Battle on the Homefront:
The Mental Health Challenges of Veteran Families

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Disclaimer

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Abbreviations

ACA – Patient Protection and Affordable Care Act
CBO – Congressional Budget Office
COSF – Code of Support Foundation
CPG – Clinical Practice Guidelines
DoD – Department of Defense
HHS – Department of Health and Human Services
IAVA – Iraq and Afghanistan Veterans of America
IOM – Institute of Medicine
NCBH – National Council for Behavioral Health
NGO – Non-governmental Organization
OEF – Operation Enduring Freedom
OIF – Operation Iraqi Freedom
PTSD – Post-Traumatic Stress Disorder
STSD – Secondary Traumatic Stress Disorder
TBI – Traumatic Brain Injury
VA – Department of Veteran’s Affairs
VSC – Veteran Spouses and Children
WWP – Wounded Warrior Project
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Executive Summary

There is substantial evidence which indicates that veteran spouses and children (VSC) face significant mental health challenges. While this poses real, multifaceted problems for the United States, there is currently no unified effort to ameliorate the issue. The VA offers family members limited to no services for their own mental health, and community-based programs can be difficult to access and navigate. As such, too many veterans’ family members fall through the cracks and continue to go untreated.

The unique contribution of this report is that it begins to sketch a practical plan to address the issues we will present. The collection of reports that exist on this topic have, to date, collectively explicated a preliminary account of the problems that veterans’ families face. However, none have proposed a systematic plan that can be implemented and executed. I will thus build on the existing literature by collecting the relevant publications, exploring the aspects of the problems that they have raised, and then suggesting workable recommendations.
Overview of Veterans and their Families

Prevalence of Mental Health Issues

Evidence suggests that the post-9/11 military campaigns have been exceptionally devastating to service members’ psyches. Additionally, due to improved medical technology, more veterans are returning home from war. Both of these combined mean that more veterans are returning to their families with mental health conditions.

It is important to understand the trend described above for the following reason. With more veterans returning home who have been exposed more heavily to the conditions of war, families are having to facilitate the readjustment of veterans to the homefront. Although not all veterans develop full blown mental health conditions, all must reintegrate into life back at home. This period of time often puts a significant amount of strain on families, who must assist veterans struggling with bouts of frustration, high stress, and erratic behavior. These episodes of behavioral issues sometimes have a spill-over effect for family members. In other words, while family members help veterans handle the psychological struggles of post-combat life, some develop mental health conditions of their own.

Veterans’ Mental Health

That family members develop mental health conditions is not surprising, given that veterans themselves experience high rates of mental health conditions.

PTSD

Among the most prevalent of these conditions is Post-Traumatic Stress Disorder (PTSD). Many publications have reported that veterans experience disproportionately higher rates of mental health conditions, especially in comparison to the total U.S. population. The Institute of Medicine estimates that 23.6 percent of OEF/OIF veterans have been diagnosed with PTSD (Wedge, 2014). The IAVA 2014 Member survey estimated that, among their members, 44 percent have been diagnosed with PTSD, and of those that have not been diagnosed, 19 percent feel that they have PTSD but have not sought treatment (Maffucci, 2014). Moreover, according to the VA, about 30
percent of Vietnam veterans also suffer from PTSD. In comparison to the veteran statistics, only about 8 percent of the general U.S. population will be diagnosed with PTSD at some point.

**TBI**

The RAND Corporation estimated that 12.2% of returning OEF/OIF veterans have reported experiencing Traumatic Brain Injury (TBI), a cognitive condition associated with military combat (Tanielian, 2008). This figure only takes into account self-reported injuries however, so the true percentage of the population affected by this disorder may be slightly different. Additionally, the IAVA 2014 Member survey estimated that 18% of their membership base has been diagnosed with TBI (Maffucci, 2014).

As for the general U.S. population, estimates show that around 1.4 million Americans will suffer from TBI each year (Langlois, 2006). Aggregated over the number of years that service members were heavily deployed in post-9/11 conflicts, this amounts to around 20 million Americans having suffered from TBI, or about 6.7% of the general population. It is important to note that, according to these numbers, veterans are about twice as likely as the general population to suffer from TBI and its related complications.

**Suicide**

The general veteran population is also at higher risk for committing suicide. Although veterans have traditionally been understood to be at lower or relatively equal risk of suicide when compared to the civilian population, some recent research indicates otherwise. One study published in 2012 found that, for all ages until 65, male veterans were at a higher risk for suicide than their civilian counterparts (Kaplan, 2012). A separate study published in the same year confirms these findings. In this report, researchers found that between 2000 and 2007, male and female veterans across all age groups who used VHA services were at a higher suicide risk than the civilian population (although they do mention that this rate has been decreasing in recent years) (Blow, 2012).

This demonstrates that, on average, veterans are more prone to developing mental health challenges than the civilian population.
The Mental Health of Veterans’ Families

The findings discussed above are already well understood by researchers. What is still currently under-explored are the effects that military life has on VSC. The research that does exist points to a VSC population that also experiences poor mental health. Military spouses in particular face serious challenges. Conditions for developing mental health conditions begin even before the veterans return. While service members are deployed, military spouses (the majority of whom are women) are challenged with maintaining their normal day-to-day lives while handling the constant stress of not knowing the condition of the deployed service members. This involves ensuring the emotional and physical well-being of any children they may have, who are also affected by an absent and endangered parent.

Once the service members’ tours are complete, spouses must face a new onslaught of challenges. They are the typically the ones who make first contact with the veterans upon their return home. They are the ones who live with and often provide support to the veterans at home as they begin the readjustment process. Facilitating this readjustment is made particularly difficult if the veteran has developed the mental health conditions described in the previous section. Many families have reported that a returned veteran seems, in many respects, like a different person. However, the expectation of most parties involved is that life will return to normal. Such pressure and stressors inevitably take a toll on not only the veteran, but his or her family as well.

Current research supports the previous claim. In general, families with returning veterans who have mental health disorders experience greater difficulties than those without mental health challenges. A longitudinal study published in 2013 found that, over the course of 20 years, families with veterans who have mental health challenges experience less family cohesion than families with mentally healthier veterans (Zerach, 2013). This indicates that, if left untreated, veterans’ families with mental health challenges will continue to experience familial problems. Problems pertaining to specific family members are further outlined below.

