and formal appeals processes for claims.
- Work with the VA to provide periodic training in online and paper-copy claims management.
- Provide all VSOs with a simple flow chart and one-hour tutorial on the claims appeals process.
- Consult with a marketing professional on how to improve the visibility of the DMVA.
- Initiate study in whether weaknesses within eBenefits can be redressed, at least in part, with VSO training.
- Add more Mobile Outreach Vans, particularly in rural communities. Equip the vans with appropriate paperwork and electronic resources for claims processing and information distribution. Ask VSOs to travel with the Vans. Incorporate service delivery within the Vans. Create a standardized schedule for when the Vans will travel to which locations;

publish that schedule, and abide by that schedule. Promote and market the Vans more effectively.

- Reconsider the cost-benefit of Welcome Home Packets and consider making them electronic. Incorporate them into the new website.
- Create a subscription service through opt-in email delivery for all veterans. Link it to the new website.

COMMUNICATION AND OUTREACH

It should come as no surprise that there are generational, socio-cultural, and regional differences in the way people communicate and process information (Pew, 2012). Ninety-five percent of younger Americans (born after 1981) rely upon the Internet for information, while 30% of those born before 1946 depend on the Internet (Pew, 2010). Of those older Americans who use the Internet, only 20% have residential broadband access, which means that some might travel from their homes in order to use online resources (Pew, 2010). However, many still have other forms of non-broadband Internet access, which would allow them to access resources from home. Veterans are no different, and their different styles of receiving and transmitting information must be accounted for in all interactions with them. Efforts to improve communication and outreach go hand-in-glove with efforts to improve access to benefits and claims processing, but this Report handles Benefits as a separate category from Communication and Outreach to more fully explore the issues and emphasize that Communication and Outreach encompass issues broader than benefit processes.

Background

One of the most enduring problems affecting Pennsylvania's veterans has been a lack of consistent communication and coordination in relation to procuring benefits that are available to them. Veterans in Pennsylvania have reported confusion in filing claims, a lack of coordination between VSOs and government officials, and a general lack of information about services and benefits available to them. In some cases, veterans indicated that they only received information about services they specifically mentioned, only later finding out that there were additional benefits to which they were entitled. OVA recognized the steep challenges inherent to communicating with many hard-to-reach veterans dispersed throughout the Commonwealth in its

strategic plan and subsequently outlined a number of approaches aimed at improving communication. For example, OVA developed a “Welcome Home” packet designed to orient returning veterans to things they will need to know. An effort is underway to make the OVA web site more user-friendly, providing easier access to important information and streamlining access. The OVA also plans to develop a county-level advertisement system, possibly in the form of a kiosk, that would serve as a repository for benefit and program information (Pennsylvania Office of Veterans’ Affairs, 2012).

Studies from outside of Pennsylvania reach similar conclusions. For example, one-third of veterans in the California Department of Veterans Affairs (CDVA) Veterans Needs Assessment Survey reported that knowing more about veteran benefits was critical (California Department of Veterans Affairs, 2011). This same survey found that younger veterans (those under 30) were one of the least knowledgeable groups regarding veterans’ benefits (California Department of Veterans Affairs, 2011). While 80% of all California veterans described their knowledge of benefits as “average or better,” the survey showed that younger veterans were less likely to know how to file a benefit claim or where to go to receive assistance with their claims (California Department of Veterans Affairs, 2011). The researchers attributed the lack of knowledge, in part, to poor communication at the state and local levels.

Similar findings arose in a handful of other states:

- A 2011 Rhode Island needs assessment of veterans found that misinformation about services offered by the VA and questions about eligibility were top reasons why veterans did not use services (Dan Cahill and Associates, 2011).
- Veterans in North Carolina also reported that navigating the complex network of veteran benefits was a major challenge (Morris, 2012). These North Carolina veterans expressed

frustration with the cumbersome mechanisms by which they receive information. In other words, they found fault with their state's efforts to communicate with them (Morris, 2012).

- Focus groups of veterans and veteran service providers in Virginia found that outreach using many modes of communication and with comprehensive information on benefits and services for veterans was a critical need (Dunkenberger *et al.*, 2010).

Findings: General

In this study, veterans similarly reported frustrations with communication. Many expressed concern that they were operating in an “information vacuum.” An important finding in this study is captured by this comment from a recently separated veteran with a service-related disability rating: “Now that I have demonstrated how much I do not know, how will someone reach me?”

Not surprisingly, younger and older Pennsylvania veterans communicate and receive information differently. The mode of communication can be as important as the information itself. As Marshall McLuhan famously observed, “the medium is the message,” meaning that the form of a communication imbeds itself in the content of the message. Younger veterans may perceive public service announcements as irrelevant to them. As one younger veteran said, “I’m not hanging out on my porch listening to NPR.” He perceived that information broadcast on public radio was not important to him. He and several others acknowledged that they pay more attention to messages transmitted electronically. In contrast, many older veterans dismissed email communications as “junk” and social media sources as “wasting time Facebooking.”

Findings: Internet Access

One overarching constraint pervades the current communication environment: Internet access. The Research Team was not surprised to learn that many older veterans lament the need to rely on “the internets” to process claims and receive information. But the Research Team was surprised to learn that a few VSOs did not have access to the Internet at all, and a striking 75% did not have mobile Internet access. While ODAGVA Staff all had Internet access in their offices, many reported that they did not have mobile capabilities. Moreover, CVAs and IVSOs had very little connectivity. This lack of connectivity might be impacting VSOs’ responsiveness. The majority of VSOs in this study said that they would like to have mobile connectivity and that being able to email, text, and make old-fashioned telephone calls while outside of the office would improve their ability to serve veterans.

Findings: Younger Veterans

Many younger veterans felt that outreach to veterans was too limited. Specifically, they suggested that command in the military, county VSOs, and the VA need to do a better job of providing information on benefits and services available to veterans. In fact, one participant described his frustration at the lack of outreach by the VA. He said, “You give enough. They can afford to put a campaign out. They can hire veterans to do that.” Another veteran gave an example of the VA requesting his help to share information about benefits with fellow veterans; he was stunned at this request and said, “You are the VA; and you’re asking *me* to get the word to veterans? You have the address; what is he asking for my help for?”

Younger veterans further stressed the need for immediate outreach upon returning home. One participant suggested, “When a veteran comes home, they should know who the first point of contact is; if they don’t find you, the first point of contact should find them!” Another

participant noted that this outreach was especially important for those who are disconnected from the veteran community. He wanted a point of contact who would “reach out and grab disenfranchised veterans – folks that don’t trust the system.” Another veteran said that “it took encouragement from fellow veterans” to persuade him to apply for assistance because he initially “didn’t even want the benefits I earned.”

Continuous outreach is important, especially for younger veterans who may not need services right away. Although younger veterans go through TAPs, one participant explained that younger veterans “don’t listen if it doesn’t affect them” immediately (see discussion below). Younger veterans uniformly stressed the great potential inherent to using Facebook, Vine, YouTube, and various other emerging forms of instant, electronic communication, some of which were not familiar to the Research Team. One veteran suggested an advertising campaign with the slogan, “We appreciate your service; this is what we have for you.”

Some recommendations, such as direct mailings, fostered intense debate among focus groups. Some veterans liked receiving information via direct mail, while others thought direct mail was obsolete. Many participants suggested that the VA should use information from the DD-214 form to send mail to veterans. However, other participants felt that this could be upsetting to some veterans who may wonder who has their contact information. They speculated that some veterans may “think the military is still watching them.” One group advised against direct mail due to high costs, saying, “I wouldn’t want to see tax dollars to send direct mail to every single vet.”

When asked to provide open-ended feedback, almost half of older veterans said that improved communication and outreach are the most pressing needs for veterans in Pennsylvania. One specific recommendation was to “have the DMVA sponsor more information sessions

across each county to capture the newly separated and recently separated veterans.” Several veterans recommended that all entities concerned with veterans’ benefits should “centralize veterans’ benefits and websites,” and many concurred in one veteran’s observation that “there are far too many different sources of information that overlap.”

Younger veterans provided general comments that conveyed great dissatisfaction with the VA and disappointment with the lengthy and cumbersome claims process. On the other hand, several veterans expressed gratitude for the benefits they have received and admiration for their local VSOs. One veteran wrote, “My VA is top notch! Saved my life twice . . . I love my VA!”

In-person visits remain an effective way of communicating. VSOs relayed positive experiences from visits to colleges and universities (to reach younger veterans) and nursing homes (to reach older veterans). VSOs recommend that outreach efforts should retain an in-person component for two reasons. First, these in-person visits reach individual veterans. Perhaps as importantly, these visits can be high-profile and publicized events that may reach additional veterans. Finally, VSOs reported that in-person visits increase veterans’ familiarity, and thus comfort level, with VSOs.

Findings: Observations from VSOs

The recommendations from VSOs for reaching veterans across all age types were consistent with all of the other findings regarding communication. VSOs perceive a need for a more systematic and scientific strategic communication plan. Many VSOs recommend that an effective strategic plan should include mass media components, but that “they” (the people designing the plan) need to “think outside the box” in terms of what “mass media means.” VSOs recommend a multi-tiered approach that incorporates websites, online chats, webinars, radio public service announcements, email blasts, RSS feeds, print media, Facebook, LinkedIn, and an

opt-in subscription service run through the DMVA website. Several VSOs expressed doubt that the DMVA had the capacity or expertise to develop a “young enough” plan, and they encouraged the Research Team to convey the need to hire some “young experts” to develop a strategic communication plan. The Research Team interpreted the word “young” in the context of these interviews to mean persons who have expertise in new and emerging methods of communication and marketing. Other VSO recommendations of interest included requests for a DMVA-run quarterly newsletter and creation of a state lottery to benefit veterans, similar to the one in Texas.

Recommendations

In light of these findings on communication, the Research Team proposes that DMVA develop a matrix for improving outreach efforts on a case-specific basis. For example, information on community-based services for PTSD or assistance with prosthetics or seizure disorder support groups might be tailored to a younger veteran audience using the most current forms of electronic communication. Information on estate planning or long-term care might be distributed in more traditional formats.

It is apparent that accurate, comprehensive, easy-to-access information for veterans and their families is needed to ensure that veterans know what benefits are available to them. More broadly, communication is essential to providing veterans appropriate education and access to all facets of veterans services in the Commonwealth, from how to register with the County veterans office to what resources are available to family members who fear a veteran is engaging in risky behavior. For context, the following recommendations were noted by other states’ needs assessments regarding information and communication with veterans:

- In Texas, a single-source referral service has been identified as an appropriate goal because the state is so large and resources are dispersed (Palladino, 2012);

- Some states have outreach programs to contact veterans shortly after they return home through phone or mail. Researchers noted that it is key to have accurate address information on veterans' departures and return windows (Southwick *et al.*, 2008);
- Many states have determined that a multi-media approach is most effective, utilizing television, social media, texting, flyers, brochures, and posters to reach veterans (Morris, 2012);
- The Ohio Department of Veterans Services created a liaison officer position with the purpose of connecting county veterans service offices to the regional VA office in order to monitor claims and identify issues (Moe, 2012). The liaison officer is then able to work with County Veterans Service Officers (CVSOs) to help resolve these issues; and
- In 2012, Ohio created the CVSO Hot-Line to allow accredited County Veteran Service Officers to track benefit claims via telephone or via an online component (Moe, 2012).

Closer to home, Pennsylvania's DMVA created a system similar to Ohio. County Directors of Veterans Affairs in Pennsylvania are able to monitor and track benefit claims with the Regional Field Offices in Philadelphia and Pittsburgh in order to help speed up claims processing for Pennsylvania veterans. The Research Team did not delve into the specifics of this program. In a report for the Center for Rural Pennsylvania two years ago, a research team at Penn State Harrisburg recommended that VSOs explore interactive technologies, provide better technological training to county and private VSOs, and establish a social media presence (Behney *et al.*, 2012).

In an ideal world, Pennsylvania would adopt the best practices identified in the literature review antecedent to this Study and the recommendations from the field as collected by the Research Team. Some of these practices include, but are not limited to: (1) A single-source portal, or clearinghouse, for links to all electronic resources for veterans claims processes, VA benefits, community-based benefits, and private resources; (2) a hotline linked by telephone

number to the appropriate regional VA office for initial inquiries and a hotline linked by telephone-client number to the appropriate VSO or advocate (based on VA-assigned claim number); and (3) an annual reminder system for benefits review, contact information for VSOs, and any other information stakeholders want to impart. The annual reminder system is familiar to veterans who are accustomed to having a variety of responsibilities attached to their birthdates and annual physicals. As one focus group veteran recommended, “Let us know each year on or near our birthday that we are in the system and that we qualify or need to update our records. And if we want to work on civil defense projects in our areas, or what we could do to make it safe for our loved ones.”

Veterans expressed a desire for more visibility for veterans in the Commonwealth. Many veterans and VSOs felt that other groups get “more press” and that visibility of veterans’ issues is not as robust as it could be. One veteran suggested creating a Secretary of Veterans Affairs in Pennsylvania and moving Veterans Affairs out of the DMVA. He enthusiastically stated,

We need a cabinet position. We need someone with clout. If we had an organization like that set up, that would result in a lot of serendipity. More visibility in the state for veterans. The Secretary of VA would be better than a Deputy Adjutant General.

He also felt that this position would have more direct access to the federal Secretary of the VA. Another veteran felt that it was important to go to a high-level Pennsylvania government official (Governor, Speaker of the Pennsylvania House, or the President Pro-Tem of the Senate) to create a “special or joint commission to let everyone know that our veterans are important . . . it has to come from the top.” These comments are consistent with feedback received from a handful of other veterans.

CRIMINAL JUSTICE

Popular media frequently suggest that veterans commit an inordinate amount of crime and that veterans are disproportionately responsible for the overall crime rate (New York Times, 2008; Star Tribune, 2010). There are no reliable national data on arrest rates among veterans, but two studies commenced since 2008 suggest that arrest rates among veterans and active duty persons are slightly higher than would be expected based on the portion of the total population they represent (Correy & Stockburger, 2013; Veterans Intervention Project, 2009). Undoubtedly, research dating from the Vietnam War era through the present establish that PTSD and short-term problems with reintegration place veterans at high risk for engaging in criminal and high-risk conduct (Collins & Bailey, 2007; Lasko *et al.*, 1994; Wilson & Zigelbaum, 1983; Yager *et al.*, 1984). Although exact figures are not available, current researchers expect the number of veterans in the criminal justice system to grow as society continues to struggle with how to help veterans who “came back different” from more than a decade of war, which included the highest deployment rate in America’s military history (Meagher, 2007; Sontag & Alvarez, 2008). Actual data are needed on the rates of criminal justice contact among veterans and the nature of the offenses they commit, and the Research Team encourages the DMVA and other stakeholders to pursue means of gathering additional data to inform policy about veteran treatment courts, interventions among veterans, alternatives to incarceration for veterans, and correctional policy.

Background: Arrest Data

National data on arrest rates among veterans are not available. However, two local-level studies reveal consistent findings about arrest rates in several counties, and these data are useful for beginning to define the scope of arrest issues for veterans.

In a 2011 study in El Paso County, Colorado, 14.1% of the total arrest population were active duty personnel and veterans (265 military persons arrested per month out of 3,182 total arrests) (Correy & Stockburger, 2013). Active duty and veterans represented 12% of the total population in El Paso County, and 91.6% of arrestees were male (Correy & Stockburger, 2013). The majority of arrested veterans were in their 20s and 40s, but veterans represented a larger percentage of the total arrest population as they aged, with almost all arrestees in their 70s being veterans (Correy & Stockburger, 2013). In this study, 28% of veterans were arrested for a felony, and 55% for a misdemeanor. Only 13% of offenses involved drug or alcohol abuse (Correy & Stockburger, 2013). In short, the El Paso County data suggest that veterans more often commit misdemeanors; did not “age out” of criminal misconduct; and represented a larger portion of the geriatric arrestee population.

In 2008, the Veterans Intervention Project (VIP) surveyed three primary points of entry into the criminal justice system in Travis County, Texas: The sheriff’s central booking agency, adult probation, and the pre-trial services offices. The survey process lasted for three months and required veterans to complete survey forms and return them to the study team. During the study period, 458 veterans were arrested, representing 3.4% of the total jail booking population (Veterans Intervention Project, 2009, p. 4). Twenty-seven percent of veteran arrests were for felonies and 73% for misdemeanors (Veterans Intervention Project, 2009). The most common misdemeanor arrests were for intoxicated driving ($n = 119$), and the most common felonies involved aggravated sexual assault ($n = 26$). Nearly all of the veteran arrestees were male (95%); 28% were in their 40s; 22% were in their 20s; 22% were in there 50s; and 54% served in non-combat billets (Veterans Intervention Project, 2009, p. 4).

Eighty-six percent received honorable ($n = 307$), medical ($n = 26$), or general honorable ($n = 63$) discharges. The arrestees' discharge statuses are relevant to whether they could have been receiving community-based services, such as PTSD support, substance abuse treatment, and other interventions. In fact, 74% of the veteran-arrestees in this study were eligible for VA services, but only 35% reported that they had ever received VA services (Veterans Intervention Project, 2009). These data suggest that the overwhelming majority of arrestees were eligible for services that may have mitigated their propensity to offend, but there are not sufficient data from this study to draw specific conclusions.

Background: Pennsylvania Arrest Data

It is not known how many veterans are arrested in Pennsylvania on an annual or monthly basis. In this study, six percent of older veterans and nine percent of younger veterans reported that they had been arrested since separating from the military. The Research Team suggests that obtaining arrest data for veterans who experience contact with the criminal justice system would be a useful undertaking for the DMVA and its research partners. A count potentially would be easy to facilitate because all correctional facilities in Pennsylvania assign an employee to serve as the veteran coordinator. However, these employees often receive these coordination assignments in addition to the other responsibilities attendant to their job descriptions (Reed, 2014). Very few facilities have a dedicated veteran coordinator, and current research indicates that there are five correctional facilities with dedicated veterans' services (Pennsylvania Department of Corrections and Pennsylvania Board of Probation and Parole, 2014).

Background: Incarceration Data

Population description. According to the most recent national-level data, just under 10% of incarcerated persons are veterans (U.S. Department of Veterans Affairs, 2011). Of those,

approximately 70% are incarcerated for non-violent offenses; 60% have substance abuse problems; 60% have a serious medical problem; 33% have a serious mental illness; and 20% are homeless (U.S. Department of Veterans Affairs, 2011). At the national level, veterans represent approximately 630 or every 100,000 persons in state and federal prisons (Noonan & Mumola, 2007). Veterans' incarceration rates are lower than rates for non-veterans, but veterans represent high rates of violent and sexual offenses (Mumola, 2000; Noonan & Mumola, 2007). While the overall incarceration population for veterans is growing, the growth rate has slowed since 2000, and the rates of incarceration among veterans who offend are lower than rates among non-veterans (Mumola, 2000; Noonan & Mumola, 2007).

As of 2010, there were 35,459 persons housed in Pennsylvania jails and 16,404 in Pennsylvania prisons, for a total incarcerated population of 51,863 (Council of State Governments Justice Center, 2012). The overall incarceration rate in Pennsylvania increased seven times faster than the national average from 2000 to 2010. According to Department of Corrections' data, there are 4,848 veterans incarcerated or under probation or parole supervision (Pennsylvania Department of Corrections, 2014). Veterans in prison are older and better educated than non-veteran inmates, and they are overwhelmingly men (99% of incarcerated veterans are men) (Mumola, 2000; Noonan & Mumola, 2007). Interestingly, veterans with a prior history of incarceration and who served in combat roles are more likely to be re-incarcerated than veterans with a history of incarceration who have not served in combat roles (Tsai *et al.*, 2012).

