TOOLKIT

ENGAGING SERVICE MEMBERS, VETERANS, AND FAMILIES:

A Toolkit for Certified Community Behavioral Health Clinics

2026

SAMHSA
Substance Abuse and Mental Health Services Administration

Engaging Service Members, Veterans, and Families: A Toolkit for Certified Community Behavioral Health Clinics

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services

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INTRODUCTION

Overview

Providing timely access to community-based mental health and substance use treatment is an essential safeguard that every community should prioritize for the health and wellness of all individuals, which includes clients with connection to the U.S. armed forces. This toolkit is designed to provide an overview of key components of working with those who are serving or have served in any branch of the military—service members, Veterans, and families (SMVF). This toolkit provides topic overviews, fact sheets, strategies, action steps, and insights from experts for everyone establishing, working for, and leading a Certified Community Behavioral Health Clinic (CCBHC).

CCBHCs play a vital role in delivering coordinated, comprehensive behavioral health care, ensuring that those who have served our nation receive the resources they deserve. In a 2024 survey, 42.7 percent of CCBHCs reported increases in access for Veterans (National Council for Mental Wellbeing, 2024). Understanding the unique experiences of SMVF (including members of the National Guard and Reserves) allows CCBHCs to lead the way in supportive community-based services to improve the lives of those who safeguard our nation through their military service. CCBHCs serve not only individuals but also entire communities, recognizing that when one person serves in the U.S. armed forces, they represent a much larger network of family members, friends, and civilian supporters.

CCBHC Certification Criteria and SMVF Clients

The CCBHC Certification Criteria establishes a framework that supports high-quality behavioral health services tailored to specific client populations, including those connected to the military. Because SMVF face distinct challenges, ranging from combat-related trauma and frequent relocation to complex benefit systems and stigma, each of the six CCBHC program areas offers an opportunity to enhance care delivery for this population. By aligning service strategies with the CCBHC criteria, clinics can ensure that their practices reflect national standards while addressing the specific needs of SMVF. The following section outlines how serving SMVF corresponds with each area of the CCBHC Certification Criteria and provides focused recommendations for applying the standards to improve access, engagement, and outcomes for military-connected clients and their families.

Criteria 1: Staffing

To meet Criteria 1.A (Needs Assessment) and 1.B (Licensure and Credentialing), CCBHCs must develop staffing plans that address the specific needs of SMVF. Staff should possess the appropriate licenses and certifications, including trauma-informed care competencies. Clinicians must receive ongoing training in the diagnosis and treatment of conditions common among SMVF—such as posttraumatic stress disorder, traumatic brain injury, moral injury, and substance use disorders—and in evidence-based practices. Training in military experiences and related clinical approaches ensures responsive, high-quality care delivery.

Criteria 2: Availability and Accessibility of Services

Aligned with Criteria 2.A (General Access Requirements), 2.B (Timely Access to Services), 2.D (No Refusal Due to Inability to Pay), and 2.E (Provision of Services Regardless of Residence), CCBHCs must provide SMVF with timely access to care that is aligned with the services they would receive through the federal providers. This includes understanding eligibility for Department of War (DOW), Department of Veterans Affairs (VA), and community-based services, coordinating referrals, and offering treatment without regard to ability to pay or location. Clinics must also develop individualized treatment plans that reflect the needs and preferences of military-affiliated clients and draw on partnerships with Veteran-serving organizations.

Criteria 3: Care Coordination

Meeting Criteria 3.A (General Care Coordination Requirements), 3.B (Health Information Systems), 3.C (Care Coordination Partnerships), and 3.D (Care Treatment Team and Planning), CCBHCs must actively coordinate with VA medical centers, TRICARE networks, and community-based Veteran organizations. Effective care coordination ensures smooth transitions across service systems and levels of care, minimizing treatment disruptions. Treatment teams should include staff trained in military experiences, with clear roles and responsibilities that promote trust, communication, and integrated support tailored to SMVF.