Spouses

Research has begun to illustrate the effects that these stressors have on veteran spouses. A study published in 2010 found that, in a sample of Army wives, around 35 percent had at least one mental health diagnosis. The most common diagnoses were those of depressive, anxiety, acute stress, and sleep disorders. This study also found that the length of spousal deployment was associated with
mental health diagnoses (Mansfield, 2010). Other research indicates similar trends. Military researchers found in 2008 that, among a sample of nearly one thousand military wives, around 20% screened positive for either major depressive or anxiety disorders (Eaton, 2008). Additionally, a separate study found that 44.2 percent of a non-randomized sample of military spouses tested positive for generalized anxiety disorder. Further exacerbating this problem is that many of these spouses who had developed anxiety disorders believed that they were physically ill when such physical health problems did not actually exist (Fields, 2012).

Spouses are also at an increased risk for a recently recognized condition known as Secondary Traumatic Stress Disorder (STSD). This condition occurs when romantic partners of veterans are continually exposed to the different symptoms that veterans experience with PTSD. These spouses report having flashbacks to the traumatic events that the veterans themselves often re-experience, and also exhibit avoidance symptoms similar to those of veterans. Though documented cases of this condition exist, some researchers believe that the numbers of spouses affected with STSD are smaller than the current numbers suggest, and believe instead that a large portion of spouses who have been diagnosed with STSD actually have more general anxiety disorders. Still, these researchers acknowledge the existence of this disorder and advise clinicians to understand both the nature of this disorder and how to treat it (Renshaw, 2011).

It is important to recognize though that most of these figures represent the mental health of active duty - not veteran - spouses. Though it likely that spouses continue to experience mental health challenges once the service member transitions into veteran life, the extent to which these problems persist or worsen is not entirely clear. Further longitudinal studies to measure the mental health effects on spouses will need to be conducted.

**Children**

Children of military families are also negatively affected. For example, a study from the Journal of Adolescent Health reported that children with parents or siblings in the military are much more likely to experience mental health complications than their non-military peers. In this sample, around 35% of military children reported feeling hopeless or sad compared to about 29% of their non-military peers. Moreover, about 25 percent of military children reported suicidal thoughts,
while only 15 percent of non-military children did (Cederbaum, 2014). Additional research echoes these findings. In another study, researchers found that the length of parental deployment was associated with mental health diagnoses in children, especially those of depressive, pediatric behavioral, and acute stress disorders (Cozza, 2013).

Veterans’ children experience educational complications as well. A report published by the Iraq and Afghanistan Veterans of America (IAVA) organization states that students who have had deployed parents are more likely to have trouble in the classroom (Banai, 2011). These problems again are exacerbated by longer stretches of parental deployment. Such problems can be directly associated with parental deployment (having to handle the stressors of not knowing whether the parent is safe, and the emotional problems that come with having had an absent parent), or indirectly linked (having to take on more responsibilities at home if the returned parent is unable to resume a head of household role, and also having potentially developed strained relationships with other family members at home due again to caring for the returned veteran).

Academic complications persist especially when teachers and school administrators fail to understand the problems that children of veterans face. Though not a direct mental health disorder, educational struggles often increase the stressors that veterans’ children face and can worsen their mental conditions.

**Family Members as Caregivers**

Finally, the RAND Corporation recently published a report that highlights the effects of providing care to a returning service member. This study is unique in that it associates providing care for returning service members with caregivers’ mental health. Yet because family members sometimes assume the role of a caregiver, this study is relevant to our interests here. It estimated that 43 percent of post-9/11 caregivers suffer from anxiety disorders, and that 38% suffer from depressive disorders. While these figures describe caregivers in general, the same study also indicated that 73.6 percent of post-9/11 caregivers were family members, and, more specifically, that 33 percent were spouses. In addition, being a family member or romantic partner of the care recipient had the strongest correlation with developing the aforementioned mental health
conditions. As such, it is reasonable to infer from this study that family members in particular are acutely affected by providing care to returning veterans (Ramchand, 2014).

**Summary**

The resounding theme here is that the mental health of veterans’ families is declining. However, to ignore the limitations of the available data would be irresponsible. What these studies have shown is that there is a strong association between being a family member of a veteran and developing mental health conditions. What this does not necessarily establish, however, is that there is a causal link between the two.

Certainly, these preliminary studies strongly suggest a causal link. This also does not, prima facie, seem like a difficult claim to support. Having to engage in helping the veterans to readjust, while also juggling the emotional stress from having had a spouse or parent who was previously deployed, places a great deal of pressure on families. However, it is always possible that other endogenous factors are at play. As such, more rigorous studies will have to be conducted in the future to better establish the extent to which being a family member of a veteran has a direct impact on one’s mental health.
Severe Limits in Access to Care for Veterans’ Families

If it is true though that being a family member of a veteran is causally related to declining mental health, then current levels of mental health provision and acquisition are not sufficient. This poses another component to the problem: not only may the service of veterans also negatively impact their families, but the United States has largely failed to respond with adequate health care coverage for these families.

**Government-Provided Care**

While still in the military, service members and their families have access to a number of mental health treatment options. In ways of preventative measures, the military offers resiliency training for service members and their families, and provides other services to help decrease the onset of combat-related PTSD. The DoD also offers counseling to veterans and their families for service related concerns. Military OneSource in particular offers free one-on-one counseling sessions to family members without having to notify the service member. This model of care provision allows family members to access the services they need without fear of stigma or harming their spouses’ careers. Finally, some private care providers outside the military also offer services to military families as contractors to the DoD.

However, the long term well-being of veterans and their families is critically dependent on the services available after discharge. A significant player in post-discharge life is unquestionably the VA.

The VA is the largest single healthcare provider for veterans. However, VSC are not covered as extensively as veterans themselves. VSC currently have access to care through two main conduits: 1) through family or marriage counseling as it relates to the mental health of veterans; and, 2) as the caregivers of veterans. As participants in family counseling, spouses may attend counseling sessions to help the veteran confront his or her own challenges related to family reintegration. Current specifications under the clinical practice guidelines (CPG) rate such services as “Insufficient” for the treatment of acute mental health disorders such as PTSD (Monson, 2012).

VSC may also act as formally recognized caregivers of veterans and thus receive counselling services targeted to assist caregivers. However, the needs of caregivers do not entirely overlap with
those of a spouse with a strained marriage. Moreover, many spouses and children who require mental health assistance do not act as formal caregivers for veterans, and are thus unable to access treatment through the VA.

Outside of family and caregiver counseling, VSC do not at present have access to direct mental health treatment for their own mental health conditions. As such, the care that VSC have access to is insufficient in addressing their mental health needs, and the care they need is not provided through the VA.