All DOC institutions employ a veteran coordinator, and two DOC facilities have dedicated Veterans Service Units (VSUs), which are opt-in wings tailored to serve the needs of veterans who are within 18 to 36 months of release (Pennsylvania Department of Corrections, 2014). These two programs, located in Dallastown and Pittsburgh, are well-received among

inmates and DOC personnel (Reed, 2014). Evaluation research should be conducted to assess the efficacy of these programs in terms of cost, recidivism, and overall benefit to veterans and society.

The majority of incarcerated veterans will depart the criminal justice system and require assistance identifying resources and reintegrating into society. The DOC maintains three community corrections centers dedicated to veterans (Pennsylvania Department of Corrections, 2014). Once veterans are released from institutions, DOC provides liaisons for all parole officers to the VA (Pennsylvania Department of Corrections, 2014). VSOs have a vital role to play in linking paroled and probated veterans with benefits, and oftentimes the VSO will be the only resource within the community for formerly incarcerated veterans.

Background: Probation and Parole Data

As of 2010, there were 179,297 people on probation in Pennsylvania (Council of State Governments Justice Center, 2012). It is not clear how many are veterans. The Department of Veterans Affairs (VA) has increased its number of justice outreach specialists to work with veterans who are before the courts or already in jail (Department of Veterans Affairs Fact Sheet, 2011). The VA has also established a Healthcare for Reentry Veterans (HCRV) Program to promote successful community integration (Department of Veterans Affairs Fact Sheet, 2011). Incarcerated male veterans have a variety of resources available to them for reintegration planning (Pennsylvania Department of Corrections, 2014); and incarcerated female veterans may be eligible for reentry services available at the Pennsylvania State Correctional Institutional at Muncy. At the Pennsylvania Board of Probation and Parole, reentry parole agents facilitate workshops and provide one-on-one interventions with incarcerated veterans at the VSU. Parole agents work directly with VA justice outreach specialists to assist veterans with housing,

treatment, and other needs. Parole agents also develop networks with community-based service providers to assist veterans.

Conventional wisdom holds that veterans “lose” their VA benefits when incarcerated. While in practice many veterans do lose access to services, it is technically incorrect to say that they “lose” their rights. Instead, they cannot access the benefits to which they are entitled because federal institutions are discretionarily permitted to defer benefit delivery to the state, federal, or local institution that is incarcerating a veteran (*38 U.S. Code 1700 et seq.*). Specifically, incarcerated veterans experience a reduction in disability compensation following the 61st day of incarceration, and veterans’ health benefits are handled differently during periods of incarceration (*38 U.S. Code 1710*). Veterans may not realize that they might be entitled to have their benefits reassigned to family members during their incarceration (*38 U.S. Code 1710*). Similarly, veterans may not know that they must apply to the VA to have their benefits fully restored within one year of being released from incarceration (Pennsylvania Department of Corrections, 2014). As explained by a veteran coordinator within a Pennsylvania prison, many veterans do not take advantage of their time in prison to repair their service records and obtain benefits (Reed, 2014). There are several avenues that incarcerated veterans can pursue for improving their discharge status, arranging for education benefits, and appealing disability ratings (Reed, 2014). VSOs could be invaluable to incarcerated and recently released veterans as they attempt to educate themselves on how to improve their prospects for the future (Reed, 2014). Unfortunately, none of the VSOs in this study had received any training on how to assist veterans who had recently been released from prison.

Veterans Treatment Court Programs

Background: Veterans Treatment Court Programs

Seventeen Pennsylvania counties host comprehensive veteran treatment courts (VTCs) as part of their larger "problem solving court" programs. Designed to provide alternatives to traditional criminal justice processing, these courts receive veterans who have been charged with one or more crimes, but the courts have individual-level differences on which types of offenses are permitted in veteran court. At the time of this research, none of the courts accept persons charged with sex crimes, but several counties accept veterans charged with other violent crimes.

VTCs provide honorably and other than honorably discharged veterans with alternatives to incarceration for their crimes, including community-based services to redress mental health, substance abuse, and related disorders. (Douds *et al.*, under review). Through these courts, veterans are diverted from traditional sentencing schemes and required to participate in two- or three-year supervised programs that include weekly meetings with the veterans court coordinator, mandatory community service, mentorship programs, community-based treatment, and compliance with terms of probation supervised by the local probation officer (Douds *et al.*, under review). These programs are too young to have undergone meaningful evaluation, but similar models based on mental health and substance abuse have demonstrated success. For example, the Buffalo, New York VTCs demonstrated success with its program in that, of the 100 veterans who had participated in the program in 2008, only two had returned to the traditional court system by March 2009 (Riccardi, 2009).

In a 2013 study of Pennsylvania VTCs, the researchers were not able to identify any formal mechanisms being used by jails or police departments to identify veterans among arrestees (Douds *et al.*, under review). Local-level initiatives, such as those pursued by Judge

Bruce Bratton in Harrisburg, Pennsylvania, report that they have received meaningful cooperation from local police and probation offices, but very little is known about the scope or reach of these programs. In other words, it is too early to tell if they are reaching a significant portion of veterans and/or whether they provide positive alternatives for veterans. Problems also remain in measuring outcomes and defining success with these programs. Additional research should be undertaken to determine the extent to which police departments, detention centers, and prosecutors' offices can better identify veterans among arrestees with whom they interact. A descriptive survey of all VTCs in Pennsylvania and a program evaluation of a VTC are forthcoming (Ahlin *et al.*, in development; Douds *et al.*, in development).

VTCs and the OVA 2012 Strategic Plan

The Pennsylvania OVA strategic plan outlines several objectives related to VTCs, including:

- Establishing VTCs in all 67 counties in Pennsylvania;
- Implementing a veteran identification system through which veteran status would be marked on state-issued drivers licenses;
- Working with police departments and prosecutors' offices to develop systems for early identification of veterans who encounter law enforcement;
- Providing training for law enforcement on issues facing veterans, where to obtain resources for them, and how to access VTCs; and
- Educating judiciary on the need to expand veterans' treatments courts' scope, eligibility, and programming.

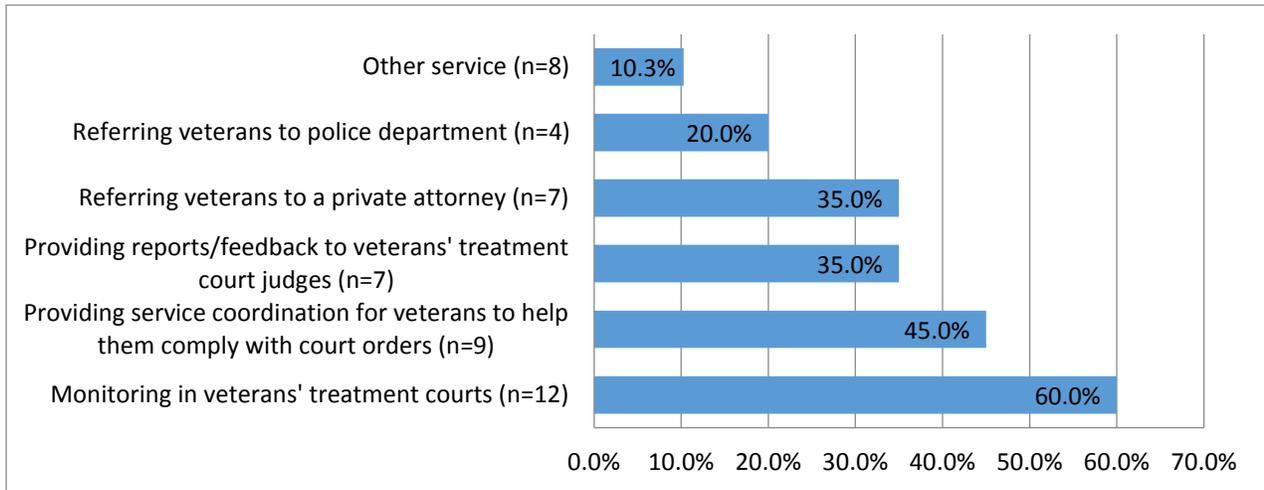
Findings: Veterans Treatment Courts

Over one-quarter of responding VSOs indicated that they provided assistance with accessing VTCs (29.9%; $n = 20$). ODAGVA staff were most likely to report providing assistance with accessing VTCs, while County Veterans' Affairs staff were least likely to report the same (40.0%; $n = 4$ versus 25.8%; $n = 8$, respectively). Almost a third of independent VSO staff indicated that they provide assistance with accessing veterans' treatment courts (30.8%; $n = 8$).

When asked about the type of assistance they provided with VTCs, over half of VSOs indicated monitoring services (60%; $n = 12$); and just under half provided service coordination for veterans to help them comply with court orders (45%; $n = 9$).

VSOs who said they facilitated interaction with VTCs reported that they served as mentors and attended court sessions with veterans ($n = 3$); provided claims assistance for veterans involved in VTCs ($n = 3$); worked with local judges ($n = 2$); acted as a service advocate ($n = 1$); and referred veterans to VTCs ($n = 1$). A few VSOs reported that they served on an advisory committee for the court. One described the experience as, "We meet every two weeks and discuss the progress of the veterans, compliance, review applications to the Veterans' Court, [and] participate in the graduation ceremony."

ODAGVA Staff were the most likely to provide VTC assistance, while CVAs were the least likely. The following figure shows the other types of assistance provided to assist veterans with accessing VTCs. "Other" assistance provided by VSOs included referrals, processing claims as needed, and recruiting and training mentors for veterans' treatment courts.

Figure 22. Types of Assistance with Access to Veterans' Treatment Courts

This study suggests that Pennsylvania veterans who are charged with crimes may not be availing themselves of Pennsylvania VTCs to the greatest extent possible due to lack of information and promotion of these programs at the county and local levels. Of all of the veterans in this study who reported that they had been arrested since separating from the military, only one had been made aware of and participated in a VTC program.

Additionally, VSOs are not being trained on any aspects of Pennsylvania VTCs. None of the VSO veterans in this study had received any formal training on how to refer veterans to VTCs, how to access programming that is available through VTCs, or what the benefits and limitations of VTC programs might be. Most VSOs reported that their knowledge of VTCs derived from informal resources, predominantly word-of-mouth. Moreover, there appeared to be grave misunderstandings about the nature and purposes of VTCs among VSOs in this study. A few VSOs thought that VTCs were community service programs designed to assist veterans with reintegration by providing them opportunities to volunteer in their communities. An additional handful of VSOs perceived VTCs to be “escape routes” for veterans, saying that VTCs are “going soft” on veterans and are allowing veterans to avoid responsibility for their misconduct.

On the other hand, the DMVA and DOC leadership with whom the Research Team conferred perceive the VTC programs to be more intensive and successful than traditional court processing (Douds, in development; 2014; Reed, 2014). Overall, however, the majority of VSOs consistently viewed VTCs favorably and recommended expansion of the programs. Respondent VSOs recommended that they receive training on how to interface with VTCs and Veterans Justice Outreach Programs.

Again, there is not yet enough research to establish empirically whether VTCs provide better outcomes for Pennsylvania veterans than traditional criminal justice processing. However, preliminary findings in other states suggest that VTCs are a positive alternative for veterans (Smith, 2012; Burns, 2010). If it is determined that developing VTCs remains a top priority for the DMVA and the Commonwealth, then this study reveals some challenges that should be considered as DMVA assists the Commonwealth in developing a strategic plan for VTC expansion.

First, the DMVA should anticipate resistance from VSOs and service providers in smaller and rural counties. Veterans in this study expressed concern that a “one size fits all” model for VTCs “will not work for [them].” They are concerned that superimposing a VTC model from a more urban county will not translate well. They also claimed that they did not have enough veterans in their counties who commit criminal offenses to justify a VTC, and they expressed concern that introducing VTCs into their counties would foster stigmatization of veterans among the general population.

Interestingly, prior research indicates that there is no such thing a “one size fits all” VTC in Pennsylvania. (Douds *et al.*, under review). A recent attempt to conduct a typological study of VTCs in Pennsylvania led to the conclusion that the many inconsistencies among Pennsylvania

VTCs prevent development of a typology (Douds *et al.*, under review). Instead, the researchers catalogued common characteristics of Pennsylvania VTCs, which is forthcoming.

Stakeholders developing new VTCs should be sensitive to the concerns expressed by veterans in this study and consider how to develop buy-in among local police, prosecutors, and probation offices. Additional study of local-level factors is needed for the launch of each new VTC, and VSOs should be consulted in the process. Education should be provided to VSOs about the rates of criminal offenses among veterans and the likelihood that there are offenders in their communities who served in the Armed Forces and might be interested in participating in a VTC.

Concerns about stigmatization should inform all discussions about veterans and the criminal justice system. However, there are limited data from this study that speak to that issue. For example, several VSO and individual veterans expressed concerns about mandatory identification of veteran status on drivers' licenses (veterans currently have the option to self-identify on their licenses). Veterans were concerned about their privacy and the risk that persons who see their drivers' licenses would make negative assumptions about them. They fear stereotyping and stigmatization. If the DMVA or other stakeholders choose to pursue this option, serious consideration should be given to administration. Police also need additional training on how to interact with veterans in high-stress situations.

Findings: Incarcerated Veterans

VSOs perceived that incarcerated veterans are significantly underserved by VSOs. While there was a pronounced dearth of knowledge among VSOs about the nature of incarceration and veterans' issues within prisons, VSOs consistently reported that incarcerated veterans are a high risk-high need population that is being underserved in Pennsylvania. When asked for specific

information or observations, VSOs called for establishment of VTCs in all counties of the Commonwealth as a palliative for problems related to incarceration because they perceived that VTCs are more responsive to needs of incarcerated veterans (40.0%; $n = 6$). Other suggestions included: (1) More counseling services for veterans in the criminal justice system ($n = 1$); (2) better coordination among VSOs and prisons ($n = 1$); and (3) better community services during reintegration ($n = 1$). Please see Volumes III: Focus Groups of Veteran Service Organizations and IV: Administrative Web Survey of Veteran Service Organization Administrators for a full list of suggestions offered by participating service officers on services that address veterans in the criminal justice system.

Recommendations

- Partner with researchers to collect data on arrest rates among Pennsylvania veterans.
- Expand existing resources for incarcerated veterans and their families.
- Expand training for incarcerated veterans and their families on disability compensation during times of incarceration, how to reassign incarcerated veterans' benefits to family members, and how to restore benefits after release from incarceration.
- Educate incarcerated veterans on how to petition for changes to their discharge status and arrange for education benefits upon release from prison.
- Work with police departments and prosecutors' offices to develop systems for early identification of veterans who encounter law enforcement.
- Train law enforcement on issues facing veterans, where to obtain resources for them, and how to access VTCs.
- Educate the judiciary in rural communities on VTCs.
- Engage research partners to empirically evaluate the value of VTCs and veterans' wings in prisons.

EDUCATION AND TRAINING

Compared with the general population, veterans are better-educated and better-trained, but they lag slightly behind the national average for bachelor's degrees (U.S. Census, 2012a). Nationally, the overwhelming majority of veterans hold a high school diploma (92% compared with 86% of the total population), but only 26% have earned bachelor's degrees (compared with 28% of the total population) (U.S. Census, 2012a). Nevertheless, important challenges remain to ensure that veterans are educated, trained, and retrained to the maximum extent possible.

Background

Education and training are critical cornerstones to a meaningful, comprehensive reintegration plan and support system for veterans. More than 73% of veterans in a 2010 national survey reported that education benefits had been "extremely important" or "very important" in helping them attain their educational goals or find better employment (Westat, 2010). In a recent California needs assessment of veterans, 64% requested information on education and training on their reintegration forms following deployments and 67% requested a referral for education or training services during personal interviews (California Department of Veterans Affairs, 2011).

In prior research, many veterans reported challenges and frustrations with the volume of paperwork required to receive education benefits through the VA. They also were dismayed by institutional fees associated with colleges and universities that may not be covered by GI Bills, such as student activity, information technology, facility, and/or lab fees (Dan Cahill and Associates, 2011; Schell & Tanielian, 2011; Southwick *et al.*, 2008). Recommendations from prior needs assessments include targeted degree programs that may be structured to meet specific veteran objectives and skill sets, and allowing veterans to receive academic credits for military and training experience (Palladino, 2012).

Pennsylvania veterans and their families have access to multiple education and training resources. At the federal level, eligible veterans can take advantage of at least seven different programs, including:

1. The Post-9/11 GI Bill (*38 U.S. Code 33*), which provides education and housing assistance to veterans who served after September 11, 2001;
2. The Montgomery GI Bill, Active Duty Educational Assistance Program (MGIB-AD) (*38 U.S. Code 30*), which provides educational assistance to active duty veterans;
3. The Montgomery GI Bill, Selected Reserve Educational Assistance Program (MGIB-SR) (*10 U.S. Code 1606*), which provides educational assistance to certain reservists;
4. Survivors' and Dependents' Educational Assistance (DEA) (*38 U.S. Code 35*), which provides money for education to veterans' eligible survivors and dependents;
5. Post-Vietnam Era Veterans Education Assistance Program (VEAP) (*38 U.S. Code 32*), which is for post-Vietnam era veterans;
6. Reserve Educational Assistance Program (REAP) (*10 U.S. Code 1607*), which provides educational assistance to Guard and Reserve personnel who served in an active duty capacity after September 11, 2001; and
7. Veterans Retraining Assistance Program (VRAP), which offers 12 months of training to eligible veterans.

As of 2012, approximately 23,000 Pennsylvania veterans were taking advantage of federal education and training benefits (U.S. Department of Veterans Affairs: National Center for Veterans Analysis and Statistics, 2014).²

² <http://www.gibill.va.gov/benefits/index.html>

Additional resources exist at the state and local levels, including assistance programs for students in the National Guard; children of POW/MIA; education gratuity for children of veterans with profound service-connected disability; education gratuity for military personnel who died during military service; state grants; and services of the State Approving Agency (Military and Veteran Benefits, News, Veteran Jobs, 2014; PHEAA Aid for Military and Pennsylvania National Guard, 2014). At the policy level, the Pennsylvania OVA has identified education as a key component to its larger initiative for combatting homelessness and unemployment. Specifically, the OVA announced in 2012 that it intends to work with the Pennsylvania Department of Education and Student Veterans of America to encourage schools to develop priority scheduling for veterans. It also intends to designate individuals at participating schools to help veterans navigate higher education and apply for veterans' benefits.