Criteria 4: Scope of Services

CCBHCs must fulfill Criteria 4.C through 4.K, ensuring SMVF have access to all nine required services. This includes 4.C (24–7 Crisis Behavioral Health Services), 4.D (Comprehensive Screening and Diagnosis), 4.E (Person-Centered Treatment Planning), 4.F (Outpatient Mental Health and Substance Use Treatment), 4.G (Primary Care Screening and Monitoring), 4.H (Targeted Case Management), 4.I (Psychiatric Rehabilitation), 4.J (Peer Support), and 4.K (Community-Based Services for Veterans). These services must follow recovery-oriented, person-centered practices and to fully address the complex needs of SMVF.

Criteria 5: Quality and Other Reporting

Under Criteria 5.A (Data Collection), 5.B (Data Monitoring), 5.C (Quality Reporting), and 5.D (Continuous Quality Improvement), CCBHCs must implement data systems that capture SMVF-related information across screenings, service use, outcomes, and experiential responsiveness. These data should inform quality improvement plans that include training in understanding military experiences and strategies for integrating behavioral and physical health. These processes help ensure that SMVF receive consistent, high-quality, evidence-informed, and responsive care.

Criteria 6: Organizational Authority and Governance

To meet Criteria 6.A (Organizational Authority and Finances), 6.B (Governance), and 6.C (Accreditation), CCBHCs serving SMVF should include Veterans and military family members in their governance structures to ensure services reflect the lived experiences of the populations served. By integrating SMVF voices in decision-making, CCBHCs can better design and deliver relevant services and support systems. This inclusive governance approach strengthens care quality, enhances service relevance, and reinforces the clinic's accountability to its entire client population.

Supporting SMVF Clients

This toolkit includes the following four modules: Identifying SMVF Clients, Military and Veteran Experiences, Key Partnerships for SMVF Support, and Clinical Considerations and Life Circumstances for SMVF. Each module includes the following sections:

- **Module Fact Sheet:** A summary of the content contained within the module, able to be printed separately and shared for quick reference
- **Module Content:** The content of each module, summarized below
- **Insights from Experts:** Reflections from subject matter experts within the field of SMVF with support pertaining to the subject of each module
- **Notes from the Field:** Summaries from CCBHCs in practice that serve SMVF within their client population
- **Ideas for Action:** Brief action items that CCBHCs could implement for each module subject
- **Resources:** Web links and descriptions for resources that support the module content

Module One: Identifying SMVF Clients

Recognizing SMVF in clinic settings plays a key role in providing effective, responsive, community-based care. By using the strategies recommended in this module, clinics can more reliably identify individuals in this population—both staff and clients—leading to stronger treatment engagement, improved responsiveness to military experiences, and more opportunities for meaningful support.

While some service members and Veterans may be easily identifiable, many choose not to share their military background unless prompted. Family members and caregivers may also wait to express their military connection unless providers ask directly. Taking a proactive approach to identifying and supporting SMVF strengthens provider–client relationships and creates an inclusive, informed care environment.

Module Two: Military and Veteran Experiences

A strong professional commitment to being responsive to the life experiences of SMVF clients significantly enhances the quality and relevance of clinical assessments, treatment planning, and engagement strategies. While personal military experience is not required to serve SMVF effectively, clinicians can strengthen their practice by pursuing continued education, learning from colleagues, and actively listening to clients with military backgrounds.

Providing care that is responsive to SMVF necessitates an understanding of the distinct experiences shaped by military service, including shared values and perspectives developed through both adversity and camaraderie. CCBHCs are encouraged to demonstrate inclusivity through visual cues, such as military-related images, flags, or signage, that signal a welcoming environment for SMVF. By fostering a responsive atmosphere, CCBHCs can improve engagement among clients, staff, and volunteers with military affiliations.