**Private Insurance Care**

Many veterans turn to private based care for their mental health needs. As it stands now, a 2010 CBO report estimated that 38 percent of veterans enrolled in the VA have healthcare coverage through private insurance (CBO, 2010). Additionally, a 2014 IAVA Member survey estimated that 21 percent of their members have insurance only through private providers, 13 percent have a combination of VA and private care, and 11 percent seek non-VA care specifically for their mental health (Maffucci, 2014). However, these figures are not as readily available for VSC. We suspect though that levels of private healthcare acquisition for VSC’ mental health is higher than the acquisition estimates for veterans themselves. This is because VSC’s mental health treatment is not extensively covered by the VA; if they wish to receive mental health treatment, they must primarily seek out private care on their own.

In response to current VA backlogs, policy makers have sought solutions for veteran health care in private markets. For example, the VA has recently offered a voucher program to veterans who wish to seek care in private networks outside of the VA. This will likely increase the current levels of private healthcare utilization in the veteran community in future years.

However, as a solution to the current healthcare backlogs for veterans, it is not yet clear whether this will be effective. Shortages of physicians are not limited to the VA; it is a problem that the entire healthcare industry in the U.S. faces. As health - and, for our purposes, especially mental healthcare provision - needs to be increased, solutions that address the current physician shortage will be required.
Community-Based Care

VSC have additional access to mental healthcare through community-based nonprofit organizations. In a RAND study on military and veteran caregivers, 17% of the analyzed service providers offered care specifically to families (Ramchand, 2014). Other publications also mention the growing availability of community-based care (Link, 2013).

However, problems still exist. Though care is available in the nonprofit sector, VSC do not always seek it out. According to one study, this is due to two major problems: 1) barriers to care; and, 2) stigma associated with receiving care. Some of the barriers that subjects identified were primarily lack of knowledge of where to access care and lack of time for care (Eaton, 2008).

The first barrier speaks to the difficulty that VSC face when trying to navigate the array of nonprofit providers. To address this concern, certain organizations have already begun developing collaborative networks. These networks will formally put organizations in contact with other local nonprofit providers. Through facilitating communication between service providers in the community, collaborative organizers hope to create networks of care that can point veterans and VSC in need to the appropriate service providers. Still though, the number of emerging collaboratives is few, and it is still too early to assess whether they will substantially improve the navigability of provider arrays.

In addressing the time-constraints associated with receiving care, service providers have begun to supplement traditional care with other technological approaches. For example, developers have created mobile phone apps that provide customizable services to users. Telehealth is also an emerging idea which aims to bring mental health services to patients everywhere through innovative measures such as video calls. Approaches like these can help facilitate faster and more convenient screenings for veterans and their families, who would otherwise have to travel far to receive care. However, these recent innovations, while potentially excellent as supplements to care, cannot readily replace traditional mental health treatments. As such, these solutions can only go so far in attempting to relieve some of the burden on currently overwhelmed mental health providers.
As for stigmas associated with receiving care, subjects feared the embarrassment of admitting the need for help, feared that receiving care would harm their (active-duty) spouses careers, and did not want to appear weak (Eaton, 2008). Addressing the problems associated with the stigma of receiving treatments for mental health has been something that mental health practitioners in general have faced for a while.

It is also unlikely that the current level of community-based care will can be sustained in the long run. Private dollar donations are at an all-time high for this sector, but experts expect this to decrease (Philip Carter, lecture comment, 2014). Funding is thus another question that leaders in the field will have to confront. This report makes suggestions for funding in later sections.

As such, it appears that mental healthcare for VSC fails on two fronts. The first is that there is a significant lack of availability. Without a comprehensive, state-sponsored program, VSC lack a centralized and organized source of care designed specifically for their needs. Additionally, VSC fail to access the care that is made available to them through community-based providers for the reasons listed above. Addressing these two central issues should serve to ameliorate the problems with veterans’ families’ mental health.
Policy Frames for the Problem

The preceding sections have established that veterans’ families are prone to developing mental health issues. This report has also indicated that mental health care utilization is too low for family members. Such a problem can be examined through the following three policy frames:

1) The negative externalities of not providing mental healthcare to veterans’ families

Limited mental healthcare access for veterans’ families is foremost a public health issue. First, there is a strong link between negative mental health and negative physical health. There are three major consequences of the correlation between mental and physical health (Fields, 2012). They are as follows:

- Poor mental health leads to poor perceived physical health. This encourages an overconsumption of healthcare services which causes a wasteful allocation of resources.
- Poor mental health leads to poor actual physical health. This results in an increased usage of healthcare services which then decreases the quality of healthcare services.
- Increased usage of healthcare services ultimately leads to an increase in healthcare costs.

Overconsumption of healthcare services and wasteful allocation of societal resources

When healthcare services are consumed at the economic equilibrium level, the costs that individuals pay for these services equal the benefits that they receive. However, because individuals with poor mental health perceive that they are more physically ill than they actually are, they sometimes receive medical treatment that they do not require. When consumption levels are thus above the equilibrium amount, the cost of these excessive treatments does not equal the benefits that they provide. Such wasteful spending harms society because the resources spent on acquiring marginally beneficial health care services could be used in more effective ways.

Increased usage of healthcare services decreases quality of healthcare services

The second negative consequence of leaving the mental health of veterans’ families untreated is associated with the relationship between mental health and actual physical health. It is not just the
case that individuals with poor mental health only *think* that they have poor physical health, but also that they may in some cases actually have comorbid physical health problems. In these cases, individuals would be consuming higher levels of healthcare that they really need. Yet such cases are still problematic. Even when health problems are real, diminishing marginal productivity renders medical services less effective when they are used more often. Common sense tells us the same thing. When the available supply of doctors and nurses treat only 100 patients, they may be able to provide adequate service to everyone. However, if 200 patients require care, then medical staff and supplies would have to be stretched across a wider population, which is likely to reduce the quality of care. Thus, when a population’s health worsens, the quality of health care will presumably diminish as well.

**Increased usage of healthcare services ultimately leads to an increase in healthcare costs**

Both poor perceived and actual physical health have one final consequence. In an insurance system, individuals rarely pay the full amount of medical treatment. So, when an individual goes in to see a doctor, the insurer ends up shouldering the cost (minus premiums and co-pays). The potential problem with this begins when individuals become sicker. When a population starts to have poorer health overall, people naturally consume higher amounts of medical treatment. But if insurance companies cover a large portion of these treatments, an increase in healthcare utilization leads to a higher total cost for these insurance companies. These insurance companies will in turn try to mitigate these costs by pushing them onto the consumers in the form of higher premiums. As such, when a society is sicker in general, individuals may end up paying more for healthcare services.