Findings: General

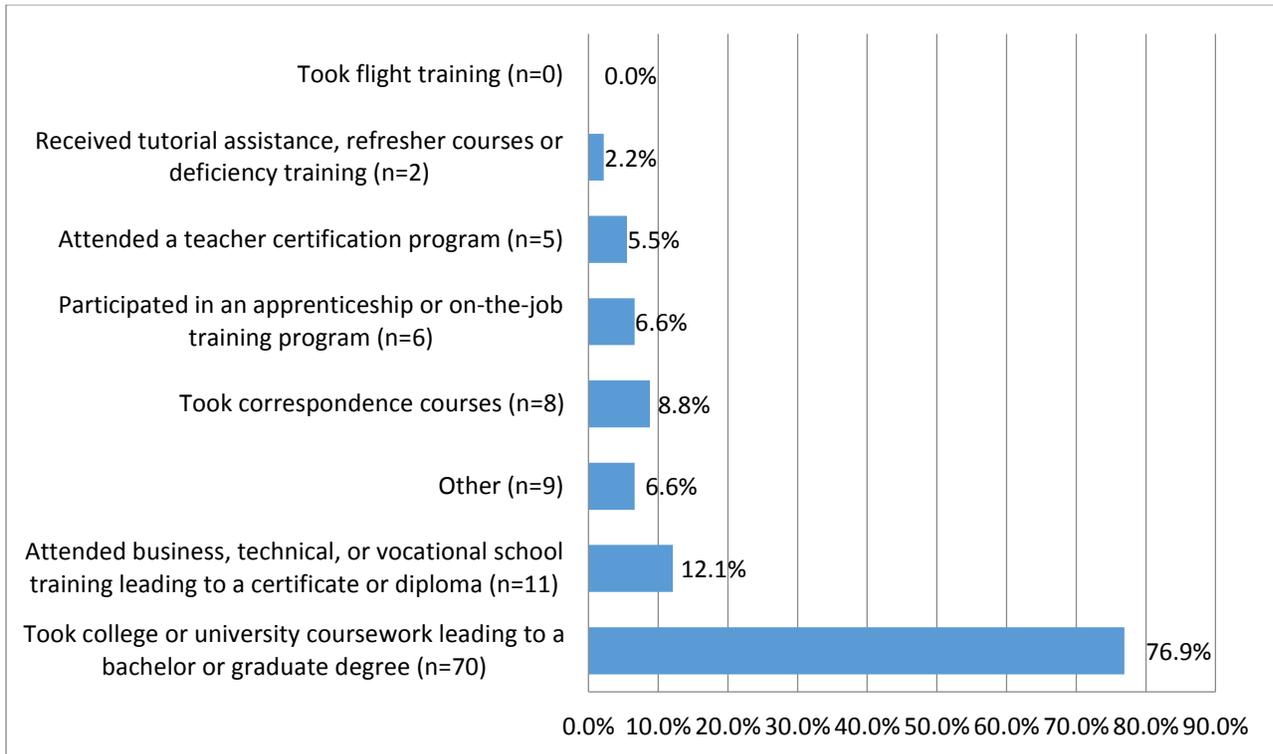
Few student or non-student veterans interviewed in this study had information about processing their GI Bill benefits or obtaining additional benefits other than the information they collected on their own from the hotline and on-line payment processing centers. In short, if the OVA initiatives have been implemented, none of the veterans in this study were aware of them.

Findings: Usage of GI Benefits

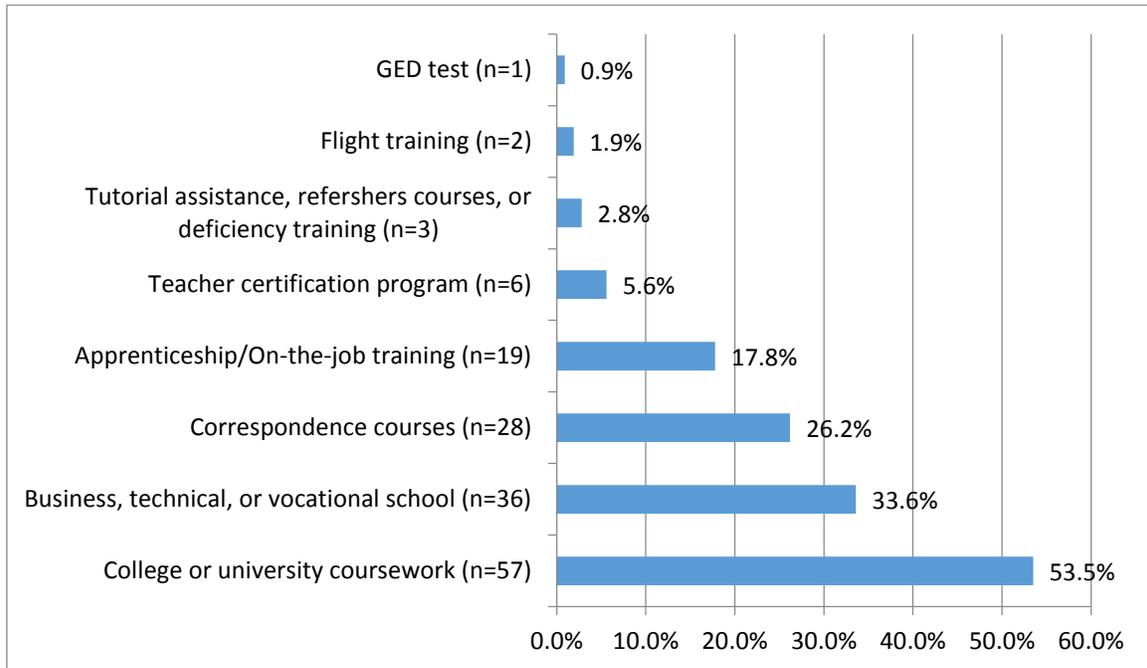
According to the statewide phone survey, a majority of younger veterans have used VA education or training benefits (70%), but only a plurality (38%) of older veterans had accessed VA education or training benefits other than vocational rehabilitation services. Over three-quarters of younger veterans and over half of older veterans who had used GI benefits have achieved a terminal degree. Just over 18% of younger veterans and close to 40% of older

veterans had used those benefits to obtain a certificate or diploma in technical, teaching, business or vocational training.

Figure 23. Education/Training Benefits Used by Younger Veterans



Among older veterans, over one-third had used VA education or training benefits other than VA vocational rehabilitation (37.5%; $n = 107$). Of those who used these benefits, most took college or university coursework leading to a bachelor's or graduate degree (53.3%; $n = 57$) and one-third attended business, technical, or vocational school leading to a certificate or diploma (33.6%; $n = 36$).

Figure 24. Education Benefits Used by Older Veterans

Younger veterans who did not take advantage of education benefits felt that they did not need them. One quarter reported that they were not aware of education benefits (25.6%; $n = 10$). Twenty-three percent ($n = 9$) never considered using the benefits, and 20.5% ($n = 8$) said they did not need additional training or education. Few veterans ($n = 4$) reported that their decisions not to use educational benefits arose from any problems within the benefit system.

Of the older veterans who had not used VA education or training benefits, one-half indicated that they did not need any additional education or training (50.6%; $n = 87$) or that the window of opportunity expired before they “got around to doing anything about it” (41.3%; $n = 71$). One-third never considering getting any education or training (32.6%; $n = 56$), and others said that they were too busy ($n = 2$), were rejected ($n = 1$) or did not want to take away from other veterans ($n = 1$).

Table 7. Older Veterans' Reasons for Not Using VA Education or Training Benefits

Reason	Number	Percent
Don't need any additional education or training	87	50.6%
My period of eligibility expired/ran out	71	41.3%
Never considered getting any education or training from the VA	56	32.6%
Don't need or want assistance from the VA	51	29.7%
Don't believe I'm entitled to or eligible for education or training benefits	46	26.7%
Too much trouble or red tape	45	26.2%
Not aware of VA education or training benefits	40	23.3%
Don't know how to apply for education or training benefits	35	20.3%
Didn't pay into training funds during active duty	27	15.7%
Another reason	8	4.7%
I used state education benefits from the National Guard instead	2	1.2%

VSOs also shared their insights on veteran usage of GI benefits. Over three-quarters reported that they assisted veterans with GI bill and other educational benefits (78.1%; $n = 57$). Most VSOs offered assistance in one of the following ways: Submitting benefits paperwork (29.5%; $n = 13$); providing referrals to the Pennsylvania Department of Education or VA education office (27.3%; $n = 12$); sharing information on the education benefits and the process to apply (22.7%; $n = 10$); and providing the GI bill hotline number to veterans (13.6%; $n = 6$).

Findings: Frustrations with Using GI Benefits

The majority of younger veterans had positive things to say about their experiences with GI benefits, but the majority also expressed frustration with the administration of the benefits. One participant exclaimed, "The GI Bill is incredible. I wouldn't have gone [to college] if I had to pay out of pocket." Another participant said that he used College Level Examination Program (CLEP) credits from his military service towards general education requirements. Several veterans currently using the GI Bill complimented the simplicity of doing so and recognized the helpfulness of veteran coordinators on their campuses.

While several veterans made glowing comments about the value of GI benefits, the majority had critical feedback for the administrative process. Veterans in this study report that they struggled with untimely delivery of their benefits and expended inordinate amounts of time processing their education benefits requests. As described in the section on benefits above, these struggles often resulted in delinquent tuition payments, which subsequently resulted in penalties being assessed against the veterans. These penalties included monetary sanctions and disenrollment from class. Veterans in this study felt penalized and criticized for using their education benefits. They expressed, for example, that they “earned these benefits,” but that they “are not perceived as exercising a right.” Instead, they feel that the people administering their benefits perceive them to be needy or a burden. Their experiences with accessing their GI benefits have been “demoralizing,” “depressing,” “frustrating,” and “discouraging.” Many reported feeling “alienated by the system” and some decided to “screw it,” to abandon their academic pursuits because of the headache and embarrassment of having to “beg” for money to pay for tuition.

According to veterans, some veterans are not using their GI benefits because some veterans are not prepared to pursue educational opportunities upon separation from the military. For example, one veteran who works at a community college noted that the GI Bill is “not great about getting veterans off campus.” He explained that the government “want[s] to see that GI Bills results [sic] in a degree or certification. Many of them wash out. We are falling short on that.” He recommended that stakeholders provide time management and training on transitioning to college life during veterans’ first semesters. Veterans in the focus groups were amenable to this suggestion. Several acknowledged that they are already members of veteran

clubs or fraternities on their campuses and that affiliation with these entities was very helpful in their transition to civilian/college life.

Many veterans described alleged inconsistencies in education benefits among states. Participants claimed that veterans from Alabama, Michigan, Minnesota and Texas receive free education at state universities, and that some states offer this benefit to spouses and children of veterans. One veteran said, “In Texas, a spouse and children can go to college for free. In Pennsylvania, I got a license plate. And, I still had to pay the registration fee. I don’t want a license plate. It’s limited in what you can do. They should set the bar higher. Not at the lowest level.”

VSOs reported that veterans with whom they interact reported problems similar to those described above. When asked in open-ended questions to provide recommendations for improving access to GI benefits, many requested more thorough information on GI bill programs (31.4%; $n = 11$). Improvements to the hotline were another area of focus (14.3%; $n = 5$). The hotline is characterized by difficulties getting through, extremely long wait times, and customer service representatives who are not helpful. Finally, VSOs identified the need for better outreach and promotion of the GI bill and education benefits (14.3%; $n = 5$). Please see Volumes III: Focus Groups of Veteran Service Organizations and IV: Administrative Web Survey of Veteran Service Organization Administrators for a complete list of suggestions offered by participating service officers on GI Bill and other educational benefits.

In sum, VSOs appeared to be well-informed about how to provide assistance on GI benefits. Across all groups, VSOs would like better, more up-to-date information on processing GI claims and a more efficient hotline. VSOs and veterans generally concurred in additional, specific recommendations for improving the GI Bill experience, such as (a) allowing veterans to

receive academic credit for “externships,” “on the job training,” and credentialing they completed as a requirement of their MOSs; (b) establishing standardized protocols for translating MOS certifications into civilian academic credits; (c) incorporating standardized lag times into payment processing by registrars and bursars offices within universities for students paying with GI benefits; (d) identifying a GI Bill liaison within each college and university who would serve as the point of contact for all veterans in that institution; and (e) encouraging all academic institutions to institute a veterans coffee hour or “happy hour” with discounted soft drink and coffee prices at a predetermined location on a weekly basis. VSOs could schedule visits to campuses during these coffee klatches.

Recommendations

- Coordinate with university and college registrars to flag veterans who are using the GI Bill and allow those veterans to sustain their registration, without penalty, when tuition payments are delayed due to circumstances beyond the veterans’ control.
- Provide VSOs with periodic updates on developments in GI claims processing.
- Establish a GI Bill hotline for veteran/students, perhaps specific to Pennsylvania.
- Develop credit-granting programs within colleges and universities to provide veterans with academic credit for externships, on-the-job training, and credentialing they obtained in connection with their military occupational specialties (MOSs)
- Relatedly, establish standardized protocols for translating MOS certifications into civilian academic credits.
- Incorporate standardized lag times into payment processing by registrars and bursars offices within universities for students paying with GI benefits.

- Identify a GI Bill liaison within each college and university who would serve as the point of contact for all veterans in that institution.
- Encourage academic institutions to institute a veterans coffee hour or “happy hour” with discounted soft drink and coffee prices at a predetermined location on a weekly basis.
- Encourage VSOs to attend weekly student coffee hours.
- Identify faculty members within each academic community who are veterans to serve as informal advisers or points of contact for student veterans and/or require VSOs to visit college campuses periodically to share information.

EMPLOYMENT

On average, veterans have lower unemployment rates and a higher median salary than non-veterans. In the 2012 Census, veterans reported a median income that was \$10,000 higher than non-veterans (\$36,264 versus \$25,337). (U.S. Census, 2012a). Additionally, veterans own nine percent of all of the businesses in the nation, generating \$1.2 trillion annually, and they employ 5.8 million people (U.S. Census, 2012a). Veterans are more likely than non-veterans to be employed in public administration, and the majority of veterans work in the public, education, and manufacturing sectors (U.S. Census, 2012a). Nevertheless, unemployment remains an intractable problem for the Pennsylvania veteran community.

Background

The federal and Pennsylvania unemployment rates for veterans are lower than those of non-veterans,³ but unemployment and under-employment remain significant challenges for Pennsylvania's veteran community, particularly its younger veterans (U.S. Department of Veterans Affairs: National Center for Veterans Analysis and Statistics, 2014). At the national level, the unemployment rate is highest for veterans of the second Gulf War (13.0%) and lowest for those who served across multiple war periods (5.9%). The unemployment rate for veterans who served during times of peace is 8.5% (U.S. Department of Labor, 2010; U.S. Department of Labor, 2014; National Survey of Veterans, 2010). According to the most recently available American Community Survey data, 7.7% of all of Pennsylvania's veterans are unemployed, compared to 8.7% of Pennsylvania's non-veteran population (U.S. Census Bureau, 2012a).

³ It should be noted that there are some contradictory data. A 2011 Rhode Island needs assessment found that 13% of veterans aged 35-54 were unemployed compared with only 9% of non-veterans in the same category (Dan Cahill and Associates, 2011). Illinois reported the 4th highest unemployment rate in the country for new veterans (those who were deployed any time after 9/11), at 13% in 2010 (Carrow, Rynell, & Terpstra, 2012).

Notably, younger veterans suffer from unemployment at disproportionate rates. Pennsylvanians between the ages of 18-34 face a much higher unemployment rate overall, with non-veterans faring slightly better than their veteran counterparts (12.0% compared to 12.6%, respectively) (U.S. Census Bureau, 2012b). In 2012, the Bureau of Labor Statistics reported that Gulf War II era veterans (those who served on active duty at some point since September 2001) had a higher unemployment rate (9.9% versus 7.9%) than non-veterans (Bureau of Labor Statistics, 2013). Nationally, 18-24 year olds are unemployed in even greater proportions, with 19.7% of veterans and 14.3% of non-veterans facing unemployment in this age cohort (U.S. Department of Labor, 2013). However, it should be noted that the data sources for the unemployment statistics provided for Pennsylvania and the United States in this section represent different time periods and are provided for illustrative purposes only.

Background: Employment Assistance

All studies that have examined employment issues among veterans call for better employment assistance programming. The CDVA Veterans Needs Assessment Survey found that employment was the most crucial need of veterans (California Department of Veterans Affairs, 2011). According to “reintegration forms” from over 50,000 California veterans returning from deployments, the number one priority was employment assistance, with over 77% of veterans requesting employment information (California Department of Veterans Affairs, 2011). Employment was also the most-cited challenge identified by veterans in a 2012 study in Charlotte-Mecklenburg, North Carolina (Morris, 2012), and New York veterans reported that high unemployment was a direct threat to their overall well-being (Schell & Tanielian, 2011).

In needs assessments from California, New York, North Carolina, Rhode Island, and Virginia, many veterans discussed the difficulties they faced during their transition from military

life back to civilian employment. They said that employers did not understand what they did in the military, and they did not know how to translate their military MOSs into civilian jargon (Schell & Tanielian, 2011). One focus group participant observed that, “One of the big misconceptions . . . coming off active duty [is that] you walk on water [but] what you’re doing is not relevant to what’s going on in the civilian world. And they are more impressed with your Microsoft certifications than they are with your leadership time” (Schell & Tanielian, 2011, p. 10). Veterans across all five needs assessments agreed that training, education, and employment need to be more focused so that the transition from the military to a civilian job can be smoother (Dunkenberger *et al.*, 2010).

Pennsylvania sustains a variety of employment assistance programs, some of which are targeted exclusively to veterans. For example, the state honors a “veteran’s preference” for civil service employment, whereby veteran applicants receive an additional ten points on their evaluative scores (Pennsylvania State Civil Service Commission, 2014a). Between 2009 and 2013, the Commonwealth of Pennsylvania hired over 24,000 new civil service positions (Pennsylvania State Civil Service Commission, 2014b). Approximately 18%, or 4,297, of those hired for new civil service positions were veterans utilizing the Veterans’ Preference Program (Pennsylvania State Civil Service Commission, 2014b).

Findings: General

Ten percent of younger veterans in this study were not working and were looking for work when they completed the survey. One-quarter of younger veterans were not working and were *not* looking for work. Over half of older veterans were not working and were not looking for work when they completed the survey.

The majority of veterans had not used employment services that are available to veterans or to Pennsylvania citizens generally (66.4%; $n = 190$). A plurality of veterans had taken advantage of resources through CareerLink (13.6%; $n = 39$); career fairs (12.9%; $n = 37$); PA Civil Service Commission (10.8%; $n = 31$); vocational training or counseling (8.7%; $n = 25$); and/or assistance with résumés and interviews. Less than 10% took advantage of the VA's Vocational Rehabilitation and Employment Program, the PA OVR Program, the PA Small Business Development Center, or the OVA Business Development Program.

Table 8. Employment Services Used By Younger Veterans since Separating from the Military

Employment Services	Number	Percent
I have not used employment services	72	53.3%
Attended career fairs	39	28.9%
PA Civil Service Commission/employment with the Commonwealth	29	21.5%
CareerLink veterans training and referral program (Veterans Employment Representatives)	26	19.3%
Vocational counseling/training	23	17.0%
Assistance with employment applications, creating resumes and cover letters, etc.	21	15.6%
VA's Vocational Rehabilitation and Employment Program	9	6.7%
Pennsylvania Office of Vocational Rehabilitation (OVR) program	7	5.2%
Another federal or state job program	7	5.2%
A Pennsylvania Small Business Development Center program	4	3.0%
An Office of Veterans Business Development (Small Business Administration) program – training or loan	2	1.5%
A non-profit job program	2	1.5%
Other employment service (WRP, Pathways)	1	0.7%

Table 9. Employment Services Used By Older Veterans since Separating from the Military

Employment Services	Number	Percent
I have not used employment services	190	66.4%
CareerLink veterans training and referral program (Veterans Employment Representatives)	39	13.6%
Attended career fairs	37	12.9%
PA Civil Service Commission/employment with the Commonwealth	31	10.8%
Vocational counseling/training	25	8.7%
Assistance with employment applications, creating resume and cover letters, etc.	23	8.0%
VA's Vocational Rehabilitation and Employment program	7	2.4%
Another federal or state job program	7	2.4%
Any other employment services	7	2.4%
Pennsylvania's Office of Vocation Rehabilitation (OVR) Program	3	1.0%
A Pennsylvania Small Business Development Center program	3	1.0%
An Office of Veterans Business Development (Small Business Administration) program (training or loan)	2	0.7%
A non-profit job program (Salvation Army and Red Cross)	1	0.3%

Among younger Pennsylvania veterans, 52% ($n = 63$) reported that they have a service-related disability rating, and one-third of those reported that their disability interferes with their ability to hold a job ($n = 18$). One-fifth of older veterans had a service-connected disability rating (20.4%; $n = 57$), and of those, one-fifth said that their disability interfered with their ability to obtain or retain employment (20.0%; $n = 11$).