Module Three: Forming Key Partnerships for SMVF Support

Forming partnerships with VA, DOW, and community-based Veteran-serving organizations enables CCBHCs to provide coordinated and tailored care to SMVF. Collaborating with VA and DOW supports continuity of care, benefits navigation, access to specialized services, especially during transitions from active duty to civilian life. These partnerships also offer opportunities for shared training and improved referral processes.

Engaging with local Veteran-serving organizations, such as nonprofits and Veteran service organizations (VSOs), helps CCBHCs address a broader range of SMVF needs, including housing, employment, peer support, and social connection. Establishing referral pathways and shared programming enhances the clinic's reach and impact. Effective partnerships are built on shared missions and mutual respect, fostering a seamless, community-based support system that strengthens behavioral health outcomes for those who have served.

Module Four: Consider Clinical Factors and Life Circumstances for SMVF

Military service equips SMVF with extensive education; technical expertise; leadership capabilities; and deeply rooted values such as service, teamwork, and structured discipline. These strengths contribute positively to their engagement in behavioral health care and community life. Alongside these protective factors, SMVF also face unique clinical considerations related to mental health, substance misuse, and suicide risk, shaped by the distinctive demands of military service-related experiences.

VA, as the nation's largest healthcare system, continues to lead in research that examines how military service influences specific physical and behavioral health conditions. Additionally, SMVF often experience challenges such as underemployment, legal concerns, and financial stress—issues that may require tailored support. This module offers targeted clinical strategies and approaches designed for SMVF populations. Integrating these resources into care practices can improve treatment effectiveness and promote long-term well-being.

How to Use This Publication

CCBHC Clinical and Support Staff

As clinical and support staff, your role is crucial in delivering high-quality care to SMVF clients. By familiarizing yourself with the content of each module, you will gain valuable insights into the unique needs and challenges that SMVF clients face. The modules provide specific guidelines and strategies that can be integrated into your daily interactions, ensuring that you provide responsive and effective care. Additionally, the toolkit offers opportunities for ongoing training and development, allowing you to continuously improve your clinical skills and understanding of military and Veteran experiences. By applying the principles outlined in the toolkit, you will be better equipped to address the complex needs of SMVF clients and provide the highest quality of care:

- **Enhance knowledge of SMVF experiences and needs:** Familiarize yourself with the content of each module. Each module provides specific guidelines and strategies to enhance your ability to serve SMVF clients.
- **Train and develop:** Use the toolkit for ongoing training and development. The modules contain valuable information that can help improve your clinical skills, and understanding of military and Veteran experiences.
- **Apply in daily practice:** Integrate the principles and practices outlined in the toolkit into your daily interactions with SMVF clients. This integrative approach will ensure that you are providing the highest quality of care.

CCBHC Leadership and Administration Staff

Leadership and administration staff are responsible for developing and executing strategic plans that align with the CCBHC model. This includes setting goals, defining objectives, and outlining the steps necessary to achieve certification and provide high-quality care. Their strategic vision ensures that the organization is moving in the right direction and meeting the needs of the community. By prioritizing the needs of SMVF clients in their strategic plans, they can ensure that resources and efforts are directed toward providing comprehensive and coordinated care. The information provided in the toolkit can guide them in identifying best practices, establishing key partnerships, and implementing effective strategies to support SMVF clients:

- **Implement strategically:** Use the toolkit to develop and execute strategic plans that align with the CCBHC model, setting goals and outlining steps to achieve certification and provide high-quality care to SMVF clients.
- **Develop policies:** Leverage the toolkit to create policies and procedures that ensure compliance with CCBHC certification criteria while also addressing SMVF needs, ensuring access to specialized mental health services and support systems.
- **Monitor and evaluate:** Use the toolkit to monitor and evaluate the effectiveness of your programs and services, focusing on SMVF needs. Use your evaluation processes to identify gaps in services and make necessary adjustments to better support this population.