**Monetizing these costs**

It is important to quantify as best as possible when considering cost. Were it within our capacity, this report would estimate the potential increases in healthcare costs as a result of over-consumption and diminishing productivity. Yet such information is unavailable.

Fortunately, however, in 2008 the RAND Corporation quantified some of the social costs of not treating veterans with mental health conditions. These exceeded the direct costs of treating the conditions themselves, and included additional costs such as losses in productivity, homelessness, family breakdowns, and more. They estimated that leaving these mental health conditions untreated costs society anywhere between $5,900 and $25,760 for the first two years after returning home. Adjusted to 2015 dollars, these figures increase to a range of $6,432.14 and $28,038.39.
With these costs in mind, the study further stated that preventing and treating veterans’ mental health disorders would ultimately provide a cost-savings for the U.S. (Tanielian, 2008).

There are some limitations to using these figures. The first is that the RAND Corporation calculated these costs as they pertain to veterans themselves and not their family members. While we expect that the societal costs for leaving these disorders untreated in VSC are largely equivalent to those of veterans, it is important to at least mention a possibly disparity. The second limitation is that these figures are a baseline estimate. For the most part, it appears that the RAND study mostly took decreases in veteran productivity into account, whereas our report here also considers cost increases associated with potential inefficiencies in the healthcare industry. As such, the figures provided by the RAND study likely do not reflect the additional costs that we have outlined here. However, we believe that these cost estimates are still good indicators for the harm that society incurs.

2) National Security

Given the nature of the All Volunteer Force, continued recruitment of service members is integral to national defense. However, internal military research has forecasted a decrease in the propensity of young Americans to enlist in the military. As the economy begins to pick back up, individuals who do not strongly feel that the military is a viable career option may be even less likely to serve (Tilghman, 2014).

The subject of our report ties into this enlistment dilemma to the extent that veterans’ children who are adversely affected by their parents military service are less willing to serve. Because the children of veterans are more prone to developing mental health issues (Mansfield, 2011), and if, as a result, they are less likely to enlist, the military could potentially face considerable recruitment problems.

Though at present there is no study that directly measures whether veterans’ children who have developed mental health issues are less likely to enlist in the military themselves, there is some evidence that supports this claim. Research has concluded that service members who developed mental health issues were less likely to reenlist (Lancaster, 2013). Though this study does not measure the propensity of children with mental health issues to serve, it indicates that mental health
issues developed as a consequence of military exposure weaken an individual’s propensity to serve. This may also suggest that veterans’ children who have developed mental health issues will be less likely to enlist in the military.

Additionally, a 2005 study reported that, overall, children have demonstrated a weaker propensity to enlist in the military. Although the same report states that a family member’s prior military service is often a strong predictor of a child’s willingness to serve in the military, the important piece is that fewer students in general considered the military as a viable option (Brown, 2005).

This is critical for the following reason. The negative mental health effects of having a veteran parent are stronger in children who have had longer exposure to parental deployment. As such, the correlation between parental military service and the increased propensity for children to enlist may have included a population of children who were not yet young enough to develop mental health issues strong enough to pull them away from military service. Younger children who have had more exposure to veteran life, and who consequently have more acute mental health issues, may thus adopt the attitude of students who in general are less willing to enlist.

The preceding commentary has described a set of opposing trends. The first is that, in general, students are displaying a diminishing propensity to serve in the military. Second is that service members who develop mental health issues are less likely to reenlist. These two trends alone would suggest that children of veterans who develop mental health challenges should be less willing to enlist. However, the available literature also states that children who have military exposure via family members are on average more willing to join the military. From all of this, we are attempting to indirectly conclude that the children of veterans who have developed mental health challenges will be less likely to enlist. While a study that directly measures this relationship would more precisely answer this question, we are left to make suppositions based on the available evidence.

The answer, then, depends on the magnitude of the trends in conflict. If the propensity of students to enlist in the military is decreasing at a high rate, and if the development of mental health issues as a consequence of military exposure is strongly correlated with a decreased propensity to enlist, then it may be the case that the children of veterans will no longer be a large recruitment base. However, if parental military involvement outweighs the negative effects of these trends, and still
encourages students to enlist, then no national security concerns may exist. This, of course, is an empirical question, but one that merits concern if left unanswered.

This discussion is ultimately relevant since having a family member in the military has traditionally been a strong predictor of whether a child decides to enlist (Kleykamp, 2006). If such an important recruitment base becomes less willing to enlist, however, then there is an even stronger case to take the mental health issues of veterans’ families into consideration.

3) Moral Obligation

The final frame through which we can assess the problem is primarily a normative one. It does not deal so much with cost-benefit analysis or quantitative metrics, but instead appeals to ideals such as fairness and rights. What particular obligations do we have to the families of veterans; what claims can these family members rightfully make on the rest of the public? Although a proper account of these potential obligations would require a more systematic philosophical discussion, it will be sufficient here to outline their possible foundations by drawing from already existing beliefs.

It would be hasty from a theoretical perspective to state that veterans’ families have a definite right to publicly-funded mental health care. Such a construction of rights, again, are better left for robust philosophical discourse. However, we can reasonably extrapolate from conceptions of rights (which I discuss below) that already exist to come close to a decent account of these rights.

Although a contentious point among rights theorists, some assert that individuals have a right to healthcare. The reason why this is contested among scholars is due to divisions on the proper way to conceive of rights. Within philosophical discourse, there are two primary ways to classify rights. Negative rights are the first; they are best understood as rights against someone acting upon an individual. For example, religious freedoms are negative rights in that an individual has a right against religious persecution or censor. Such rights act as barriers that ensure the space in which persons can do freely as they wish. The second class of rights are positive rights. These are rights which guarantee particular things to individuals. Welfare rights thus grant individuals access to certain monetary provisions.

As such, a right to healthcare is best classified as a positive right. To proceed further, the reader must grant that positive rights exist. For some this will not be difficult to do, for such a conception
of rights fits neatly within their political ideology. However, for those with libertarian leanings, it will be difficult to move past this point. Such readers may consult other articles that deal with libertarian justifications of minimal positive rights if they wish to further pursue the issue\(^1\).

Granting that a positive right to healthcare exists, it seems more likely that VSC should have some kind of access to the healthcare that they need. The extent to which this care should be provided is of course debatable; some recognize a right to healthcare as mandating complete state coverage, while some interpret it to mean safety-net level provision.