Overall, one-third of younger and older veterans did not have access to public transportation, which they thought interfered with their ability to hold employment. Of those who cited transportation as an obstacle to employment, over one-third observed a need for better public transportation in their communities (36.7%; $n = 36$). Most veterans did not use veteran transportation services (87.1%; $n = 249$), but several used VSO vehicles (5.9%; $n = 17$); transportation vouchers (5.6%; $n = 16$) and other transportation services (2.1%; $n = 6$).

Pennsylvania veterans shared many of the same concerns as veterans in prior needs assessments in other states. All focus groups identified employment as a significant need. One

participant expressed frustration with his long-term unemployment when he said, “I don’t want to hear ‘thank you for your service.’ That’s not putting anything on the table.” Veterans also discussed the difficulty in translating certain military skills (leadership, problem solving, teamwork, judgment) into civilian terminology. Many veterans also perceived that employers harbor negative perceptions of returning service people and make assumptions about mental health and PTSD. For example, one veteran attributed his inability to get a job to visceral prejudice against deployed veterans. He explained that, “Employers think I’ll freak out on the job.” Another focus group participant heard a human resources representative say, “You can’t find good veterans.” However, one participant who is a hiring manager said that he would “love to hire fellow veterans,” but he was not able to find them.

Focus group participants shared mixed feelings about the civil service “veteran’s preference” (Pennsylvania State Civil Service Commission, 2014a). One older participant felt that the younger veterans deserve more than the ten points given on the State Civil Service exam; he thought that increasing the points could help lower unemployment in the veteran population. Conversely, another veteran felt like utilizing veteran’s preference held a negative connotation, even though she had used it herself. Specifically, she stated, “The way it is used, it almost backfires in a way. Being considered first, you get hired first. It leaves a bad taste in others’ mouths.” Another veteran in that group followed up by saying, “You need a hand up, not a hand out.”

Many participants expressed dissatisfaction with the application of veteran’s preference, and their sentiments were captured by one veteran’s observation that, “Veteran’s preference is largely a joke. All kinds of employers systematically ignore and sabotage these laws,” and “If Pennsylvania says we are going to work to hire vets, do it. Don’t just give me a bumper sticker.”

Findings: VSOs and Employment

The majority of VSOs perceived themselves to be involved in developing employment opportunities and perceive that employment assistance is one of their responsibilities (65.2%; n = 45). CareerLink is their main place for referrals (95.6%; n = 43). Many VSOs maintained ad hoc lists of employers and connected veterans with the PA Civil Service Commission. ODAGVA VSOs were more likely than others to refer veterans to Civil Service opportunities and to promote career fairs.

Figure 25. Employment Efforts by VSOs

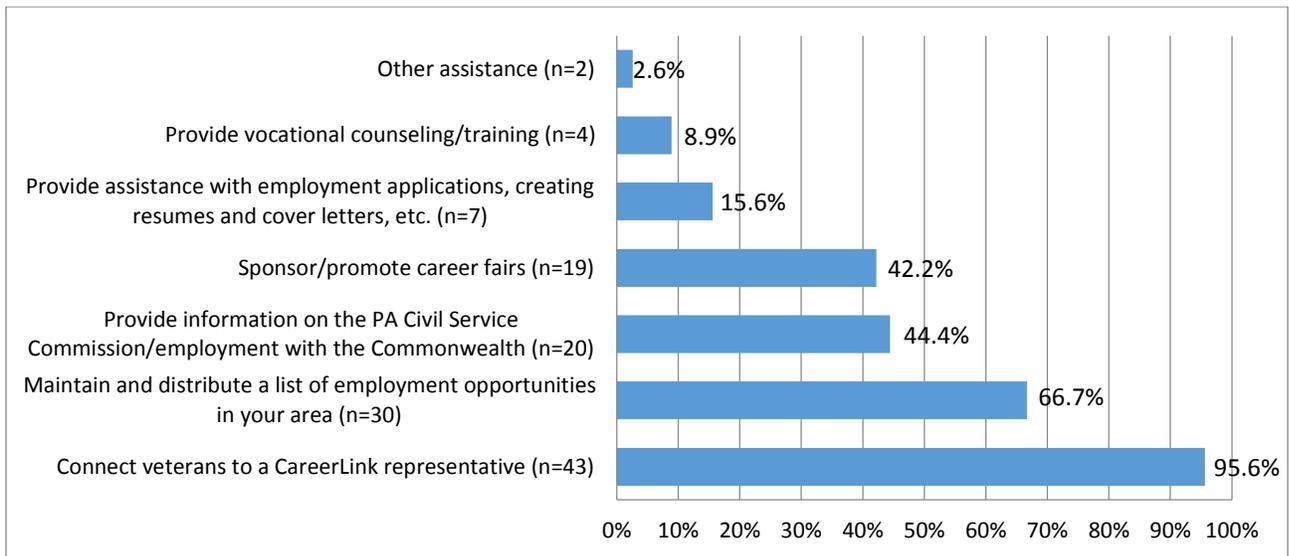


Table 10. Employment Efforts by Organizational Affiliation

Efforts	ODAGVA staff	County Veterans' Affairs staff	Independent VSO staff
Connect veterans to a CareerLink representative	100.0%	95.0%	93.8%
Maintain and distribute a list of employment opportunities in your area	77.8%	60.0%	68.8%
Sponsor/promote career fairs	66.7%	30.0%	43.8%
Provide information on the PA Civil Service Commission/employment with the Commonwealth	77.8%	30.0%	43.8%
Provide assistance with employment applications, creating resumes and cover letters, etc.	22.2%	15.0%	12.5%
Provide vocational counseling/training	11.1%	10.0%	6.3%
Other service	0.0%	2.6%	3.4%

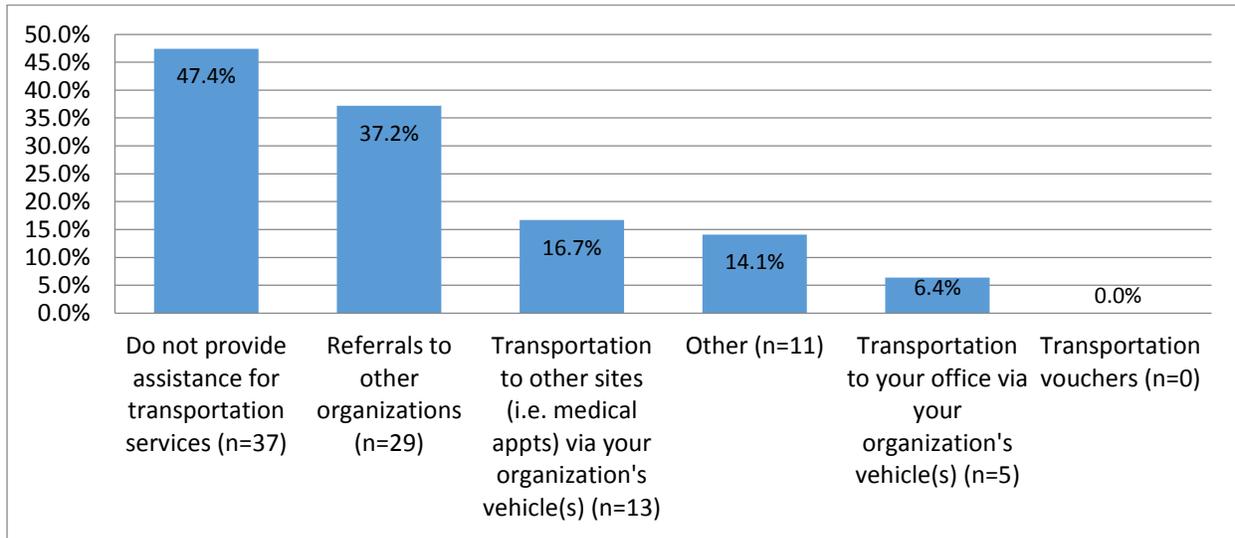
Findings: Transportation and Employment

Transportation is not just an employment issue; it is central to responding to veterans' employment needs. Transportation also is relevant to health care, education, claims processing, and myriad other veterans' services. It is discussed here because it arose most frequently as an employment issue among the veterans in this study.

Over two-thirds (70.3%; $n = 52$) of service officers reported that veterans in their area have access to public transportation. A majority of ODAGVA VSOs identified public transportation in their communities (90.9%; $n = 10$). Approximately two-thirds of both CVSOs and IVSOs said that veterans in their communities had access to public transportation (66.7%; $n = 24$; and 66.7%; $n = 18$). VSOs concurred with veterans that many communities need better and more public transportation, especially in rural areas where veterans must travel significant distances to access VA hospitals and offices. When asked what types of transportation would be useful in their area, one-quarter of VSOs requested bus service (25.0%; $n = 5$). Other responses included a handicapped accessible van or bus, taxis, van or shuttle service, and county transportation accountable to the CVSOs. A few VSOs complained that many transportation services are limited to medical assistance or veterans over the age of 65. They expressed a need for more transportation for more veterans for more purposes. Finally, one VSO observed a need for emergency, itinerant transportation services in his community.

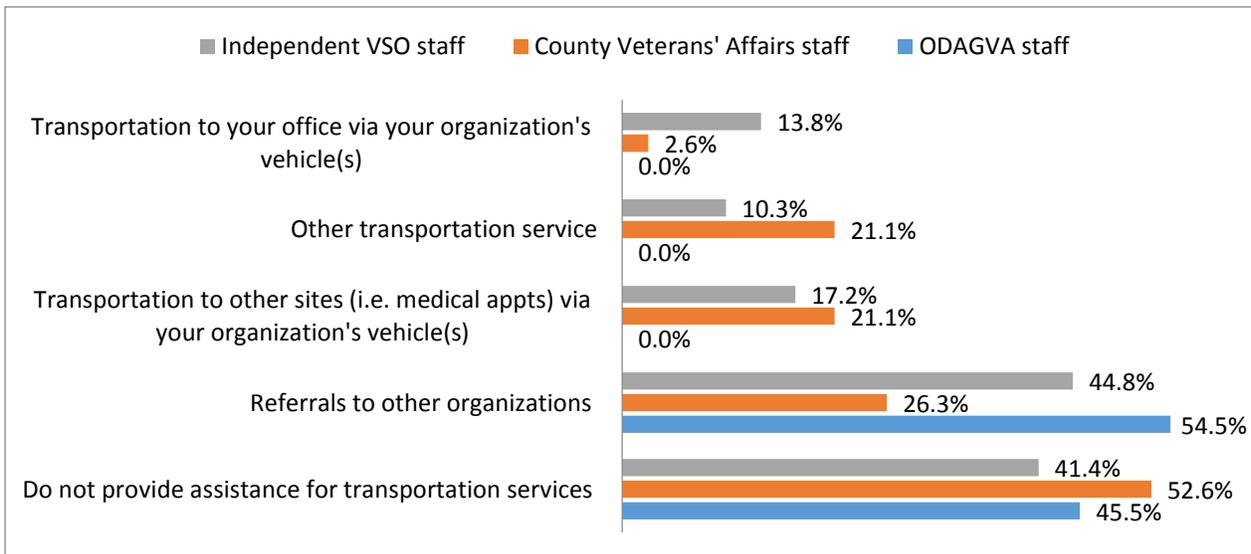
Almost half of VSOs (47.4%; $n = 37$) indicated that their offices did not provide assistance for transportation services. Of those that did provide "assistance" (52.6%; $n = 41$), most indicated that they referred veterans to other organizations that provide transportation assistance (37.2%; $n = 29$). The remainder had access to one or more modes of transportation.

Figure 26. Types of Transportation Services Offered by VSOs



IVSOs were most likely to provide transportation via their organization’s vehicle(s) (13.8%; $n = 4$). CVSOs were least likely to provide transportation assistance (52.6%; $n = 20$). ODAGVA VSOs said that they did not provide direct transportation services; they only refer veterans to other organizations (54.5%; $n = 6$). Finally, no VSOs reported that they had ever provided transportation vouchers.

Figure 27. Types of Transportation Services Offered by Organizational Affiliation



OVA's strategic plan outlines a number of other strategies for helping veterans find work.

They include:

- Developing a statewide veterans' employment task force,
- Establishing a Local Veterans' Employment Representative (LVER) in each county to advise veterans and serve as liaisons between veterans and employers,
- Improving advertisement of Pennsylvania CareerLink,
- Working to achieve veteran representation on the Workforce Investment Board and Workforce Investment Areas,
- Developing and sponsoring job fairs and vocational seminars,
- Promoting and advocating for veteran-owned small businesses, and
- Providing incentives to the private sector for hiring veterans.

(Pennsylvania Office of Veterans' Affairs, 2012). The Research Team speculates that all of these efforts would be well-received by veterans, but the Research Team does not have any status or outcome data on any of these objectives from which to draw any conclusions.

Additionally, the Pennsylvania Veterans Chamber of Commerce, which opened in October 2013, and the Pennsylvania Veterans Resource Center provide new resources for veterans in the forms of advocacy, job creation and placement, business and community support, and education (Pennsylvania Veterans Chamber of Commerce, 2013). Data were not available on the success of these programs.

Recommendations

This Study merely scratches the surface of transportation issues and how those issues impact veterans' services. To the extent data are not already being collected on county-level transportation services, the Research Team recommends that stakeholders catalog the modes of transportation available to county residents, including veterans. In light of the significant communication issues identified above, it is possible that transportation infrastructure exists in

some areas but is not being promoted among veterans. Therefore, the Research Team recommends further study of this issue.

The Research Team further recommends that stakeholders expand existing matrices and crosswalks to better translate MOS descriptions into civilian job descriptions. O*NET OnLine, in partnership with the American Jobs Center Network, maintains a robust example of a functioning crosswalk that meets this recommendation in part (O*NET OnLine, 2014). Alternatively, or perhaps in conjunction, stakeholders should work with existing employment infrastructure to incorporate veteran-specific services within the state's workforce development organizations (Morris, 2012).

The data on the veteran's preference garnered in this study were sparse, but alarming. If the veteran's preference is not being used properly, or is somehow having adverse, unintended consequences, then stakeholders need to know. Moreover, stakeholders need to develop means of remediating any negative correlates of the veteran's preference (Pennsylvania Office of the Auditor General, 2008; Pennsylvania State Civil Service Commission, 2014a).

Veterans also offered a variety of transportation recommendations, which could assist veterans in finding and maintaining employment. They included:

- Have more service organization-sponsored transportation ($n = 4$)
- Offer transportation other than to VA hospitals ($n = 4$)
- Have more volunteer drivers ($n = 3$)
- Offer transportation from clinics ($n = 3$)
- Offer handicapped accessible transportation ($n = 2$)
- Relax standards for volunteer drivers ($n = 2$)
- Change the view that transportation is an entitlement ($n = 1$)
- Increase availability and awareness of Disabled American Veteran vans ($n = 1$)

- Increase awareness of available transportation services in general ($n = 1$)
- Provide more availability to veterans ($n = 1$)
- Offer more types of transportation for veterans ($n = 1$)
- Provide more vans from VA hospitals to pick up veterans ($n = 1$)
- Provide a county vehicle with volunteer drivers ($n = 1$)
- Create transportation options that are not dependent on volunteers ($n = 1$)
- Offer a veteran pick-up service ($n = 1$)

See Volumes III: Focus Groups of Veteran Service Organizations and IV: Administrative Web Survey of Veteran Service Organization Administrators for a complete list of suggestions offered by participating service officers on transportation services.

HEALTH CARE

Throughout 2014, the federal government grappled with how to redress egregious failures in the VA health care system. The Research Team understands that President Obama appointed a new Secretary for the VA in 2014, and the problems that new Secretary seeks to remedy are beyond the scope of this Study. However, the Research Team feels it is important to read the following data with the understanding that the interviews and surveys were conducted during the height of media attention to VA mismanagement and disclosures of deaths arising from VA neglect. With that said, the following data can inform state- and local- level efforts to improve access to VA benefits and other health services. The data in this section focus less on claims processing and more on macro concerns about the VA culture. Findings specific to claims processing are contained in the Benefits section above.

Accessing VA Health Care in VA Facilities

Background

Health care historically has been a concern for all segments of society, and veterans are no different. During personal interviews conducted with recently discharged veterans in California, almost three-quarters (74%) requested health care referrals (California Department of Veterans Affairs, 2011). These included requests for specific information on VA health care, traumatic brain injury, post-traumatic stress disorder, family counseling, substance abuse, and women's health.

Unfortunately, veterans' access to health care often hinges upon their ability to access VA resources. It is not known exactly why, but only a minority of veterans is taking advantage of services available to them through the VA. In a 2010 National Survey of Veterans, only about 28% of veterans reported having used VA health care services at some point (Westat, 2010). A

survey of Virginia veterans found that veterans from Operation Iraqi Freedom and Operation Enduring Freedom frequently reported trouble accessing health services because available appointment times conflicted with their work schedules or child care availability (Dunkenberger *et al.*, 2010). Veterans in Connecticut and New York also mentioned challenges with appointment times that were only available during a regular work day (Schell & Tanielian, 2011; Southwick *et al.*, 2008).

The Virginia study (Dunkenberger *et al.*, 2008) also reported low utilization rates for VA health services, finding that many veterans instead used Tricare or employer-based insurance (Dunkenberger *et al.*, 2010). It is not apparent from this research whether those who used Tricare or employer-based services would have been eligible for VA health services. Finally, VA facility locations present challenges. In New York, veterans noted that, unless you live within close proximity to a VA medical facility, you could spend an entire day traveling to and from your appointments (Schell & Tanielian, 2011).

Additional data on access, awareness, and claims are available in the Benefits section above. Claims for VA benefits are mentioned again in this section to acknowledge the interconnectedness between health and access to care, but the bulk of data on claims processing are set forth above. The following relate more to general accessibility and other health matters.

Findings

Approximately two-thirds of younger veterans and just over one-half of older Pennsylvania veterans had enrolled in VA healthcare, but almost all focus group veterans had enrolled in VA healthcare. While almost all focus group veterans also reported that they had used VA healthcare at least once, only 43% of other veterans in this Study actually used VA health care benefits. Of those who had not ever used any VA health benefits, 43% of younger and 25%

of older veterans said that they never used benefits because they had never needed them. The numbers were too small to make any generalizations, but it is interesting to note that a few younger veterans reported that they did not use VA healthcare as a matter of principle and out of disdain for the organization.