State Authorities, Regional Entities, and State and Local Governments

State authorities, regional entities, and state and local governments, in addition to Tribal and Territorial governments, can use this toolkit to enhance their support for CCBHCs in serving SMVF clients. These groups provide funding and resources, such as grants and Medicaid reimbursements, to ensure sustainability and effectiveness. Policy development and implementation are essential, with regulations and guidelines tailored to address the specific needs of SMVF clients. Collaboration and coordination among key partners can help integrate services and improve access to care. Training and technical assistance enhance the capabilities of CCBHC staff, focusing on understanding military experiences and addressing the mental health and substance use challenges that Veterans and their families face:

- **Support CCBHCs:** Use the toolkit to support CCBHCs in your jurisdiction. The modules provide an overview of the needs of SMVF clients and can help you understand the needs and challenges that CCBHCs face in supporting this population.
- **Identify funding and resources:** Leverage the toolkit to identify funding opportunities and resources that can support the implementation and sustainability of the CCBHC model as it applies to supporting SMVF clients.
- **Collaborate and coordinate:** Utilize the toolkit to foster collaboration and coordination among key partners, including community organizations, health care providers, and Veteran services.

Service members participate in an armed forces full honors wreath-laying ceremony at the Tomb of the Unknown Soldier at Arlington National Cemetery, Va., Oct. 4, 2023.

Photo by Army Cpl. Gabriel J. Bacchus, U.S. Army. Image courtesy of the U.S. Department of War (public domain).

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MODULE 1

IDENTIFY SMVF CLIENTS

Overview

One of the most important aspects of providing community care for service members, Veterans, and their families (SMVF) is the need to identify SMVF in Certified Community Behavioral Health Clinics (CCBHCs), including both staff and clients. Without a systematic approach to identifying SMVF, your clinic may overlook clients or staff that should be included in this population, which could lead to ineffective treatment and missed opportunities to provide support. While it may be obvious through observation that someone is serving or has served in the military, not all service members and Veterans voluntarily identify themselves, and family members and caregivers are not likely to share such information at early stages of care unless asked directly. However, it is beneficial to both staff and clients to ensure that the SMVF population is identified and supported.

In this section, we will share internal and external strategies to identify SMVF and suggest ways to explore a client's military background and identify needs related to mental health and substance use disorder treatment, medical care, and other factors that influence health. We will also share insights from subject-matter experts (SMEs) who support SMVF, highlights from CCBHCs in practice, ideas for action, and resources to support identifying SMVF in your clinical population.

Fact Sheet: Identifying Service Members, Veterans, and their Families in Clinics and Communities

Overview

Ask The Question	Exploring Background	Identifying Needs
» To effectively support SMVF, CCBHCs can implement intentional strategies to identify individuals with military connections. » By embedding the "Ask the Question" campaign into internal operations and community outreach, clinics can foster a welcoming environment, demonstrate responsivity, and ensure that the needs of SMVF populations are recognized.	» Once a client identifies as SMVF, CCBHCs can deepen engagement by asking thoughtful follow-up questions about their military background. » This approach supports accurate diagnosis and treatment planning (Criteria 4.D) while building trust and rapport. » Encouraging open dialogue helps staff understand clients' lived experiences and ensures care is responsive, respectful, and informed.	» To ensure supportive, coordinated care for SMVF, CCBHCs should proactively research available resources across mental health, substance use, and medical domains. » This supports comprehensive service delivery (Criteria 4.A) and strengthens care coordination (Criteria 3.C). » By understanding eligibility, risks, and other factors that influence health, staff can better connect SMVF clients to benefits, treatment, and community-based support.

Insights from Experts

Establishing trust with SMVF is a recurring theme emphasized by both Veterans and clinical mental health professionals. One CCBHC expert notes, many SMVF clients may hesitate to share their military experiences unless they feel safe and understood. This insight underscores the importance of responsive care and trauma-informed engagement strategies.