Determining the extent of this care is facilitated by an appeal to fairness. John Rawls defines fairness as the removal of arbitrary considerations in determining the distribution of a society’s resources. This typically means correcting for things like socioeconomic starting points, natural talents, gender, race, etc. Because individuals do not choose their beginning place in society or other inborn traits, Rawls believed that a just society would be fair in aiding those who, by chance, were placed in disadvantageous positions (Rawls, 1971).

Of course, a family’s decision to serve in the military is not entirely something based on chance. In many cases, people actively and autonomously decide to enlist. However, the principle behind the concept of fairness - that we ought to correct for the unfair, disadvantageous state of individuals - remains applicable to veteran families. The military is structured such that it requires the willingness of individuals to enlist. Although there is no draft in place that legally coerces people to serve, that the military depends on individuals’ enlistment essentially requires their service. Because *someone* has to enlist, the U.S. hopes for and relies on the fact that certain people will

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\(^1\) See Adrian Bardon (2000) From Nozick to welfare rights: Self-ownership, property, and moral desert, Critical Review: A Journal of Politics and Society, 14:4, 481-501, DOI: 10.1080/08913810008443570. This article takes a Nozickian starting point, and discusses how Nozick’s deontological concern for respect and need requires that his theory take positive rights into account.

See also Lomasky, Loren E.. *Persons, rights, and the moral community*. New York: Oxford University Press, 1987. Print. This text is one the most robust libertarian accounts of rights within the literature. Its systematic derivation of rights includes reasons for defending a limited account of positive rights within a libertarian framework.


choose to do so. This creates an obligation on the state’s part to compensate individuals for damages they incur from enlistment.

Such a line of thinking is not novel. In fact, it is the line of thinking that exists behind many of the state-provided programs that exist for veterans today (Buchanan, 1984). What is novel - and oddly so - is that this has yet to be extended to families of veterans. Historically, this was likely the case because fewer service members survived combat, and also because fewer service members were married or had children. However, today’s military is more married, and the survival rate for service members has increased, so more veterans are returning home to families. Now that new research is linking the proliferation of mental health challenges to military involvement, it would thus seem morally dubious for the state to deny that their obligations extend to families as well.

It is now more evident that strong support exists for the claim that the state has an obligation to meet the mental health needs of veterans’ families. Yet this does not provide an exact framework for how the state ought to meet this obligation. Many factors go into developing such a framework - to name a few: efficiency, cost-effectiveness, the number of people treated, etc.

These considerations are left to be further evaluated by policy makers (which later sections of this report will address as well); however, we would be remiss to ignore that, before enacting policy, a clear moral obligation should drive whatever actions we take.
Policy Analysis

With the problem adequately described and framed, I will now conduct an analysis of a set of policy options that could each potentially resolve the issue. First, I will list out the options. I will then outline the criteria by which I will evaluate the options. I will then take this analysis and offer a final policy recommendation.

Alternatives

Allocate funding to the VA to deliver care to VSC

This first alternative attempts to take a relatively simplistic approach to the problem. The VA is an already existing institution. It has a long-run standing with the veteran community, and it understands this group’s particular culture. Since the VA is arguably the most central institution within veterans’ affairs, considering an alternative that utilizes the VA is a natural first move.

As far as programs go, the VA offers reportedly excellent quality mental health services to veterans (Kellermann, 2012). The only change the VA would need to make, then, would be to expand these services to include spouses and children as well. However, logistical problems may exist even at the outset. Because the VA is already overburdened with its current workload, expanding services to include a new population set may be infeasible.

Encourage VSC to acquire care through the ACA

Fortunately, the newly enacted ACA has expanded access to mental health care to an unprecedented degree. And, because the ACA makes health insurance more affordable, VSC should be able to acquire the mental health services they need.

One wonders, then, why this alternative is not immediately the determined to be the optimal one. This is because of two primary problems. The first is that the political future of the ACA is, at this point, still unsure. Still unsure of how the Supreme Court will rule in King v. Burwell, certain
states may eventually provide limited to no access to the ACA insurance market for their residents.
Second is that mental health providers in the civilian sector are less competent at treating issues that arise within the veteran community.

1) Bolster the NGO and community-level service networks

The last alternative deals with the under-examined services within the NGO community. Currently, community networks of care are often difficult to navigate. In other words, care seekers are sometimes unaware of what providers exist in the community, and what services they provide (Kristina Kaufmann, personal correspondence, 2014). This makes it such that the services offered within these networks are sometimes under-utilized. Complicating the problem further is the fact that private dollar funding for NGOs may not be sustainable in the long-run (Philip Carter, lecture comment, 2014), meaning that some organizations may not be able to continue operations in the future.

This option would thus attempt to accomplish two things. First, it would designate community network leaders within different regions throughout the U.S. This team of leaders would map out the available service providers throughout the nation. After developing this network map, both providers and care seekers will be better able to know what services exist in their communities. Secondly, this option would recommend that additional funding be allocated to mental health NGOs so that they can better serve their communities.
Evaluative Criteria

I will now outline the evaluative criteria used in this analysis. There are four primary categories I use for assessment. For convenience, I will list them below, and then go into further discussion of each criterion:

1) Cost
2) Complexity
3) Expansion of Care
4) Likeliness for VSC to Seek Care

Cost

This criterion is relatively basic and fundamental to most policy analyses. Especially in a time of high national debt, and in a political climate which reacts severely to proposals that would significantly add to this debt, cost is an important metric to consider. As such, the cost component to each alternative I will consider is of great importance to this analysis.

Complexity

The criterion of complexity attempts to gauge how complicated it would be to implement each alternative. Like cost, this criterion is pragmatic in nature. Regardless of how creative a potential solution is, if it is not logistically feasible, it would perhaps be better left unpursued.

Measuring this criterion entails a qualitative approach. I will thus measure complexity along the spectrum ranging from low to medium to high. For each alternative, I will provide reasoning behind assigning each particular score.

I should note before continuing that I intentionally elected to use the term complexity over what is more conventionally known as feasibility. This is because each option differs across the range of whether it is difficult or simple to execute. A synonymous term would perhaps be logistical feasibility; however, it seemed simpler to use the term complexity.

Expansion of Care
Ultimately, the main goal for this analysis is to assess which intervention most effectively expands care to VSC. The degree to which each intervention does so will be extremely important to the evaluation. In order to measure this criterion, as I will describe further in the sections for each alternative, I will have to use proxies from the existing literature to best estimate the degree of expansion. For example, some measurements will be based on predictions for active duty – not veteran – spouses, or some will use predictions for veterans themselves as a basis for estimation.