Table 11. Reasons Younger Veterans Did Not Use VA Health Care

Reason	Number	Percent
I use other sources for health care	21	38.2%
Did not need any care	15	27.3%
Not entitled to or eligible for health care benefits	11	20.0%
Not aware of VA health care benefits	10	18.2%
Too much trouble or red tape	10	18.2%
Don't think VA health care would be as good as that available elsewhere	8	14.5%
Never considered getting any health care from VA	7	12.7%
VA care is difficult to access (parking, distance, appointment availability)	6	10.9%
Do not know how to apply for health care benefits	6	10.9%
Did not need or want assistance from VA	3	5.5%
Other	4	2.9%
Applied, but was told I am not eligible	1	1.8%

Table 12. Reasons Older Veterans Did Not Use VA Health Care

Reason	Number	Percent
I use other sources for health care	122	77.7%
Did not need any care	68	43.3%
Did not need or want assistance from VA	55	35.0%
Never considered getting any health care from the VA	45	28.7%
Not entitled to or eligible for health care benefits	42	26.8%
Too much trouble or red tape	41	26.1%
Don't think VA health care would be as good as that available elsewhere	36	22.9%
Not aware of VA health care benefits	35	22.3%
Do not know how to apply for health care benefits	32	20.4%
VA care is difficult to access (parking, distance, appointment availability)	26	16.6%
Applied, but was told that I am not eligible	23	14.6%

Interestingly, opinions about the VA were quite different among focus group veterans versus veterans consulted through other means. Many veterans who participated in the focus groups were very pleased with VA health benefits and services. For example, one group described their satisfaction with the facility and staff at their local outpatient VA clinic. A veteran from this same group said that Tricare proactively contacted him to provide training about diabetes after his wife was diagnosed with the disease. Participants in another focus group were pleased with the modernization of the local VA hospital, saying, “It’s not your father’s VA anymore; it’s a gorgeous facility.” Despite these positive comments, some focus group veterans felt that the VA needs a more modern approach to doing business. One veteran observed, “The military is a corporation; they should not be so archaic in how they do things” and their “business practices are ancient.” In general, these veterans wanted less paperwork, more timely service, and better access to the VA.

In contrast, younger veterans were dismissive of VA facilities but touted the MyHealtheVet website as a great way to correspond with doctors. Several younger veterans made comments such as, “It’s user friendly; I like it;” “I love it;” and “[It] saves me a trip.” Younger and older veterans alike were overwhelmingly dissatisfied with the amount of bureaucracy within the VA. They perceived bureaucracy to be a direct and indirect obstacle to care. The direct burden arises because appointments “take so long” and “it takes forever to see a doctor.” They complained that “it is really, really disorganized. No one really knows what’s going on.” One veteran claimed he “knew one dude who, like, died, while waiting to get in [to the VA].”

Indirect obstacles arose because veterans who “hate or fear bureaucracy—those above them” may “avoid getting or seeking services, dodge everything, and fall through the cracks.”

One veteran described the VA as “the monstrosity.” Veterans from all walks of life complained that the VA required hardcopies of paperwork and will not accept files electronically or even by fax. As one veteran noted: “Lots of applications and paperwork to fill out – it’s an understatement.” Another veteran succinctly summarized the collective sentiment: “The VA feels like the abyss. It is where information goes to die.”

Veterans also expressed concern about the future capacity of the VA. Specifically, they had concerns about whether the VA could handle the influx of returning veterans with many medical issues. In fact, one participant noted, “I don’t think they realize what these wars are going to cost in the long-run, like with healthcare. I don’t think they’ve begun to see how much money they are going to be shelling out. The VA is going to go bankrupt.” Other veterans in this group noted that many veterans did not seek services right away; therefore, the impact on the system “won’t be seen for years to come.”

Lastly, older veterans shared concerns about prescription costs and long-term care services through the VA. A few veterans claimed that prescriptions were more expensive through the VA than through private health insurance, and prescription costs were of particular concern to veterans on a fixed income. Several veterans, in particular those in rural areas, mentioned that they would like to see assisted living facilities for aging veterans.

VSOs comments reflected those shared by the veterans as described above. VSOs also offered ideas for low-cost programs that could improve morale and VA health care utilization, such as free parking “like they do at Walter Reed;” parking vouchers where lots are not controlled by the VA; same-day call-ahead appointments “like they do at Outback;” and valet parking with “candy striper-type” attendants, using veteran volunteers and veterans doing community service through the courts as drivers.

Veterans' Homes and Long-Term Care

Background

The DMVA operates six extended care facilities for veterans and their spouses. These full-service facilities offer the amenities common to most nursing home and long-term care facilities, including 24-hour nursing care, medical care, recreational and religious programming, on-site pharmacies, and modern accommodations. According to an internal evaluation, the DMVA's Veterans' Homes scored 94% on a family satisfaction survey (Pennsylvania Department of Military and Veterans Affairs, 2014). The OVA has indicated it plans to develop a new evaluation system for residents and to increase VSO visibility within veterans' homes (Pennsylvania Office of Veterans' Affairs, 2012).

Veterans who used these homes reported that they prefer them to other nursing home options because of the opportunity to live with other veterans and because of the relatively low cost (Senior Veterans Service Alliance, 2013). A 2009 study of state veterans' homes looked at the feasibility of increasing the number of state DMVA facilities that provide nursing or personal care to the Commonwealth's veterans who are not eligible to receive care via Medicaid or the VA. The study recommended creating three new geographically targeted facilities, redistributing beds geographically, and shifting some nursing beds to personal care use to better meet existing and anticipated needs (Tompkins *et al.*, 2009). However, there is a nationwide backlog of 130 VA homes due for construction (Senior Veterans Service Alliance, 2013).

Findings

According to the telephone survey, more than three-fifths of veterans (61.9%) were not aware that the DMVA operates six veterans' homes within the Commonwealth. These homes were not a significant topic of conversation among focus group veterans, and none of the survey

veterans provided meaningful data about them. Several VSOs did express a desire to work more with residents of veterans' homes. VSOs indicated that they thought they could "get a lot done" if they worked more regularly within veterans homes and had mobile Internet capabilities to take with them to those homes.

Recommendations

- Increase transportation through IVSOs.
- Include more volunteer drivers and work with IVSOs to identify volunteers within communities.
- Improve handicapped-accessible transportation.
- Offer free parking "like they do at Walter Reed."
- Increase availability and awareness of Disabled American Veteran vans.
- Increase awareness of available transportation services in general, and post lists of transportation services at all medical facilities, in libraries, and at local coffee hours.
- Analyze why My HealthVet and telemedicine are popular among younger veterans and apply lessons learned to development of The Website and other forms of health delivery.
- Consult with marketing experts to heighten awareness about Veterans' Homes.
- Consider on-call private driver services, such as Uber and Lyft, and consider how such entities could become transportation partners, particularly in more urban areas where these services currently operate.

HOUSING

Across the nation, homelessness among veterans has declined, but veterans remain at greater risk than civilians of becoming homeless. Moreover, Pennsylvania defied the national trend in the majority of the last four years, and its veteran homeless population had the largest numerical increase of all states between 2009 and 2013 (U.S. Department of Housing and Urban Development, 2013, p. 41). From 2009 to 2012, the national homeless veteran population decreased by 24%, and from 2012 to 2013 it decreased by 8% (U.S. Department of Housing and Urban Development, 2013). The decline in numbers largely was attributable to a reduction in the number of veterans living in unsheltered locations (U.S. Department of Housing and Urban Development, 2013, p. 38).

Background: Population

Homeless veterans represent 12.3% of the entire national adult homeless population (U.S. Department of Housing and Urban Development, 2013, p. 39; Khadduri *et al.*, 2010). Ninety-two percent of homeless veterans are male, but housing problems among female veterans should not be underestimated. Researchers in a needs assessment among Virginia veterans found that female veterans have higher rates of homelessness, with 12% of female veterans reporting that they were homeless (Dunkenberger *et al.*, 2010; Institute for Veterans and Military Families, 2013). Over half of all homeless veterans are African American, and the majority suffer from mental health and/or substance abuse problems (U.S. Department of Veterans Affairs, 2012).

On a reference date in January 2013, there were 57,849 homeless veterans in the United States, 40% of whom were living in an unsheltered location (U.S. Department of Housing and Urban Development, 2013, p. 38). Homeless veterans are usually younger than the overall homeless population. Approximately 9% of homeless veterans are between the ages of 18-30 and

41% are between the ages of 31-50 (Khadduri *et al.*, 2010). During personal interviews conducted as part of the California veterans' needs assessment, almost one-quarter (23%) requested housing services, including shelter, transitional housing, and mortgage/foreclosure assistance (California Department of Veterans Affairs, 2011). Housing and homelessness continue to be problems for many Pennsylvania veterans, and younger veterans in particular (Behney *et al.*, 2012; Pennsylvania Department of the Auditor General, 2006). In 2009, Pennsylvania and Colorado both ranked 9th in the nation in size of homeless veteran populations, and 9.5% of Pennsylvania's total veteran population was homeless (U.S. Department of Housing and Urban Development, 2011). On a reference date in January 2013, 1,462 veterans were homeless in Pennsylvania (U.S. Department of Housing and Urban Development, 2013, p. 40). Homelessness remains a pervasive problem among veterans in the Commonwealth.

Background: Resources and Initiatives

There are a variety of federal, state, and local resources and opportunities available to homeless persons (veterans and non-veterans) within Pennsylvania. They include the following:

- VA's Supportive Services for Veteran Families;
- PA's Homeless Assistance Program (HAP), run through the Pennsylvania Department of Public Welfare (DPW);
- HUD's Emergency Shelter Grants;
- HUD's Emergency Solutions Grants;
- PA DPW's Project for Assistance with Transition from Homelessness (PATH);
- HUD's three Federal Continuum of Care resources;
- VA's Veterans Affairs Supportive Housing (HUD-VASH); and
- HUD's Homeless Prevention and Rapid Rehousing (HPRR) resources.

There also are websites that provide linkage to homelessness resources, including:

- Pennsylvania Homeless Shelter Directory (<http://www.homelessshelterdirectory.org/pennsylvania.html>)
- Pennsylvania Women's Shelters website (<http://www.womenshelters.org/sta/pennsylvania>)⁴

In conjunction with an effort by the federal VA to eradicate veteran homelessness by 2015, the PA OVA has proposed a number of solutions:

- Provide financial support to the (HUD-VASH) program for permanent housing vouchers;
- Create more transitional housing through partnerships with statewide nonprofit organizations;
- Offer specialty loans for veterans buying a home or farm, allowing for penalty-free payment deferment for those called to active duty;
- Create a new law requiring that veterans receive housing preference from landlords; and
- Develop a screening mechanism to assess whether veterans need domiciliary care, transitional housing, life skills classes, financial management training, vocational training, or stress management. (Behney *et al*, 2012).

Findings: Homelessness among Veterans

Over 10% ($n = 13$) of younger veterans and 4.5% ($n = 13$) of older veterans in this study reported that they had been homeless at some time after separating from the military. Only 3% of younger veterans and less than 1% of older veterans reported that they had taken advantage of temporary financial assistance that is available for veterans, and none of the younger veterans who had been homeless had used temporary housing benefits. None of the focus group veterans said that they had been homeless. Nevertheless, many focus group participants noted that

⁴ Please note that the Pennsylvania Department of Corrections provides housing assistance to formerly incarcerated veterans through a variety of organizations, including VISN 4 Edward Sesak; VISN 4 Ebony McDonald; Vietnam Veterans of America; PA Prison Society; Delaware County Reentry Program; PA Justice Project of Chester, PA; Delaware Center for Homeless Veterans (DCHV); Delaware County Reentry Housing Initiative (Mr. Richard Carter); Robert M. Jackson Veteran Center (Harrisburg); Scranton Catholic Social Services; Fresh Start, Inc.; American Legion; and 33 VA Grant Per Diem Sites (DOC, 2014).

homelessness is a big issue for veterans. Participants discussed the idea that homelessness and unemployment were inter-related. In fact, one veteran stated, “We need housing. The first thing they need is a job, to take care of family, hous[ing] themselves – that requires a job.”

VSOs perceive that homelessness affects veterans of all ages, genders, and eras of service; however, over one-quarter specifically indicated that Vietnam-era veterans seem to have more of an issue with homelessness (25.6%; $n = 20$) and several said that Persian Gulf War and Iraq/Afghanistan War veterans are more vulnerable than others to homelessness.

Findings: Utilization of Housing Assistance/Homelessness Remediation

More than half of younger veterans (59.3% $n = 80$) and more than three-fourths of older veterans (80.6%; $n = 229$) had not used housing benefits since they separated from the military. Almost one-third of younger veterans used the VA Home Loan (30.4%; $n = 41$), compared to just 17.6% of older veterans. A few veterans used temporary financial assistance for housing needs, transitional housing, housing vouchers, and transportation to a shelter.

Figure 28. Housing Benefits Used by Younger Veterans since Separating from the Military

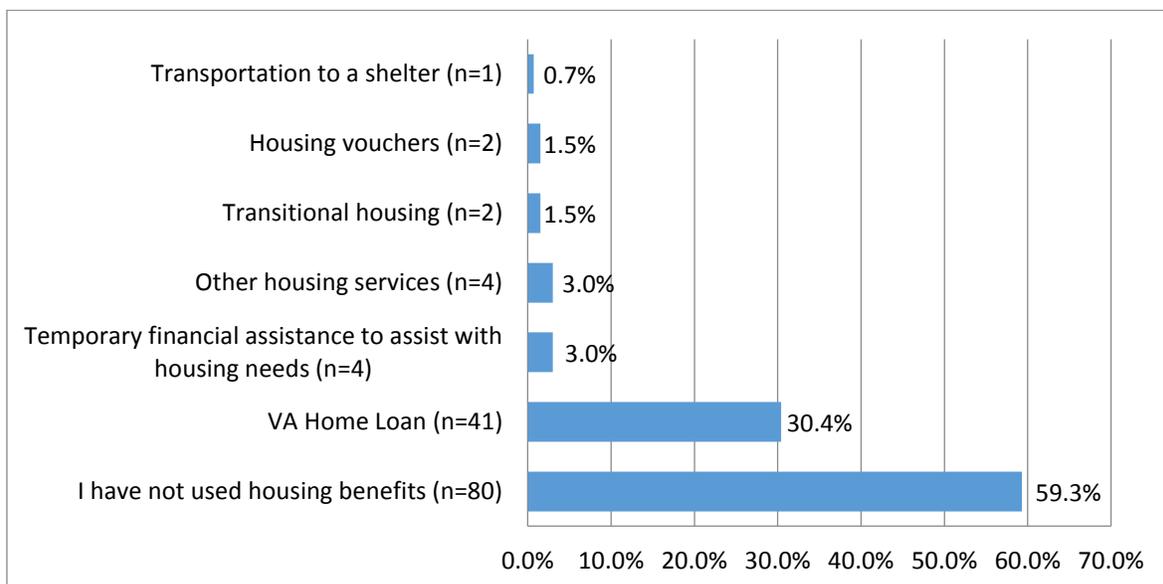
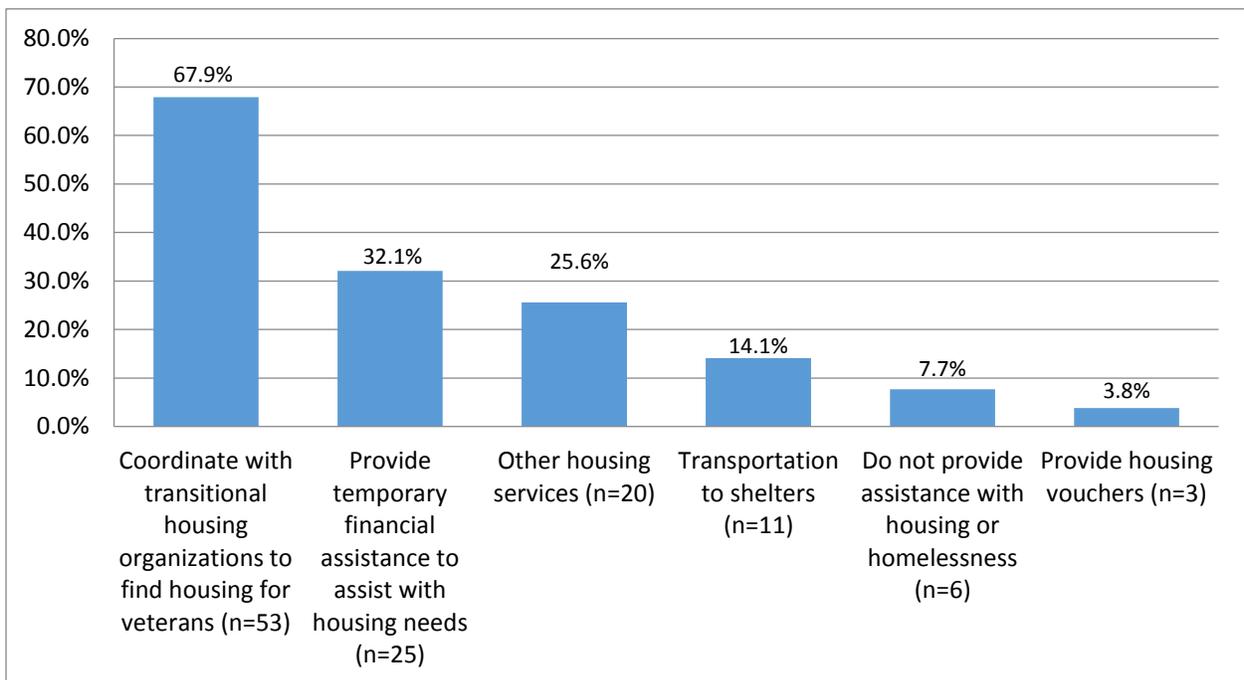


Table 13. Housing Benefits Used by Older Veterans since Separating from the Military

Housing Benefit	Number	Percent
I have not used housing benefits	229	80.6%
VA Home Loan	50	17.6%
Housing vouchers	3	1.1%
Temporary financial assistance to assist with housing needs	2	0.7%
Transitional housing	1	0.4%
Transportation to a shelter	1	0.4%
Other housing benefits	1	0.4%

VSOs described several efforts that they undertook to address housing issues and/or reduce homelessness in the veteran population. Over two-thirds (67.9%; $n = 53$) reported that they have coordinated with transitional housing organizations, and almost one-third have provided temporary financial assistance for housing (32.1%; $n = 25$).

Figure 29. Housing Efforts by Veteran Service Officers

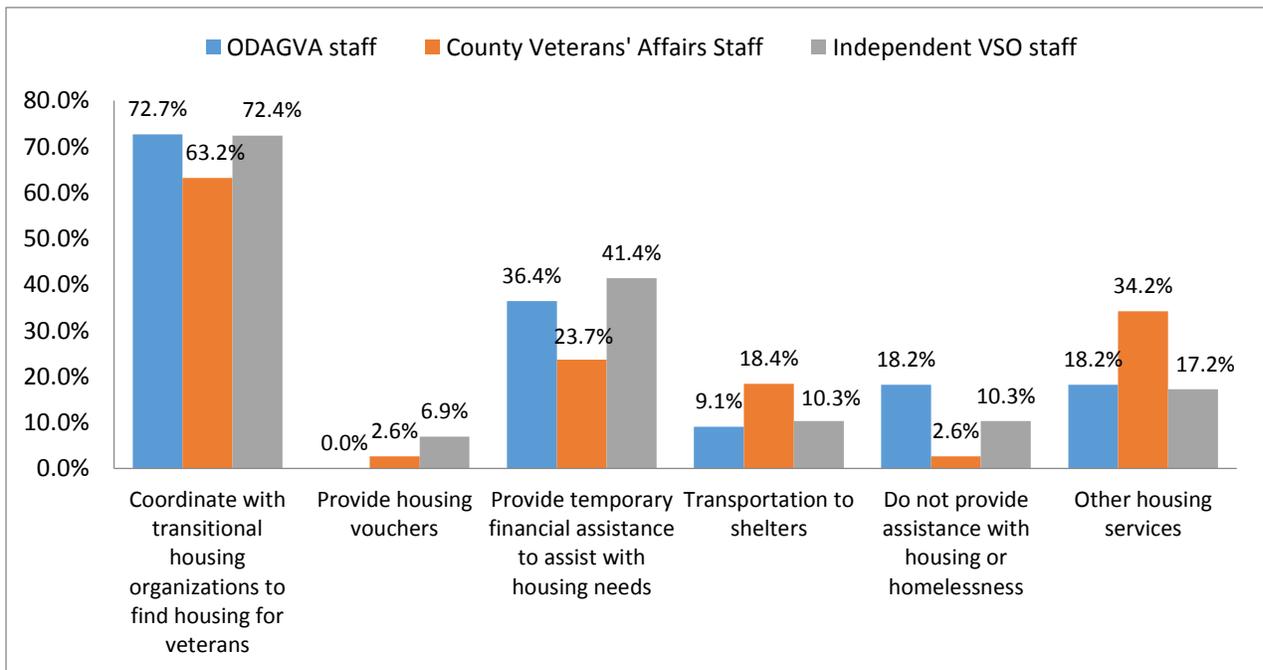


Other housing efforts mentioned by VSOs included:

- Coordinating with the local VA homeless coordinator (*n* = 1)
- Filing claims for homeless veterans (*n* = 1)
- Offering a monthly stand-down for homeless veterans (*n* = 1)
- Outreach efforts to homeless veterans (*n* = 1)
- Providing housing (*n* = 1)
- Referrals to VA social workers (*n* = 1)
- Providing support services for veterans’ families (*n* = 1)

When looking at housing efforts by organizational affiliation, IVSOs and ODAGVA VSOs were most likely than CVSOs to have coordinated transitional housing organizations to find housing or provide temporary financial assistance. CVSOs were more likely to have provided transportation to shelters to report that they helped provide other housing services.