Experts offer practical guidance on tailoring safety planning and intake processes to meet the unique needs of SMVF clients. Examples include incorporating tools like Wellness Recovery Action Plans and involving Veteran peer specialists or asking about military service in multiple ways to ensure inclusiveness. These perspectives, grounded in lived experience and clinical expertise, help CCBHC staff build rapport, improve assessments, and deliver more personalized care.

Fact Sheet: Identifying Service Members, Veterans, and their Families in Clinics and Communities

Notes from the Field

CCBHCs across the country have developed effective strategies for identifying and supporting SMVF. For example, Volunteers of America–Massachusetts uses a centralized intake process with a dedicated military service section and employs Veteran case managers to guide clients through housing, employment, and VA benefits. They also require proof of service and assist clients in obtaining military records, ensuring accurate identification and tailored support.

Other clinics, like Community Counseling Center in Ohio and Berks Counseling Center in Pennsylvania, integrate military status questions into their intake and assessment processes and coordinate with local Veteran services for specialized care. Family Service of Rhode Island uses "Ask the Question" training and proactive outreach by military case managers to build rapport. Meanwhile, High Plains Mental Health Center in Kansas and Valley HealthCare System in West Virginia offer comprehensive assessments, peer support, and Veteran-specific navigation services. These examples highlight how CCBHCs can adapt their workflows to ensure SMVF clients receive informed, coordinated care that is responsive to their military experiences.

Ideas for Action

- **Embed screening questions:** Incorporate the question, "Have you or a family member ever served in the military?" into all intake forms, electronic health records (EHRs), and assessment tools to systematically identify SMVF clients.
- **Train staff:** Provide training for all staff on the different branches of the military, types of service, and the unique needs of SMVF to improve understanding and support.
- **Create a welcoming environment:** Display military branch emblems and other military-related images in the clinic to make SMVF clients feel recognized and welcomed.
- **Develop a referral system:** Establish a process to refer identified SMVF clients to military/Veteran liaisons or case managers and connect them with county Veteran service officers for benefits and support.
- **Promote awareness:** Use social media, websites, and printed materials to communicate that the clinic values and honors military service, encouraging SMVF clients to self-identify and access available resources.

Resources

- NH ATQ website
- Have You Ever Served Pocket Card
- ACMF Risk Reduction Framework
- Maine Veteran Suicide Prevention Toolkit
- Military Family Research Institute Measuring Communities Database
- Finding and Using Policy-Relevant Data About Veterans

Identify Service Members, Veterans, and Their Families

Initially adopted from a successful launch in New Hampshire, one of the primary steps that CCBHCs can take to identify SMVF is to adopt the "*Ask The Question*" campaign into their clinic's internal and external operations. CCBHCs can embed screening questions to ask their employees, volunteers, and peer support specialists about their military service history. CCBHCs can also share information and provide training to educate their staff on military knowledge and understanding. An example would be to ensure that staff are aware of the different branches of the United States Armed Forces and the different types of military service:

- Air Force
- Army
- Coast Guard
- Marine Corps
- National Guard
- Navy
- Space Force

Internal Strategies to Identify SMVF

- Embed the question *"Have you or a family member ever served in the military?"* in applications for employment, peer support, and volunteer roles at CCBHCs. Doing so supports Criteria 1.A (General Staffing Requirements) because it helps identify and support staff members with military backgrounds. It also ensures that the composition of the workforce reflects a variety of perspectives, including those of the SMVF population.
- Ask your human resources department to create a brief survey for current staff. Ask for their consent in sharing their provided military service history as part of "getting to know our team."
- Provide opportunities for staff to share information about their military service or that of their family throughout the year.
- Encourage staff to add their military branch or service type and status to their email signature and business cards. Consider adding this information to any visible staff names as well, such as those on the organization's directory and office doors.
- Offer staff the opportunity to identify their connection to military service for others to see; do this when providing visible name badges and identification. One example of this is to provide a pin for a badge lanyard that reflects their military service or military family member status.
- Consider including all military branch and service emblems and other related images in the interior or exterior design of the clinics and offices. Consider adding flags for all branches of the military in the clinic's lobby to encourage SMVF to feel welcome when they arrive at a CCBHC.