*Likeliness for VSC to Seek Care*

The last criterion is critical because it addresses another central problem to the mental health problems of VSC. Even if care is expanded, it is not necessarily the case that spouses and children will seek care. This is true for a number of reasons, as described in previous sections. Thus, the measurements for this criterion will estimate how likely VSC will be to seek the newly offered care under each alternative. Again, I will have to use proxies as a basis for my own estimates.
Analysis of the Alternatives

Having laid out the options and criteria, I will now run through each alternative and measure them against the selected criteria. After going through this process for each alternative, I will then produce an outcomes matrix, which will have synthesized this analysis into one chart. From here, I will be able to assess which alternative would be most successful in addressing the problem at hand.

Option 1: Allocate funding to the VA to deliver care to VSC

Cost

For its 2015 budget, the VA has allocated $7.5 billion to providing veterans with mental health care services. In 2011, an estimated 1.3 million veterans received mental health care services through the VA (Department of Veterans Affairs, 2011). A rough estimate of per capita mental health care spending for the VA thus comes out to about $5,769 per person. To calculate how many VSC would be eligible for care after expansion, we can look at how many veterans are married and the average number of children per household. The following figures, however, are based on the family demographics of active-duty service members, which was the best available information.

That said, an estimated 56.6 percent of post-9/11 veterans are married. Additionally, an estimated 44 percent of veterans have children, and, if they have children, the average number per veteran is 2 (Clever, 2013). So, if 56.6 percent of veterans are married, this means that for the roughly 2.5 million post-9/11 vets (Census Bureau, 2011) there are around 1.4 million spouses and 2.2 million children. As previously mentioned, studies have indicated that somewhere between 20 and 44 percent of spouses have developed at least one mental health condition; as many as 35 percent of children report symptoms that point to longer term mental health complications. This means that an estimated 622,600 spouses and 770,000 children require mental health services. In total, around 1.4 million VSC experience negative mental health conditions.

To estimate the cost for the VA, we have a few options. The first is a rather conservative, worst-case scenario estimate. For the VA to treat each member of the VSC population who has a mental
illness, this would total out to about $8 billion. However, it is not likely to be the case that every VSC will seek mental health care through the VA. To generate a better, more reasonable cost estimate then, we will need to determine how many VSC will seek mental health services through the VA. Unfortunately, because the VA does not currently offer mental health services to this population, we will have to use estimates from a closely related group to get a better idea. To do this, we can use the propensity for veterans to seek mental health care through the VA to predict the propensity of VSC. According to two surveys, one conducted by IAVA and the other by the Wounded Warrior Project, 56 percent and 62.5 percent of survey respondents sought mental health services through the VA (Maffucci, 2014) (Franklin, 2014). An average of these two proportions comes to about 59 percent. Although this proportion is likely skewed higher than the actual population average, it is reasonable to predict that about the same proportion of VSC would seek mental health care through the VA. Using this number then, we can predict that around 821,634 VSC would seek care through the VA, totaling to $4.7 billion. However, this number is likely the low-end of the range, because some of the reasons why veterans do not seek care through the VA do not appear as though it would carry over for VSC.

Complexity
This option would have a low complexity score. Because the VA already possesses the infrastructure involved in offering mental health care services with a military focus, it would not require significant alterations to offer care to VSC.

Expansion of Care
If the VA receives the estimated required funding, then the VA should possess the necessary resources to extend care to all VSC. However, the VA is hardly a model case of efficiency, so it is unclear how many VSC that enroll in VA health care would receive care in a timely manner.

To measure the reported inefficiency of VA mental health services, we can look at the wait times that current veterans face. While the VA standard is a 14 day wait period before receiving care,

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2 To get this number, I multiplied the total number of VSC with a mental illness and the average cost to treat a mental illness in the VA, which I said was around $5,000.
3 These surveys measured the tendencies of veterans who were members of each organization. A survey response group such as this is thus not representative of the population as a whole. We can also assume that more active members are more likely to be more likely to act on the issues that challenge the veteran population, and would thus be more likely to seek mental health services. As such, the rates at which members sought mental health services are likely higher than the average population rates.
4 I will discuss this more below.
the current average of wait times for mental health services is 35 days (Morgan, 2014). More strikingly, 51 percent of care seekers wait an average of 50 days (Horton, 2012). These figures are corroborated by care seeker testimonies. In the IAVA member survey, 68 percent of respondents reported difficulty scheduling an appointment with the mental health provider through the VA (Maffucci, 2014). One member lucidly described the problem, stating that “care, when I can get it, is great. However, they (the VA) have an immense workload. Too many patients and not enough doctors.”

In a best case scenario, allocating the necessary funding to the VA would keep these wait times at least unchanged. However, the VA’s recent policy that gives enrollees a voucher to seek care outside of the VA indicates that the VA simply lacks the capacity to treat the total number of enrollees. If this enrollee number were to increase dramatically with the new influx of VSC members, it is unlikely that the VA could deliver timely care. I thus assign it a low-to-medium score.

**Likeliness for VSC to seek care**

It isn’t immediately clear whether VSC would be likely to seek care through the VA or not. This is so for a few reasons. First, VSC have never had access to mental health services through the VA before. This means again that we need to make predictions based on data that measures different but closely related populations. As I noted before, surveys have measured that somewhere around 59 percent of veterans seek mental health services through the VA. The IAVA survey in particular noted the top reasons for why veterans currently do not seek any form of mental health care, and it is conceivable that these reasons would also be shared by VSC themselves. Another study looked at the mental health care utilization of active duty spouses. Utilization rates for this sample were somewhat higher: around 68 percent of spouses who screened positive for mental health disorders were actively receiving care of some kind (Eaton, 2008).^5^ Furthermore, the top reported barriers to care and stigma concerns either do not apply or will dissipate if care is made available through the VA. For example, it is reasonable for active duty spouses to have concerns about harming their spouse’s career; however, it is less likely that such

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^5 It is important to note, however, that this study relied on a rather small sample size of wives who tested positive for mental health diagnoses (n=74). Thus, results drawn from this study should be made with caution. Again, further research is recommended.
a concern would apply for veteran spouses whose spouse has retired. Additionally, not knowing where to receive care and concerns over the cost of care would all conceivably cease to be barriers to care if services are made available through the VA. As such, rates at which VSC may seek care through the VA option may be relatively high. This option thus receives a medium-high score.