Figure 30. Housing Efforts by Organizational Affiliation



Findings: Observations and Recommendations from VSOs

Over half of participating VSOs shared suggestions to improve housing services and homelessness among veterans (55.1%; $n = 43$). The top suggestions offered included:

- Better coordination with the VA (16.3%; $n = 7$)
- More targeted outreach efforts (14.0%; $n = 6$)
- Education and training of VSOs on housing resources (9.3%; $n = 4$)
- More HUD-VASH vouchers (9.3%; $n = 4$)
- Job training and acquisition
- A veteran-only homeless shelter
- A central office that service officers can contact for housing assistance
- Allowing homeless veterans to live in some of the abandoned buildings in the area

See Volumes III: Focus Groups of Veteran Service Organizations and IV: Administrative Web Survey of Veteran Service Organization Administrators for a full list of suggestions offered by participating service officers on housing issues and homelessness.

VA Home Loan Program

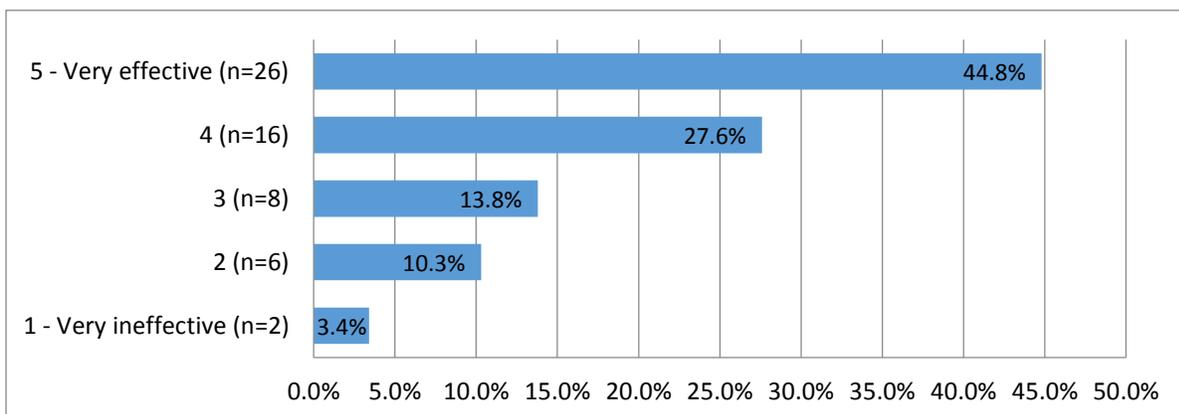
The VA Home Loan Program, first launched as part of the Serviceman's Readjustment Act of 1944 (Servicemen's Readjustment Act, 1944), guarantees home loans and provides optimal interest rates for veterans to aid with economic aspects of post-war readjustment into civilian society. Thirty percent of younger veterans in this study had taken advantage of a VA home loan and 3% used an adaptive housing grant program or credit union grant program. One out of six older veterans had used VA home loans (17.6%; $n = 50$).

Veterans in the focus groups shared mixed feelings with regard to the VA home loan program. Although many veterans used this program without issue, some described difficulties and questioned the value of the program. Many veterans claimed that there were "hidden fees"

and “a lot of paperwork.” Specifically, one veteran who used the program felt, “It was sort of taking advantage – baiting veterans. If you’re going to pursue this, you have to pay this, this, and this...I’m not really sure that this is really giving a value to veterans.” Lastly, one participant noted that even realtors say “It’s a lot of trouble” to use the VA home loan program.

Nearly three-quarters of VSOs rated the VA home loan program as effective (72.4%; $n = 42$). The most-noted reason for rating the VA Home Loan Guarantee Program as effective was the idea that the program makes home ownership more attainable for veterans (36.7%; $n = 11$). Other reasons included: The loans are guaranteed ($n = 4$), many veterans have taken advantage of this program, which shows it is good ($n = 3$), the program offers no down payment ($n = 3$), and lenders are supportive of the program ($n = 2$). Conversely, only 13.7% ($n = 8$) of the service officers that rated the VA Home Loan Guarantee Program rated it as ineffective. Reasons for rating the program as ineffective included: Too much paperwork involved ($n = 2$), not enough information available ($n = 1$), not timely ($n = 1$), and the program is used as a last resort ($n = 1$). Finally, a few service officers did not rate the program and noted not using or not being familiar with the VA Home Loan Guarantee Program (13.4%; $n = 9$). The following figure shows the VSOs’ effectiveness ratings for the VA Home Loan Guarantee Program.

Figure 21. VSOs’ Effectiveness Rating for the VA Home Loan Guarantee Program



SUB-POPULATIONS OF VETERANS

Background

Subpopulation research works on the presumption that certain subsets of a given population (*e.g.*, veterans) share an additional characteristic (*e.g.*, homelessness) that distinguish that subset from the population or create an additional dimension for consideration. Several sections of this report address subpopulations such as younger veterans, older veterans, homeless veterans, and disabled veterans. This section provides a synopsis of the literature and the findings from this Study on some additional subpopulations.

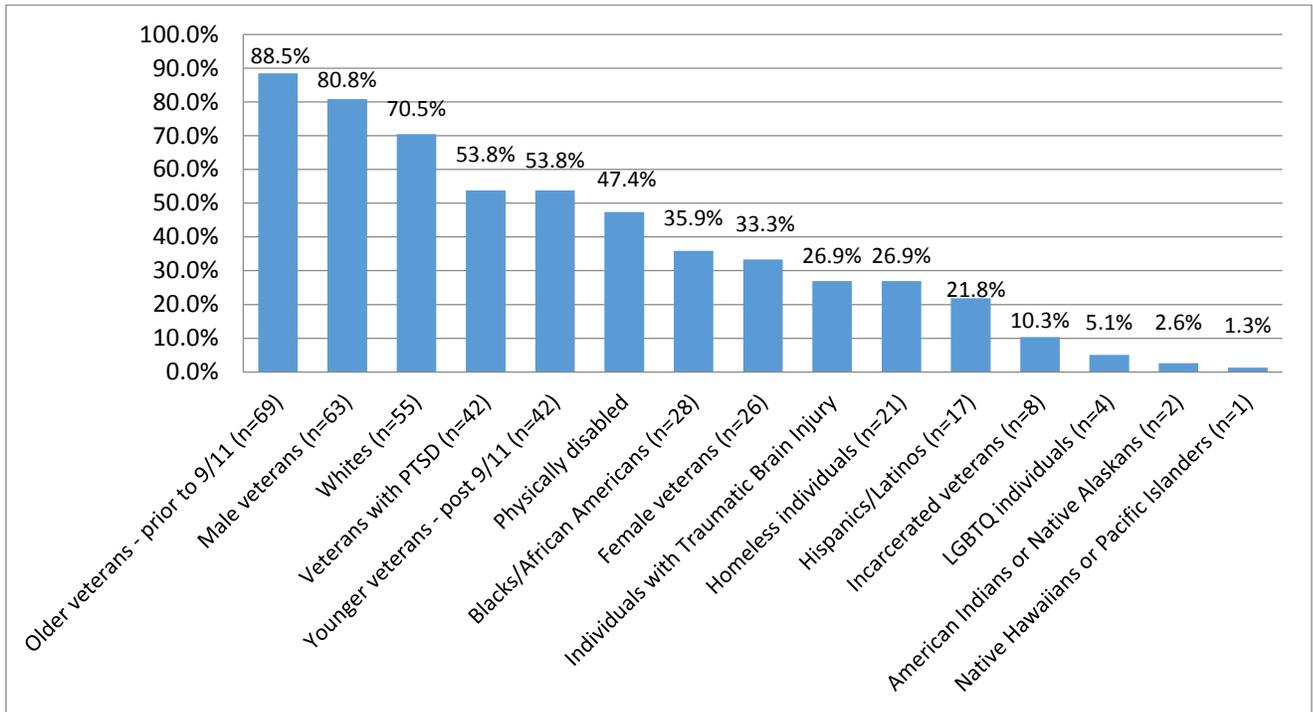
Findings: Subpopulations Generally

Generally, the veterans and VSOs in this Study were not familiar with the concept of “subpopulations” and instead spoke of the special needs of a few subsets of veterans—in particular, homeless, recently deployed, and disabled veterans. These groups garnered special consideration from veterans and VSOs alike, and it seemed to the Research Team that it was culturally acceptable to recognize these subpopulations as sharing a unique characteristic that warranted additional, or different, policies and programming.

The Research Team inquired about additional subpopulations of (1) female, (2) minority, (3) LGBTQ, and (4) rural veterans. While the veterans in the Study commented at length on each subpopulation, the VSOs generally reported that they did not think of females, minority, or LGBTQ veterans as subpopulations. The following data provide insights into subpopulations generally, and the four aforementioned subpopulations specifically, throughout the veteran and VSO communities.

Over 70% of VSOs reported that the majority of their clients are predominantly older (served prior to 9/11), male, and Caucasian.

Figure 31. VSOs’ Populations Most Served by Number of VSOs Reporting⁵



From VSOs’ perspectives, LGBTQ and homeless veterans were the most greatly underserved populations (2.19 and 2.24 respectively). A few VSOs shared that LGBTQ veterans were underserved due to bias/prejudice ($n = 2$) and the impression that the VA system caters to the heterosexual male demographic ($n = 2$). VSOs said that homeless veterans are underserved because they are “hidden” and “embarrassed to seek assistance” (42.1%; $n = 8$); because of a lack of facilities or resources for homeless veterans in smaller communities ($n = 3$); due to a lack of funding ($n = 2$); and also due to a lack of outreach to homeless veterans ($n = 1$).

⁵For the purposes of analysis and to calculate a mean rank, responses were recoded from “greatly underserved,” “underserved,” “served,” and “greatly served” to a scale of 1 to 4, where 4 was “greatly served” and 1 was “greatly underserved.”

Female Veterans

Background

Subpopulation size. As of 2010, there were 1.6 million female veterans in the United States, and this number is increasing (American Community Survey, 2010; Department of Veterans Affairs, 2014c). According to VetPop2011, 8% of Pennsylvania veterans are women (U.S. Department of Veterans Affairs: National Center for Veterans Analysis and Statistics, 2012). In addition, sixteen percent of all active duty troops are women, and over half of them have deployed to Iraq and/or Afghanistan (U.S. Department of Veterans Affairs, 2014d; U.S. Department of Veterans Affairs, 2014e). Of these women, anywhere from 40% to 75% have experienced combat (Dutra *et al.*, 2010; Milliken *et al.*, 2007; Street *et al.*, 2013). The data are mixed on whether women experience combat at rates that are lower than men (Dutra *et al.*, 2010; Rona *et al.*, 2007). As the number of women in the military continues to grow, and as deployment cycles increasingly place women in treacherous circumstances, women veterans' needs will expand.

Sociocultural. Female veterans are less likely than their male peers to enjoy supportive social networks during their periods of military service, and they are more likely to feel isolated (Rosen *et al.*, 1998; Vogt *et al.*, 2011). Because social networks and support structures are highly related to resilience, it is important for persons who work with veterans to take the social networks of veterans seriously (Bliese, 2008; Griffith & Vaitkus, 1999; Brailey *et al.*, 2007).

Reintegration. In general, female veterans' reintegration experiences are more complicated than men's experiences. Female military members generally are younger and of a lower socioeconomic status than civilian women of the same age (Adler-Baeder *et al.*, 2005), and military women are more likely to be single mothers and/or divorced (Joint Economic

Committee, 2007). Female veterans also are likely than men to be married to a deployable military person, which means that they may be dealing with their own issues, as well as those of their spouses (Joint Economic Committee, 2007). Finally, research suggests that female veterans' reintegration experiences are more likely than men's to be impacted by familial stressors and their family roles (Kelly *et al.*, 2013).

Health care. Women tend to under-utilize VA health care compared to men (Washington *et al.*, 2011). Even more specifically, younger and minority women have a higher prevalence of delayed care or unmet need (Washington *et al.*, 2011). Despite the availability of female-specific services, many female veterans are unaware of their existence. In prior research, female veterans have attributed this lack of service uptake to lack of information: “[Female veterans] don't know there's such a thing as women's primary physicians and women's clinics. I think this is the best kept secret in the whole VA” (Washington *et al.*, 2007, p. 813).

Issues related to the gender-sensitivity of health care workers are another barrier for female veterans. In fact, a recent focus group study noted that female veterans wanted health care providers that specialize in women's health care, diseases, anatomy, and the special needs of female veterans (Washington *et al.*, 2007). Related to this, facilities, equipment, and programs that are geared toward male veterans can also turn female veterans away from seeking services. Washington *et al.* shared a quote from a female focus group participant that drove home the idea of male-dominated environments: “There were all these men, World War II vets and everything. I felt out of place. I felt I was the only woman there, and here I am about a breast thing, which has nothing to do with them. I don't think they were set up for something like that” (2007, p. 815).

Sexual assault and harassment. Data on rates of sexual assault and sexual harassment in the military are mixed. In a recent study among 1,207 female and 1,137 male veterans of OEF and OIF, women were significantly more likely to report having endured an unwanted sexual experience and sexual harassment during deployment, with over half of the women reporting specific incidents of unwanted sexual experiences (Street *et al.*, 2013). A nationally representative study of female veterans found that over half ($n = 1,942$; 55%) experienced sexual harassment and nearly one-quarter ($n = 805$; 23%) of female veterans experienced a sexual assault (Skinner *et al.*, 2000). In contrast, an older study found that just under one-quarter of female veterans experienced sexual trauma while in the military (Hankin *et al.*, 1999). In an analysis of women's experiences during a twelve-month period in the mid-2000s, 9% of women experienced some form of sexual coercion during their military services, 31% experienced unwanted sexual touching or attention, and over half endured unwanted sexual behaviors (Lipari *et al.*, 2008). Women also are far more likely than men to have experienced gender harassment, which is distinguishable from sexual harassment. Gender harassment involves abusive or demeaning treatment based not on sexually-oriented matters, but on gender-specific traits (Rosen & Martin, 1998b; Vogt *et al.*, 2011).

Regardless of the rates of assault, it is apparent that women experience sexual assaults and sexual harassment in the military at much higher rates than men. (Murdoch *et al.*, 2007; Street *et al.*, 2013; Vogt *et al.*, 2011). These experiences have long-term physical and emotional effects, and they can impact future use of VA services. For example, Kelly and colleagues found that although those who experienced military sexual assault were more likely to use VA care, they were less satisfied with the services than other patients (2008). Specifically, these study participants perceived that the care was geared toward male patients, and they had difficulty

accessing female-specific services (Kelly *et al.*, 2008). Similarly, women who experienced direct and indirect combat exposure were less likely than other groups of patients to use VA services because they felt it was male-oriented, noted more problems with VHA health care physicians and staff, and had lower opinions of VHA facilities as compared to other health care facilities (Kelley *et al.*, 2008; Owens, Steger, Whitesell, & Herrera, 2009).

PTSD. Findings are mixed as to whether gender influences rates of PTSD, and the best analyses indicate that gendered PTSD experiences are nuanced (Crum-Cianflone *et al.*, 2014; Street, 2013). Crum-Cianflone and colleagues conducted a systematic review of studies on gender differences in post-deployment PTSD. The findings of that review highlight the dearth of data available on gender differences in veterans' experiences. Seven studies found that women were more likely than men to experience post-deployment PTSD, and seven found that they were not more likely than men to suffer from PTSD. Four studies conducted by the VA found that women were less likely to suffer PTSD following deployment. In their summary of research, Crum-Cianflone concluded that the research suggests that women have a moderately higher risk for experiencing post-deployment PTSD, but the researchers were cautious in that conclusion.

Other studies also found that women are more likely than men to experience post-deployment PTSD, but that men are more likely to engage in substance abuse postemployment (Gibbons *et al.*, 2014; Smith *et al.*, 2008; Tanielian & Jaycox, 2008; Vogt *et al.*, 2011). The most current research reveals that gender differences in PTSD diagnoses and combat experiences cannot be explained simply by gender or pre-deployment risk factors. Women appear to be more impacted by combat related stressors, prior victimization, victimization during deployment, and concerns about family life (Cobb *et al.*, 2014).

Some studies suggest that women are most susceptible to PTSD, even when controlling for pre-deployment mental health diagnoses. However, Dutra and colleagues found, in their study of 54 active duty, post-deployment women that the only factor that significantly related to the differences between the genders was sexual harassment (Dutra *et al.*, 2010). Again, the research on gender and PTSD is mixed and evolving. For now, VSOs and the veteran need to be aware of the issue, but no firm conclusions can be drawn or recommendations made.

Pennsylvania's OVA includes four objectives related to female veterans in its 2012-2016 strategic plan: (1) create an online database for specialty Military Sexual Trauma mental health professional; (2) assist statewide nonprofit organizations in creating female-only veteran "sanctuaries;" (3) initiate public service announcements or advertising campaigns regarding the needs of female veterans; and (4) conduct an annual "Women Veterans Symposium" to discuss issues facing female veterans (Pennsylvania Office of Veterans Affairs, 2012). None of the veterans in this Study who were questioned about the above priorities were familiar with any of the OVA's objectives.

Findings: Gender

Looking at the telephone survey, 5.2% of participants were female. This is comparable to American Community Survey data that indicates that 5.5% of all veterans are female (U.S. Census Bureau, 2012a). No veterans participated in any gender-specific veterans programming, and only a few veterans provided feedback on gender-specific issues. Some Pennsylvania female veterans did not pursue services because they felt that they did not deserve them, which has been a recurring theme among all veterans. One female veteran explained, "I don't have a lot of active duty time, so I don't want to bother them when there are other people that need help." She went on to say, "My perception of the VA is that it is not for someone like me. It's for people with a

full career in the military. I don't feel deserving. I was four years active, three years reserve, plus ROTC time. It's reserved for those who really need it.”