External Strategies to Identify SMVF Clients

- Embed the question *"Have you or a family member ever served in the military?"* into standard operating procedures, including the electronic health records or documentation system that your CCBHC uses.

- Consider including the same question in all printed and online intake and assessment forms that CCBHCs use.
- Add language to social media posts, websites, and in print that shows support for SMVF. One example is as follows: *Our clinic values and honors military service. If you or someone in your family has served in the military, let us know! You may be eligible for additional support and resources.*
- Consider adding QR codes or links to SMVF services, resources, and programs in staff signatures for clients to view and share.
- Reach out to local media outlets to share information about your CCBHC and ways your clinic serves SMVF clients.

Women Veterans

Women are currently the fastest-growing demographic in the military. As of 2023, there are over 2 million women Veterans in the United States, constituting approximately 11.3% of the total Veteran population. This marks a significant increase from 2000, when women made up about 6.3% of all Veterans (U.S. Department of Veterans Affairs, 2023). Regarding potential combat exposure specifically, women accounted for greater than 10% of the more than 2.7 million service members who deployed to Iraq and Afghanistan from 2001 to 2014 (DACOWITS, 2020). While a recognizable segment of service members during military service, their relatively few numbers of the greater population of Veterans leads to their frequent designation of "invisible Veterans." It is no longer assumed that military service members are exclusively men or that military spouses are exclusively women. Women service members and Veterans may not identify themselves unless specifically asked about their military service. Therefore, it can be beneficial to ask all clients about their military service history or military family status, regardless of sex. This relates to Criteria 4.D (Screening, Assessment, and Diagnosis) because asking about military service history regardless of sex ensures that women Veterans are identified, and their unique needs are addressed. Your clinic might also consider displaying specific symbols or materials recognizing clients who identify as women Veterans.

Military and Veteran Families and Children

It is essential to identify military family members when screening for military service history because they face unique stressors that may influence their mental and physical health. This aligns with Criteria 4.B (Requirement of Person-Centered and Family-Centered Care) because identifying military family members ensures that treatment plans address their unique stressors and needs. Family stressors include frequent moves, changing schools, difficulties finding employment, lengthy separations because of deployments, and caregiving responsibilities for adults and children. They may also experience trauma related to a loved one's illness, injury, or death. It is also important to understand that although a client identifies as a Veteran spouse, they may not have any lived experience as a military spouse if the relationship began after their partner left military service. Identifying family members will ensure that the many resources dedicated to military families are available to them.

Exploring SMVF Background

Once clients have identified as service members, Veterans, their families or caregivers, ask follow-up questions to further explore their military service type and background. This relates to Criteria 4.D (Screening, Assessment, and Diagnosis) because asking follow-up questions helps gather comprehensive information about clients' military backgrounds for accurate diagnosis and treatment planning. Support your staff in learning more about the branch, rank, era, type of service, and discharge status of their clients or loved ones. Inquire about the client or loved one's experiences in the military, reintegration into the community and civilian life, or experience accessing primary and behavioral health services. Example questions could include the following:

- What military branch did you serve in?
- When did you serve?
- Was your service active duty or full time, or was it through the National Guard or Reserves?
- Where were you stationed?
- Did you deploy during your service?
- How was your transition out of the military?
- What is your discharge status?
- Are there resources or benefits you would like to learn more about?

There are additional questions that could be explored related to mental health specifically, likely during initial consultations with clinical staff. When considering these topics, staff must be familiar with how to address potential responses. These questions might include the following:

- Did you receive any mental health or substance use disorder care while serving?
- Have you survived suicide loss?
- Have you ever experienced suicidal thoughts or behaviors yourself?