Option 2: Encourage VSC to acquire care through the ACA

Financial
According to the CBO, the estimated cost to insure each individual through the ACA comes to around $50,000 (CBO, 2014). To insure the estimated current number of untreated VSC, this would total to around $20.9 billion; to insure the whole VSC population that is afflicted with mental illnesses, this would cost $69.6 billion.

While this number is large, especially in comparison to cost of treatment through the VA, these costs are already accounted for in the federal budget. This is because the ACA is already implemented policy in the United States. In this way, the ACA is in some regards a status quo option. As a result, these costs are expected to be offset by expected revenues from taxes, fees, and penalties specifically designed in response to these costs. These costs will thus net out to an estimated $1.2 billion, which is the lowest cost estimate out of the three options (CBO, 2014).

Expansion of Care
The ACA provides significant coverage of mental health care services without taking preexisting conditions into consideration. The average monthly cost to each individual who seeks coverage through the ACA comes to about $328 for silver plan insurance (Department of Health and Human Services, 2013). Compared to the 2010 average premium cost of health insurance through employer-based coverage of $4,940 (Department of Health and Human Services, 2011), health insurance packages are significantly cheaper under the ACA. Because cost of treatment was a significant barrier to care for about a quarter of active-duty spouses (Eaton, 2008), these lowered costs should remove this barrier for a number of VSC. As such, it seems that care would be made available to all VSC who decide to seek treatment.

Moreover, because this option is nation-wide, and not dependent upon one single-provider, care centers that would become available to VSC through the ACA are high in number. Contrasting this to the other options, expansion of care may very well be the highest. NGOs that offer care
specifically to VSC appear to be relatively low, and access is likely not uniform throughout the nation. Moreover, the private health care providers do not experience the same backlog issues that providers in the VA face.

One major problem exists, however. While not completely under the umbrella of “expansion of care”, the quality of mental health care through private providers will be lower when compared to care provided through the VA. This is because veterans and their families require specialized treatment that focuses explicitly on veteran-specific issues (Tanielian, 2014). As such, the ACA option may have some problems regarding the expansion of quality care.

**Complexity**

Again, because this option is tied to the already existent ACA, it should pose little additional complexity to implement. Most implementation problems would come from coordinating with the different bodies that would work together to ensure that more VSC are covered through the ACA. This would entail things like opening communication channels between the DoD and the VA to better understand which VSC remain uninsured during the transition from active-duty to veteran life. The VA could also reach out to families of veterans who have been diagnosed through the VA with a mental health condition to see whether they too have access to mental health care, as these families are more likely to develop mental health conditions of their own. However, these action-items are significantly less complex than providing care itself, and so the ACA option receives a low complexity score.

**Likeliness for VSC to seek care**

It is unclear at present how likely VSC would be to seek care if the ACA option is implemented. First, because the ACA would make private providers more affordable for VSC, these individuals could affordably receive mental health treatment. Again, this removes a significant barrier for VSC who previously have cited high cost as a major deterrent for acquiring mental health care.

Looking at the percentage of uninsured Americans after the ACA’s implementation, this number has decreased from 18 to 13.4 percent (Levy, 2014). This at least indicates that more Americans are receiving care. While some of this increase in insured Americans may include VSC, more data collection will have to be done to determine how many VSC are actually receiving more care as a result of the ACA; and, more importantly, how many VSC exist amount the 13.4 percent of Americans who are still uninsured.
Option 3: Bolster the NGO and community-level service networks

Cost
Costs for this option vary. On the low end, some entity – either the government, a private donor, or coalition of non-profits – would need to develop and implement a platform that better maps the networks of community-based care centers nationwide. This would have minimal upfront and maintenance costs.

However, a higher-cost version of this option would include the development of such a platform, but would also include funding from the government to bolster the nationwide set of community-based providers. Fortunately, the cost to treat mental health conditions through community-based providers is cheaper than the calculated cost of care through the VA. According to the National Council for Behavioral Health, the average cost per person to treat a mental health condition in the community is $3,433 (NCBH, 2012). To sufficiently treat the estimated number of currently untreated VSC, this would total to about $1.4 billion.

It is important to note, however, that not all community-based care centers for veterans formally provide care for family members as well. In another study conducted by RAND, only around 20 percent of the care centers they examined explicitly listed services offered to family members (Ramchand, 2014). If this option is implemented, such funding would have to be in the form of grants conditioned upon using the funds to provide care for VSC specifically.

Complexity
This option would be moderately complex, especially in relation to the other options. Most of this complexity comes from the fact that community-based care is not centralized, rendering it difficult to gain a full understanding of the entire system. This is this part of the reason for developing a platform that maps out these community-based networks. Once that task is complete, it would then be easier to identify which areas within the community networks required more attention than others.

Expansion of Care
Though the exact amount of care available through community-based networks would require a comprehensive scan nationwide, prospects are likely such that these networks alone would not
provide as much care as would be possible through large, government-based projects. This is because funding for community-based networks is neither as high nor as consistent as it is for federal health programs.

Although the RAND survey was a convenience sample, and thus not reflective of the population, it appears that, at present, few of the community-based providers offer care to family members as well (Tanielian, 2014). Thus, without allocating funding to the community networks, this option would fail to significantly expand care to VSC. To make any kind of significant impact at the community level, then, legislator would need to allocate the necessary funds to the community-based providers that require it.

**Likelihood for VSC to seek care**

Among the list of reported reasons why active-duty spouses do not seek treatment for their mental health conditions, 20.6 percent reported that they did not know where to get help (Eaton, 2008). Developing and distributing an application that provides information about local community-based providers would thus help to address this one barrier to care. Ideally, VSC would be made well informed about the existence of such an application. To do so, whenever a new veteran enrolls, the VA could include details of the application and its services in an information packet given to a veteran’s spouse. However, while this may properly reach a large number of VSC, it would ultimately only reach VSC of veterans who enroll in the VA. As it stands now, somewhere around 56 percent of post-9/11 veterans are enrolled in VA healthcare (Bagalman, 2013), meaning that such information would fail to reach the families of the other 44 percent of veterans who are not enrolled. An additional option would be to distribute the same informational packet, but, instead of the VA distributing this information upon VA enrollment, the DoD would be in charge of distributing the information during the off-boarding process for each veteran. This way, every soon-to-be veteran and his or her family would receive this information.