Fewer than half of participating service officers reported that their offices offered services specifically for female veterans (44.1%; $n = 30$). A few had provided assistance with filing a claim for military sexual trauma. One VSO reported that his office employs female counselors, provides sexual assault counseling, refers veterans for sexual assault and trauma counseling, and advises on gender-specific benefits through the VA.

IVSOs were most likely to indicate that they offered gender-specific services (53.8%; $n = 14$), while CVSOs were least likely (34.4%; $n = 11$). Half of ODAGVA VSOs reported offering services for female veterans (50.0%; $n = 5$). Almost two-fifths of VSOs have female VSOs available to deal specifically with issues and claims of female veterans (39.3%; $n = 11$). Other gender-specific services reported included: Filing claims for military sexual trauma (MST) and other female-specific medical claims (17.9%; $n = 5$); VA claim assistance ($n = 2$); availability of female counselors ($n = 1$); availability of sexual assault counseling ($n = 1$); VA clinics ($n = 1$); and referrals for sexual harassment, trauma, and counseling ($n = 1$). Almost one-fifth of the comments describing female-specific services offered focused on the idea that services were the same for *all* veterans (17.9%; $n = 5$). One service officer noted that female-specific services are the “same as males.”

VSOs consistently insisted that no distinctions were made among veterans with regard to services or benefits; the VSOs in this study spoke with pride about their “blindness” with regard to race and gender. They explained that “a veteran is a veteran,” and that they “do the same thing for all veterans, and [I] don't care what they look like or what sex they are.” In the opinion of the Research Team, the VSOs appeared to be attempting to convey that they are fair and that

they serve all veterans equally. Unfortunately, the VSOs did not seem to be aware of gender-specific needs.

Many VSOs (53.8%; $n = 42$) shared suggestions to improve services for female veterans. Over one-third focused on the need for more or better outreach to female veterans (35.7%; $n = 15$). Additional training and knowledge of female-specific issues were also mentioned by service officers (14.3%; $n = 6$). One service officer noted, “Good resources exist via the VA for female vets. Education about the availability of these resources would be helpful.” Other suggestions for improvement included: Adding more female VSOs ($n = 4$); more female counselors ($n = 3$); more females in veterans’ centers ($n = 1$); and gender-specific programs ($n = 1$). See Volumes III: Focus Groups of Veteran Service Organizations and IV: Administrative Web Survey of Veteran Service Organization Administrators for a complete list of suggestions offered by participating service officers on improving gender-specific services for veterans.

Minority Veterans

Background

According to VA data, racial and ethnic minorities comprise 21% of all veterans nationally, and that percentage is expected to grow to 34% by 2040 (U.S. Department of Veterans Affairs: National Center for Veterans Analysis and Statistics, 2013). For reasons that are not yet clear, Hispanic veterans have been shown to have higher rates of PTSD than other veterans and lower rates of accessing care (Penk *et al*, 1989; Escobar *et al*, 1983). Hispanic and African American veterans also are more likely to report poor physical and mental health than white veterans (Penk *et al*, 1989; Escobar *et al*, 1983). Minority status cuts across multiple areas of need contemplated by this Study, and brief insights into those crosscutting concerns are addressed in this section.

Health. Research about African American, Hispanic, and Asian American veterans suggests that experiences of discrimination and racism may influence a veteran's health status (Friedman, Schnurr, & McDonagh-Coyle, 1994; Loo, Fairbank, & Chemtob, 2005; Sohn & Harada, 2008). In a study of more than 3,000 veterans in California and Nevada, African American and Hispanic veterans were more likely to report poor health as compared to white veterans (Villa, Harada, Washington, & Damron-Rodriguez, 2003).

PTSD. Research in jurisdictions outside of Pennsylvania indicates that Hispanic veterans are more likely than other races or ethnicities to experience PTSD (Duke *et al.*, 2011). Some researchers have found a relationship between ethnicity and duty assignment, with Hispanics receiving more hazardous assignments than other ethnicities. These studies suggest that the nature of the MOS, and not the ethnicity, are related to the PTSD (Dohrenwend *et al.*, 2008). Regardless of the origin of the PTSD, there are sufficient data to conclude that, for whatever reason, Hispanics experience PTSD at higher rates than non-Hispanics (Canive, *et al.*, 2001; Dohrenwend *et al.*, 2008; Duke *et al.*, 2011; Pole *et al.*, 2005; Ruef *et al.*, 2000). Accordingly, it is appropriate to train VSOs and care providers on this risk factor.

Hispanic veterans face several barriers to receiving assistance. First, Hispanics have a greater likelihood of being misdiagnosed, since the symptoms of PTSD can take the form of physical complaints, such as back or stomach pains (Canive, Castillo, Tuason, Tseng, & Streltzer, 2001; Pole *et al.*, 2005; Ruef *et al.*, 2000). Next, the Hispanic culture places a high value on downplaying distress and turning to family for assistance, rather than formal sources of assistance (*familismo*) (Canive *et al.*, 2001; Dohrenwend *et al.*, 2008; Pole *et al.*, 2005). Lastly, another barrier for accessing services is the lack of cultural competency on the part of the VA mental health system. For example, a study of perceived barriers to mental health treatment for

Hispanic and Native American veterans noted the following issues related to providing culturally appropriate services: Difficulty discussing personal matters, a feeling that the VA does not understand their needs, mistrust of the VA system, and a lack of outreach to these cultural communities (Westermeyer *et al.*, 2002). Without adequate education for those working with Hispanic veterans and outreach to these communities, these individuals may remain underserved.

Frueh and colleagues found that African American and white veterans who experienced combat-related PTSD are similar with respect to their PTSD symptoms and use of VA medical and mental health services (2004). Despite these similarities, research suggests that minority veterans with depression benefited more than white veterans from primary care settings that offered collaborative care programs (Davis, Deen, Bryant-Bedell, Tate, & Fortney, 2011; Miranda, Schoenbaum, Sherbourne, Duan, & Wells, 2004). These programs approach health care collaboratively, including primary care, mental health care, case management, and pharmacotherapy.

Finally, research has established that persons who experience racial, ethnic, or sexual discrimination or harassment are at higher risk for PTSD (Freidman, *et al.*, 1994; Loo, *et al.*, 2005; Sohn, *et al.*, 2008; Villa, *et al.*, 2003). Regardless of whether the discrimination or harassment occurs prior to deployment, during deployment, or during the reintegration process, these adverse experiences increase the likelihood that veterans will suffer from PTSD.

Findings

Almost all (92%) veterans in this Study were non-Hispanic Caucasians. None of the data collected in this Study spoke to differences in need by ethnicity or races, and none of the data indicated that VSOs tailor their behaviors to veterans' races or ethnicities.

LGBTQ Veterans

Background

Research indicates that there are over 1 million veterans (and approximately 66,000-75,000 active service members) who would describe themselves as being part of the LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Queer) community (Cameron *et al.*, 2011; Service Women's Action Network, 2011; Simpson, Balsam, Cochran, Lehavot, & Gold, 2013). Estimates for Pennsylvania's LGBTQ community were not available as of this writing. There is limited research on the use of Veterans Health Care Administration services, and it is not clear whether gay, lesbian, and bisexual (GLB) veterans utilize VHA services at the same rates as the general veteran population or whether they experience unique barriers to services (Simpson, *et al.*, 2013, p. 223). However, a recent study found that approximately one-quarter (25.6%) of GLB veterans avoided using at least one VHA service due to concerns of stigmatization. The most frequently avoided types of services included individual counseling, general outpatient medical care, and dental care (Simpson *et al.*, 2013). These veterans expressed concerns that staff or other patients would not accept their sexuality, and over one-third had not shared their sexual identity with VA personnel (Simpson *et al.*, 2013).

Research suggests that LGBTQ veterans may have experienced unique stressors during military service, including the need to conceal personal information, harassment, and the fear of being discharged for their sexuality (Cochran, Balsam, Flentje, Malte, & Simpson, 2013). The LGBTQ individuals in this study were prone to an overall lower health status and higher rates of smoking, alcohol and substance abuse, mental illness, sexually transmitted diseases, depression, PTSD, and suicidal thoughts or behaviors (Cochran *et al.*, 2013; VHA Office of Health Equity,

2011). LGBTQ service members also experienced higher levels of military sexual trauma when compared to heterosexual service members (Mattocks *et al.*, 2013).

Findings

Statistically, it is highly likely that Pennsylvania has a substantial number of LGBTQ individuals among its veteran population, but none of the veterans in this study identified as LGBTQ.

VSOs perceive that LGBT veterans are among the least well-served by VSOs in the Commonwealth, but they did not share any insights into these opinions. This topic yielded the least of all areas of inquiry.

Rural Veterans

Background

It is estimated that about 28% of all veterans nationwide (6.1 million) live in rural areas and approximately 32% of Pennsylvania's veterans live in rural areas (Center for Rural Pennsylvania Newsletter, 2012). Although rural veterans share many characteristics with their suburban and urban counterparts, they face a number of challenges that are unique to their geographies. Their biggest problems revolve around access: Access to services and access to transportation to reach those services (Weeks *et al.*, 2004; Weeks *et al.*, 2006). Several studies have found that the level to which health care needs are met can vary considerably, with those living in rural areas exhibiting higher levels of unmet need (Weeks *et al.*, 2004; Weeks, Wallace, Wang, Lee, & Kazis, 2006). Rural veterans also have lower health-related quality of life scores and a lower likelihood of being able to pay for care through private pay or insurance (*Fact Sheet: Information About the Office of Rural Health and Rural Veterans*, 2013; Weeks, Wallace, West, Heady, & Hawthorne, 2008; West & Weeks, 2009).

A number of initiatives have been developed over the last decade to attempt to bridge these gaps in access and care. For example, the VA has developed localized and regionalized rural care initiatives, and Congress established the Rural Veterans Care Act of 2006 to investigate methods of improving rural health care (Weeks *et al.*, 2008). In 2007, the VHA created the Office of Rural Health to develop evidence-based policies to improve access to and quality of care for rural veterans (*Fact Sheet: Information About the Office of Rural Health and Rural Veterans*, 2013). In addition, the Patient Protection and Affordable Care Act was passed in 2010, in part, as an effort to expand access to health care coverage; however, there is not yet literature available detailing its effects on veterans.

Despite these attempts to improve access and health-related quality of life for rural veterans, a number of barriers remain. First, it can be challenging to recruit and retain qualified medical providers in more geographically remote areas. The VHA Office for Rural Health estimates that only 9% of physicians practice in rural areas, despite the fact that 20% of Americans live in a rural area (*Fact Sheet: Information About the Office of Rural Health and Rural Veterans*, 2013; Weeks *et al.*, 2004). In addition, rural veterans are less likely to have private insurance and more likely to have more complicated health care needs, which can make providing comprehensive care especially challenging (Weeks *et al.*, 2006, 2008; West & Weeks, 2009). Finally, rural veterans are less likely to utilize care available to them through the VA system due to travel limitations (Weeks *et al.*, 2006; West & Weeks, 2009).

Findings

In this study, half of the younger veterans lived in urban counties; 30% lived in rural counties; and 21% lived in suburban counties. The breakdown was similar among older veterans, with 39% living in urban counties; 35% in suburban; and 27% in rural counties.

One-third of VSOs said that they work with veterans in rural counties (32%), 10% served veterans in urban counties, and 9% served veterans in suburban counties. An additional 19% reported that they served different types of counties, while 30% said that they served veterans in all counties. Two-thirds (66%) reported that they have assisted veterans from outside of Pennsylvania.

Rural veterans described a critical need for transportation services. Specifically, they said that transportation in their rural areas is not convenient or reliable. They described waiting at bus stops for hours to get to medical appointments because buses only run at certain times. Although Disabled American Veterans (DAV) provides free transportation for veterans in some of these areas, there often are not enough cars or vans to meet demand. One veteran suggested that the state should provide funding to assist with getting rural veterans to their appointments. Another rural veteran was not aware that he could claim his mileage to travel to medical appointments.

Recommendations

- Education. Education. Education.
- Determine the best means of disavowing VSOs of the “one size fits all” preconception about veteran subpopulations.
- Work with academic partners to develop research briefs on subpopulations. Consider developing partnerships with top-level schools, such as the Army War College, whereby masters-level officer/students can provide research briefs on subpopulation issues as part of their thesis work.

VETERANS SERVICE OFFICERS (VSOs) and VSO PROGRAM MANAGEMENT

Background

As explained in the Introduction, the term “VSO” in this study is used collectively to refer to all persons tasked with providing assistance to veterans through their respective organizations, including ODAGVA, County VSO offices, and independent VSOs. The legal and fiscal climates in which VSOs operate are complicated. ODAGVA VSOs are employees of the Commonwealth and answer to the Adjutant General. CVSOs are county employees and are appointed by county commissioners; they report to the county commission. County commissioners appoint a county-level director of veterans’ affairs (DVA) whose duty it is to oversee obligations assigned to the county by law, but this appointment does not include any direct funding to support these obligations. The DVAs (or CVSOs as they are called in this Study) administer state and federal programs, so they are beholden to state and federal oversight systems (Behney *et al.*, 2012). IVSOs are authorized by Act 66 of 2007, through which they receive state funding based, in part, on how many veterans’ claims they process.

Fiscal Context

With almost one million veterans, Pennsylvania ranks fourth in the United States in veteran population behind only California, Texas, and Florida (U.S. Department of Veterans Affairs: National Center for Veterans Analysis and Statistics, 2012), as depicted in the following table.

Table 14. States with the Highest Veteran Populations

Rank	State	Total Veteran Population
1	California	1,844,803
2	Texas	1,675,689
3	Florida	1,543,496
4	Pennsylvania	980,529
5	New York	918,093
6	Ohio	899,615
7	Virginia	837,051
8	Georgia	776,205
9	North Carolina	771,654
10	Illinois	764,203

However, it is important to consider the geographic distribution of Veterans Affairs (VA) expenditures, which is the total estimated federal dollar expenditures for major VA programs from the following categories: Compensation and pension, education and vocational rehabilitation and employment, insurance and indemnities, construction, general operating expenses, loan guaranty, and medical care. In 2012, Pennsylvania ranked low as compared to other states in terms of the total estimated federal expenditures, with a total expenditure amount of \$4,075,364,000 (U.S. Department of Veterans Affairs: National Center for Veterans Analysis and Statistics, 2013). This equals approximately \$4,156 federal dollars per veteran for the state of Pennsylvania, which is below the national average of \$5,415. The following table shows Pennsylvania's expenditures per veteran along with the states with the highest federal expenditures per veteran, as determined by dividing the total estimated federal expenditures for major Veterans Affairs programs by the total veteran population.

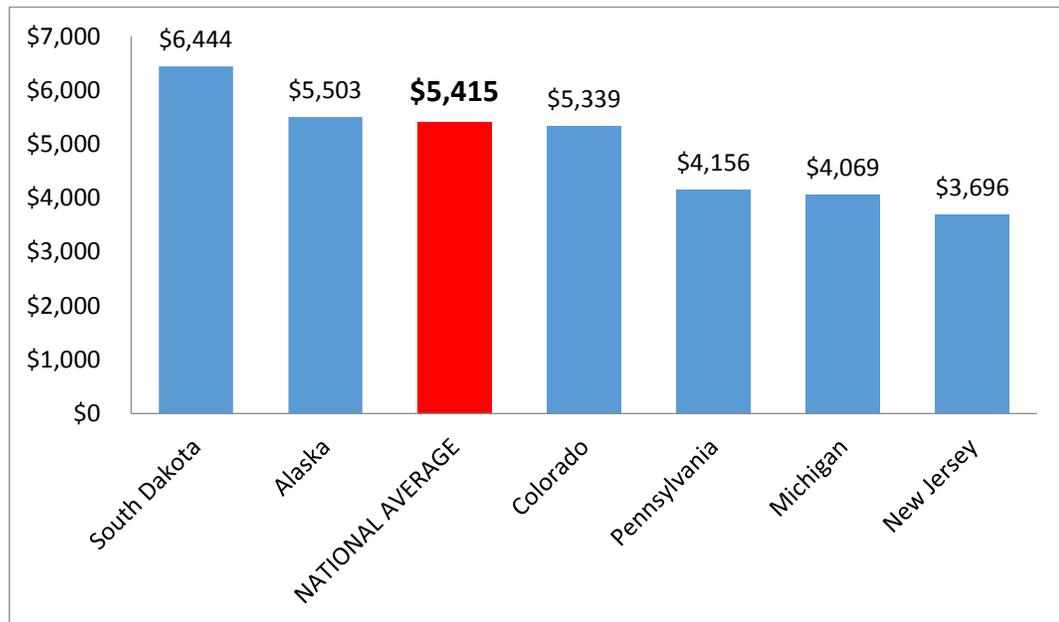
Table 15. States with the Highest Federal Expenditure Spent Per Veteran

Rank	State	Expenditures Per Veteran
1	West Virginia	\$7,833
2	Texas	\$6,663
3	Arkansas	\$6,637
4	New Mexico	\$6,561
5	Oklahoma	\$6,463
6	Ohio	\$6,453
7	South Dakota	\$6,444
8	Nebraska	\$6,291
9	Maine	\$5,967
10	Rhode Island	\$5,959
45	Pennsylvania	\$4,156

Even though Pennsylvania ranks fourth in veteran population, the federal dollar expenditures per Pennsylvania veteran is close to last in the nation.

The Pennsylvania Department of Military and Veterans Affairs (DMVA)

Pennsylvania's veterans are served by the DMVA. The DMVA serves a dual role, providing services to Pennsylvania veterans and their families, as well as overseeing members of the Pennsylvania National Guard. Most states have a dedicated department headed by a cabinet-level director whose sole purpose is to assist veterans and their families. Only five states in addition to Pennsylvania have a dual purpose DMVA; these include Alaska, Colorado, Michigan, New Jersey, and South Dakota. Of the 10 states with the highest veteran populations, only Pennsylvania veterans are served by a dual purpose DMVA. Furthermore, two-thirds of states whose veterans are served by a DMVA have per-veteran expenditure amounts that fall below the national average of \$5,415 in federal expenditures per veteran. The following figure shows the federal expenditures per veteran for the states whose veterans are served by a DMVA.

Figure 32. Federal Expenditures per Veteran for States Served by a DMVA**Background: State Funding and Services**

Looking beyond federal dollars expended for veterans, a 2011 study by Behney and colleagues found that funding deficits negatively impacted a number of core veterans' services, including county veterans' office staffing, claims processing, communication with veterans, and education on services and benefits. This study also estimated that 10% of Pennsylvania's veterans were served by the DMVA during the study period, which the authors relied upon to suggest that improving funding levels could help VSOs and the DMVA reach more veterans and enhance service delivery to existing veterans (Behney *et al.*, 2012). No data from this current study support or refute that assertion. Additional research is required to examine this very specific issue.

According to the OVA's strategic plan for 2012-2016, funding reductions in recent years have resulted in the OVA finding itself expending an average of only \$3.34 in state funds on veteran services for each veteran in the Commonwealth. Concurrent cost increases and budget

cuts in recent years, both at the federal and state levels, have led the OVA to seek alternative sources of funding. The DMVA expects appropriation amounts to be reduced further in coming years (Pennsylvania Office of Veterans' Affairs, 2012).

A study conducted in 2012 for the Center for Rural Pennsylvania included the following recommendations for the DMVA: Develop standardized regular performance measures to better assess performance of county veterans affairs offices (CVAOs), require CVAOs to report key performance indicators to DMVA annually, develop a records management system, and create a separate Department of Veterans Affairs for the Commonwealth with cabinet-level rank for its Secretary (Behney *et al.*, 2012).