A centralized intake could help determine various service access points and provide a comprehensive assessment covering living situation, family history, education, employment, substance misuse, mental health, medical, military, legal history, risk assessment, and other factors that influence health. A trained intake clinician familiar with SMVF could conduct initial assessments, helping clients learn about additional services beyond their initial request.

When the client identifies as a Veteran, staff should initially determine if the Veteran has U.S. Department of Veterans Affairs (VA) health care, receives disability compensation, or has filed a disability claim. Encouraging the client to explore connections to VA can help them access a wide range of available support. This aligns with CCBHC Criteria 3.A.7, which emphasizes assisting individuals and families in accessing benefits—including Medicaid—and enrolling in programs or supports that may benefit them.

You and your staff can learn more about the experiences of SMVF through open dialogue. This communication will help your staff increase rapport and improve trust with clients while learning more about their lived experiences with military service.

When connecting with military family members, consider a different group of questions, such as the following:

- Where were you stationed as a family member?
- How did the family manage any deployments or frequent separations? What impact did these have on spouses' careers?
- How many schools have the children (if any) attended?

- Have spouses and children maintained friendships across multiple duty stations, and how have they done so?

Additionally, consider asking questions based on the specific ages of family members during deployments. With various levels of responsibilities and awareness depending on age, a family with a 14-year-old will experience different reactions and communicate different expectations around absences and deployments than a family with a 7-year-old.

While these questions are provided as options for consideration, ensure that your staff are not treating these items as a checklist or questionnaire to be completed, but rather approach clients in a natural way. It may be appropriate for intake or crisis response staff to answer some questions while clinical staff answer others. Peer specialists and case managers could also solicit some of this information.

Another step in identifying and supporting the SMVF population is to ensure that your clinic refers any identified SMVF to a military or Veteran liaison, case manager, or care coordinator on your staff. Also consider referring your client to the county Veteran service officer (VSO) or a VA-accredited Veteran service officer where the client lives. VSOs are well-versed in military and Veteran experiences and can provide insight and support in understanding complex SMVF benefits, including assisting with applications and appeals. The "Partnerships" section of this toolkit has more information about partnering with external organizations.

Identifying Needs: Clinical, Medical, and Other Factors That Influence Health

CCBHCs should research and review resources available to SMVF across the clinical mental health, substance misuse, and medical care landscape. This aligns with Criteria 4.A (General Service Provisions) because researching and reviewing resources ensures that SMVF clients receive comprehensive and holistic care. CCBHCs could also provide a welcoming, informed environment for SMVF and remind them that they have the right to access services, even if they are enrolled in VA care. A history of military service may entitle SMVF to additional resources, based on a number of factors with proper authorizations. Staff should encourage SMVF to find out if they or their loved one are eligible for benefits, including VA health care, VA mental health and substance use disorder treatment, and financial and educational benefits.

Clinical Mental Health, Substance Misuse, and Suicide Risk

Comprehensive real-time assessment, treatment, and referrals for SMVF can decrease the likelihood of a crisis and improve outcomes. Establish a standardized operating procedure to ask about any prior history of suicidal ideation, behaviors, or attempts. This relates to Criteria 4.D (Screening, Assessment, and Diagnosis) because asking about suicidal ideation and behaviors is crucial to assessing risk and providing appropriate interventions. Research has indicated that Veterans face a significantly higher risk of suicide than nonveterans. According to the 2024 National

Veteran Suicide Prevention Annual Report published by the U.S. Department of Veterans Affairs, the age- and sex-adjusted suicide rate for Veterans in 2020 was 32.6 per 100,000, more than double the rate of 16.1 per 100,000 observed among nonveterans (VA, 2024). Some possible reasons for this increased risk are exposure to traumatic events or suicide loss within the client's social network. Incorporating tools such as the Columbia-Suicide Severity Rating Scale within a comprehensive assessment helps identify risk immediately. Additional assessment tools could include offering evidence-based treatments as described in the federal Clinical Practice Guidelines. Your clinic may also encourage clients to participate in established recovery support programs, such as peer-led alcohol and other substance misuse meetings.