Once such information is distributed adequately, VSC would be able to identify what community-providers exist in their regions, and would be able to match the provided services with their own mental health needs. Such services may be appealing to VSC who are looking for alternative services, or simply services in addition to what they are presently receiving. The gamut of services available will of course be greater if additional funds are allocated where services are currently
thin; however, even without these additional funds, utilization of community-based care centers may still increase.

Another reported barrier to care is the fact that mental health services cost too much money (Eaton, 2008). Community-based care centers may also help to reduce the severity of this barrier. Services provided through the community are often low-cost or even free. As such, the 26 percent of spouses who reported high cost as an issue would find a number of affordable services in their communities.

As for stigma, it is unclear whether community-based providers will alleviate these concerns, and, if so, to what extent. To begin exploring this question, we can analyze the recent trend of veterans switching over to community-based care. The NCBH reported that, over time, veteran utilization of community-based care has increased from 27 percent to 40 percent (NCBH, 2012). They do not explain why; however, it seems reasonable to make the following assumptions. Some of this shift is likely due to frustration with the VA, especially as the VA’s capacity decreases. However, it is reasonable to also assume that some of this shift may have resulted from veterans feeling decreased pressures from the stigma surrounding mental health conditions in community-based care centers. Although there appears to be little research in this area, intuitive reasoning can provide some support for this claim. If a veteran is to seek mental health services in the VA, he or she is surrounded by a community of people who have, when he or she was an active-duty member, expected him or her to be resilient and unaffected by the casualties of war. Admitting mental weakness may thus generate an even stronger feeling of vulnerability and discomfort for the veteran. Contrast this to community-based care centers, where the veteran can largely feel anonymous within a network of a variety of individuals.

If veterans are switching over to community-based care centers at least partially because of reduced stigma in these locations, then VSC may also feel less negative pressure going here as well. Although empirical analysis would certainly strengthen this argument, it appears intuitively sound. VSC may thus increase their utilization of mental health services if community-based services are made more available to them.
Outcomes Matrix

The following chart synthesizes the above analysis into one location. This chart makes a comparison between the three options a simpler task.

<table>
<thead>
<tr>
<th>Alternative</th>
<th>Criterion 1: Cost</th>
<th>Criterion 2: Complexity</th>
<th>Criterion 3: Likeliness for VSC to Seek Care</th>
<th>Criterion 4: Expansion of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA Option</td>
<td>$4.74 billion - $8.03 billion</td>
<td>Low</td>
<td>Medium</td>
<td>Medium-Low</td>
</tr>
<tr>
<td>ACA Option</td>
<td>$1.2 billion(^6)</td>
<td>Low</td>
<td>Medium-High</td>
<td>Medium-High</td>
</tr>
<tr>
<td>NGO Option</td>
<td>$1.44 billion</td>
<td>Medium</td>
<td>High</td>
<td>Low</td>
</tr>
</tbody>
</table>

\(^6\) Recall that this figure is actually the net cost of the ACA over the next 10 years, according to the CBO. This number thus does not reflect the cost of treating VSC only. However, I chose to put this number in to reflect the fact that the ACA already had cost-offsetting measures in place.
Recommendation and Implementation

Given the analysis above, I recommend that lawmakers implement Option 2, and potentially supplement it with a variation of Option 3. Although I have given my analysis for each option according to each criterion above, I will now discuss why I have determined Option 2 to be the optimal choice from a more holistic point of view.

Option 1 is clearly attractive in some regards. Especially in terms of quality of care, it appeared that a solution involving the VA would be able to provide the greatest help to VSC in need. However, given that the VA is at such high capacity already, it would very likely be operationally infeasible to bring on an entirely new population of eligible individuals into the VA. Not only would this lead to an under-provision of care to VSC, but it would also likely make the VA more inefficient as a whole, and consequently reduce the quality of care for veterans themselves. This would of course make veterans worse off, but it would also eventually harm VSC too, whose mental health conditions are affected by the mental health of veterans.

Interestingly, in comparison to Option 1, Option 2’s strengths and weaknesses are reversed. Relatively speaking, private health markets have a much higher capacity than that of the VA. They are, however, according to researchers, significantly less equipped to handle the particular mental health conditions of veterans and their families. In the short-run, this option appears only slightly better than the first one. Although VSC would be able to access a wide range of mental health options at affordable rates, some would receive treatment that did not adequately meet their needs. In the long-run, however, doctors may gain more experience with the veteran community, and become more effective at treating veteran-specific cases. Additionally, interested medical professionals could be encouraged – or required, given the right location and circumstances – to take training courses that prepare health professionals to handle veteran-specific cases. Many of these courses are made available conveniently and for free, so it seems that encouraging professionals to take these courses would be feasible. Finally, if the VA agrees, private care professionals could work closely with and learn from VA mental health providers to learn the subtleties of veteran health care. Thus, by receiving proper training and becoming more
familiar with veteran communities overtime, the private sector could potentially provide sufficient care to VSC.

To encourage VSC to take advantage of the opportunities provided to them by the ACA, as stated above, the DoD and VA could work together to clearly describe what benefits VSC have available through the ACA, and directions on how to enroll. The VA should also have individuals on staff who would be available to answer ACA related questions that veterans and their families might have.

As for a supplemental version of Option 3, the low-cost version of this option may still prove beneficial. Knowing what additional services exist around them may make VSC aware of the additional services that exist around them. Although the RAND study found only a small number of community-based providers that offer care specifically to families, because these community-based provider networks are so poorly mapped out, it may be the case that more exist than is currently thought. Thus, some organization or coalition should work to take a deep environmental scan of all community-based providers throughout the U.S., and make this information available to all VSC.

However, even if community-based provision is more limited than would be ideal, even modest acquisition of aid in the community can be beneficial for VSC. Support groups and faith-based services that do not provide clinical treatment are still associated with improved mental health outcomes, typically so long as an individual is receiving clinical treatments as well.
Conclusion

It is clear that VSC are in need of mental health services, and that adequate care is not available to them. This analysis has hopefully indicated that there are certain measures to alleviate this problem. Encouraging enrollment in the ACA alongside better understanding and higher utilization of community-based networks should work to make positive changes in the lives of these individuals. Doing so will help improve the mental health of veterans as well, whose mental health conditions are linked to the well-being of their families, and will also yield cost-savings in the future.

However, this analysis is not the end. Further data must be collected on this population, especially studies that focus on longitudinal analysis. The current level of understanding regarding the mental health of VSC is still too low. Yet, if researchers work to improve our understanding of this issue, then we will only be better equipped to address additional problems as they arise.
References