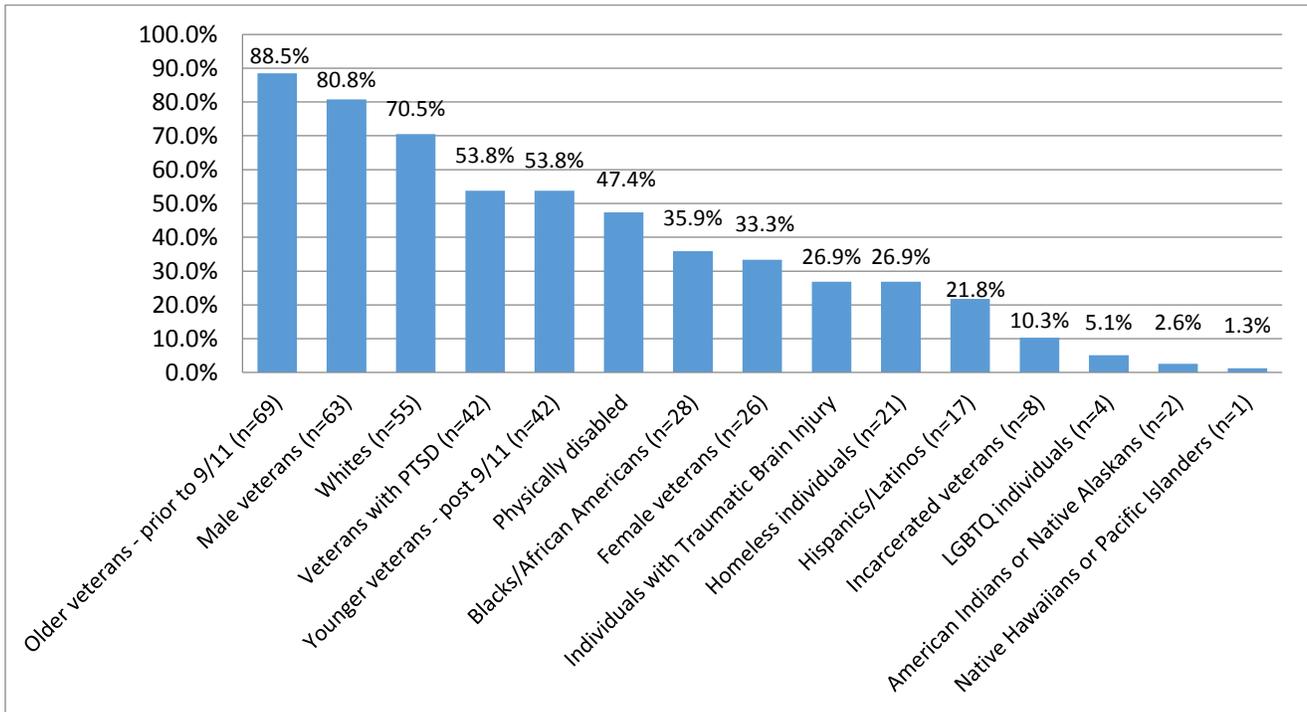
Findings: General

VSOs as a whole have been in their positions for approximately 8 years, with little variation among the types of VSOs (7.89 years for ODAGVA, 8.32 years for CVSOs, and 8.76 years for IVSOs). All volunteer VSOs in this Study were affiliated with independent nonprofit organizations. Like ODAGVA VSOs and CVSOs, almost all IVSOs assisted with new and existing claims, pension claims, and disability claims. ODAGVA VSOs predominantly reported that they provided assistance with five⁶ main types of claims, while CVSOs and IVSOs reported assisting with many claim types.

All VSOs reported that they most frequently assist older, white, male veterans, but over half of the time they assist younger veterans.

⁶ Service-connected disabilities, pensions, non-service connected disabilities, state benefits, and death benefits

Figure 33. Veteran Populations Most-Served on a Daily Basis by Service Officers



Over three-quarters of VSOs worked full-time in their positions (79.5%; $n = 62$), 14.1% ($n = 11$) reported that they worked part-time, and 6.4% ($n = 5$) worked as volunteers. All ODAGVA VSOs worked full-time ($n = 11$), and a most CVSOs worked full-time (92.1%; $n = 35$). IVSOs had the highest percentages of part-time and volunteer workers (27.6%; $n = 8$, and 17.2%; $n = 5$ respectively).

The Research Team posed some additional questions in the administrative web survey to CVSOs specific to their county-level jobs. One in ten ($n = 4$; 10.5%) County Veterans’ Affairs staff reported that they performed multiple county functions, including some not related to veterans’ affairs. Many CVSOs perceived their offices as being understaffed. The average number of full-time staff working with CVSOs was 2.68, and the average number of part-time staff was less than one (0.43).

Veteran Awareness of VSOs

According to the data from this Study, Pennsylvania veterans are under-informed about VSOs, and particularly about CVSOs and ODAGVA VSOs. While three-quarters of veterans were aware that they could receive assistance with claims through IVSOs, over 40% did not know that assistance was available through the DMVA, and over half did not know that CVSOs existed. More than half of all veterans did not know where their CVSOs' offices were located, and over half did not know how to file a claim for VA benefits.

More younger veterans (53.7%) than older veterans (29%) were members of independent, nonprofit veterans' organizations, such as the American Legion or the Veterans of Foreign Wars. Finally, nearly three-quarters of Pennsylvania veterans surveyed indicated that they were aware that Veteran Service Organizations, such as the American Legion and VFW, are available to assist them with learning about veterans' benefits, services, and programs (71.9%; $n = 205$). The figures below depict the survey veterans' levels of awareness with each of the VSOs noted above.

Figure 34. Older Veterans' Awareness of Available Assistance

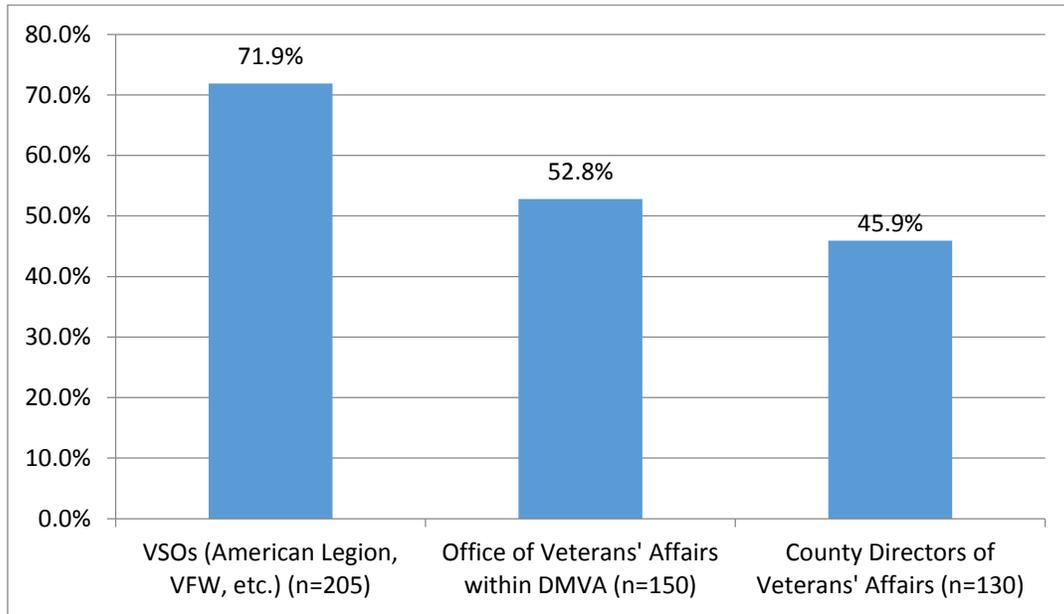


Figure 35. Younger Veterans' Awareness of Available Assistance

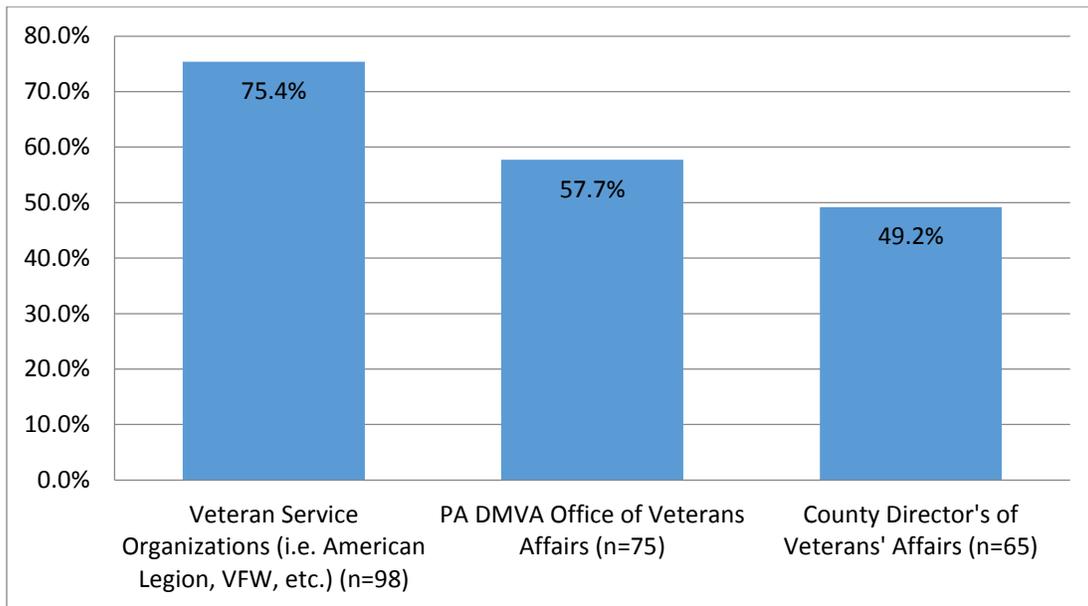
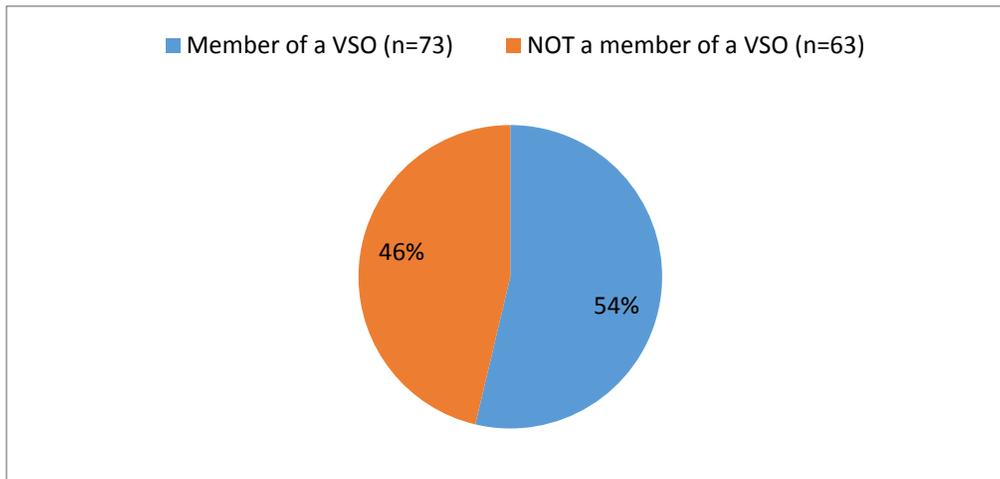


Figure 36. Younger Veterans' Membership in Independent Veteran Organization**Challenges Facing VSOs**

As H.L. Mencken said, “When someone says it’s not about the money, it’s about the money” (Mencken). The VSOs in this Study frequently prefaced their feedback by saying, “It’s not just about the money . . .” then uniformly reported that lack of funding is one of the biggest barriers to providing for veterans. On a scale of one to 10, with one being most challenging, both ODAGVA VSOs and IVSOs ranked funding as the most important issue facing their organizations (mean score 2.38 and 2.62 respectively). CVSOs indicated that staying up-to-date on technology was most challenging for their organizations (3.89), while funding ranked second (4.05). Staff turnover and staff burn-out also ranked very high for both ODAGVA VSOs (3.88 and 5.00 respectively) and IVSOs (4.69 and 4.59 respectively). Interestingly, staff burn-out and staff turnover were ranked lower by CVSOs (5.83 and 7.33 respectively), while staying up-to-date on issues in the field/new services (4.10) and collaboration with other organizations (4.60) ranked as more challenging for these organizations.

Table 16. Mean Ranking of the Most Challenging Issues Facing VSOs by Organizational Affiliation⁷

Challenge	ODAGVA VSOs	CVSOs	IVSOs
Funding	2.38	4.05	2.62
Outreach	3.25	6.14	5.25
Staff turnover	3.88	7.33	4.69
Staff burn-out	5.00	5.83	4.59
Collaboration with other organizations	5.33	4.60	4.94
Ability to find veterans	5.63	5.57	6.36
Training	5.67	6.22	4.33
Staying up to date on issues in the field, etc.	5.71	4.10	5.00
Staying up to date on technology	6.71	3.89	4.94
Ability to provide linguistically diverse services	7.60	7.46	9.70
Ability to serve culturally diverse veterans	7.80	8.23	8.55
Having access to necessary technology	8.20	5.50	5.44
Other issues	8.00	8.25	10.00

Many VSOs across all organizational types drew a parallel between their work as VSOs and their military service. In both professions, they found that they often had to “get creative” when trying to get services for the veterans they serve. Almost 43% ($n = 27$) have “gone around the system” to get services. ODAGVA VSOs were most likely to “work around the system” (60.0%; $n = 6$), followed by IVSOs (47.8%; $n = 11$), and CVSOs (33.3%; $n = 10$). The Research Team understood in context that “going around the system” meant finding alternative solutions to problems through legal but unorthodox means. For example, one-third called people in authority to help (33.3%; $n = 5$). Two service officers specifically mentioned asking for Congressional assistance. Over one-quarter of VSOs used community resources instead of the VA to get help for their veterans (26.7%; $n = 4$). Other examples included ignoring geographical lines when helping veterans ($n = 1$) and visiting VA regional offices and hospitals monthly to help expedite claims ($n = 1$).

⁷ One was “most important” and 13 was “least important.”

Table 17. Most-Requested Improvements by Organizational Affiliation

Items Needed	ODAGVA VSOs	CVSOs	IVSOs
Funding/money	81.8%	56.8%	72.4%
Additional staff	81.8%	56.8%	48.3%
Training for staff	45.5%	37.8%	34.5%
Cooperation from other agencies	54.5%	40.5%	55.2%
Community education	45.5%	37.8%	48.3%
Outreach efforts	81.8%	45.9%	55.2%
Community support	54.5%	21.6%	44.8%
Legislation	81.8%	43.2%	37.9%
Better technology	45.5%	24.3%	27.6%
Other need	0.0%	10.5%	3.4%

VSO Training

The large majority of VSOs across all organizational types perceived themselves as adequately trained. ODAGVA VSOs were least likely to want better training (9.1%, $n = 1$), while one-fifth of CVSOs wanted better training (19%; $n = 6$), and nearly one-quarter of IVSOs wanted better training (23%, $n = 6$). When asked whether VSOs *outside of their own organizational affiliation* needed better training, the majority of VSOs said that other VSOs were not as well-trained as they were. For example, ODAGVA VSOs perceived that their training, which is administered internally and pursuant to standardized protocols, was superior to the training administered through in-house IVSO programs. Conversely, IVSO personnel perceived that their training, which many of them develop internally and is based on their own research, was more responsive to “real world” issues. IVSOs perceived themselves as “more in touch” with actual veterans, while ODAGVA VSOs perceived themselves to be more professional than others. CVSOs fell somewhere in the middle, but CVSOs appeared to feel less connected to the “professional” VSO persona and simultaneously detached from “veterans on the street.”

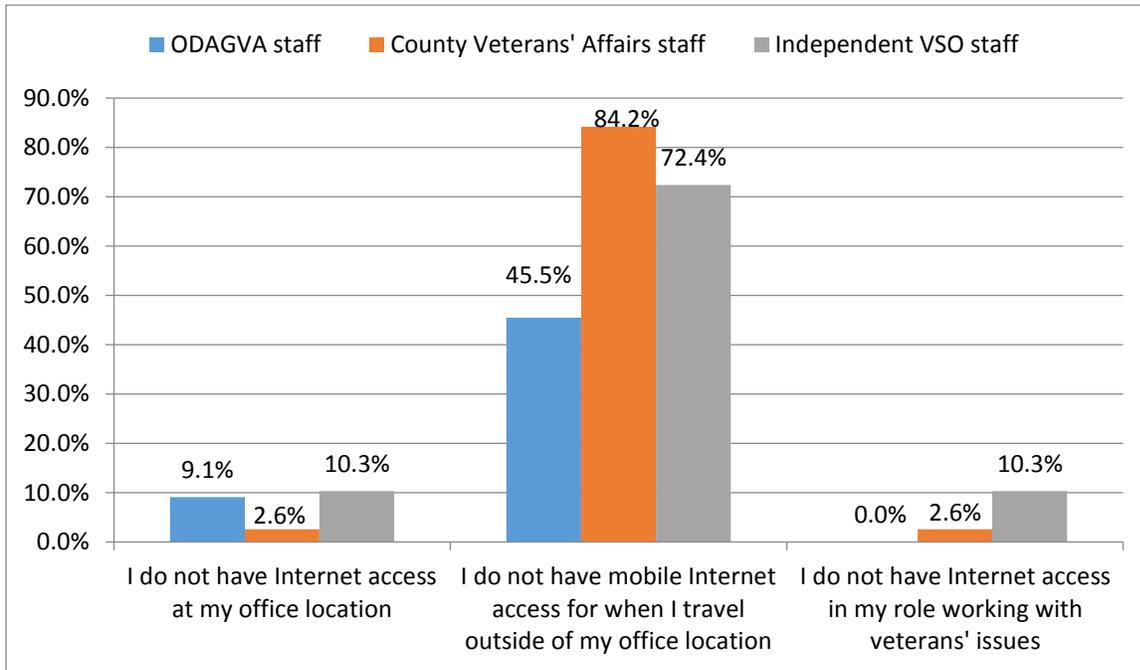
As an aside, CVSOs seemed to be most adversely impacted by a sense of isolation from the system, the perception being that they are not current on information or connected to others in the VSO field. Recommendations from VSOs for improving training included:

- Hands-on training with filing claims, perhaps using mock cases, real time, in an online environment;
- Incorporation of tablet computers and Internet access to facilitate on-line assistance with claims during in-person meetings with veterans;
- Email accounts for all VSOs;
- Website training for all VSOs;
- Quarterly webinars for VSOs;
- Certification of VSOs to create a more professionalized field;
- Professionalization of VSO field and career development planning;
- Medical claim training;
- GI Bill training; and
- Refresher training

Internet Access

Five percent ($n = 4$) of VSOs did not have Internet access available through their positions. When asked specifically about access within their office locations, 6.4% ($n = 5$) indicated that they did not have Internet access. IVSOs were less likely to have Internet access in their offices than CVSOs (10.3%; $n = 3$ versus 2.6%; $n = 1$). All ODAGVA staff had Internet access. Although, almost three-quarters (74.4%; $n = 58$) did not have mobile Internet access for travel related to their work. Of those service officers who did have mobile Internet access (25.6%; $n = 20$), all indicated that they had a laptop ($n = 20$) and half reported having a cell phone with Internet access/email ($n = 10$).

Figure 37. Internet Access by Organizational Affiliation



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