Given the risk of suicide in the SMVF population, staff must be familiar with and able to provide comprehensive suicide prevention safety plans as well as lethal means safety counseling on firearms and other potentially dangerous items. This can ensure safety during a crisis.

Medical

Military service can affect health adversely over time. Back pain from carrying equipment, respiratory symptoms from toxic exposure, and cognitive changes resulting from blasts and impacts are only a few examples of the importance of having a medical provider well-versed in military and Veteran experiences. Depending on where someone served in the world, their duties in the military, and their present health condition, medical professionals who understand military and Veteran experiences can help find the best treatment options.

Encourage all SMVF to find out if they are eligible for VA care because eligibility and access to VA health care does not disqualify someone from accessing additional health care in their community if they choose to. This aligns with Criteria 4.G (Primary Care Screening and Monitoring) by promoting attention to the physical health needs of SMVF alongside behavioral health care, and it also supports Criteria 3.C (Care Coordination Partnerships) by reinforcing the importance of collaboration between CCBHCs and VA. Connect with a VA Medical Center to collect contact information around health care and benefits eligibility and refer your client to a VA healthcare specialist or benefits advisor. VA care and benefits eligibility has various requirements, and referring your client to a VA specialist or advisor would provide CCBHCs the best avenue to support their SMVF clients.

Also, encourage SMVF to be open and honest when discussing military service duties, diagnoses, and injuries when applying for service-connected disability benefits. This information can open access to financial support and other health care benefits someone may not otherwise qualify for.

For military families, access to medical care in postmilitary life is more complicated. Families are provided with medical care while their loved ones are active in the military. However, Veteran family members no longer have access to that same medical care, except in certain cases such as military retirement or medical discharge. In these cases, military family members may use private insurance or payment methods to access care and therefore may not be as easily recognizable as a military family member based on their reimbursement method for medical services.

Factors That Influence Health

Encouraging SMVF to build a network of stable social support that includes family, caregivers, friends, colleagues, and other SMVF is key to improving connections and decreasing loneliness. This aligns with Criteria 4.A (General Service Provisions) by addressing factors

that impact health through the promotion of stable social support networks, which are vital to improving overall well-being. It also supports Criteria 4.G (Primary Care Screening and Monitoring) by recognizing that social isolation can affect physical health and should be assessed alongside behavioral health needs, and it aligns with Criteria 3.C (Care Coordination Partnerships) by emphasizing the role of coordinated community and family support systems in delivering holistic, integrated care. Consider whether your CCBHC can provide drop-in groups or other social support programs, ideally where Veterans often congregate such as near a local VA facility or on a college campus with a large student Veteran population. Also, share opportunities for your SMVF clients to connect with other service members, Veterans, or military families. Assess your clients for any financial crises, housing instability, and food insecurity, and research military-related and nonmilitary-related referrals that your staff can provide. Financial benefits for SMVF could include service-connected disability screening and rating and home loans. Also, consider referrals to organizations that specifically support family members of those who have served.

National, state, regional, and local VSOs often provide free services to SMVF, including help with benefits, education, and connection to community resources. Vetting VSOs will ensure that they are not charging fees and have positive reviews in the community. In many cases, county and state governments have accredited VSOs who have a responsibility to support filing benefits claims. Not all individuals who represent themselves as claims specialists are properly accredited, and thus do not have the legal authority to represent clients in their efforts to obtain or modify VA benefits.

Insights From Experts

Establishing trust with individuals in the SMVF community who struggle with behavioral health conditions is paramount to successful service delivery. It is important to consider that SMVF may be wary of discussing their military histories and traumatic military-related exposures with people they do not believe they can trust. *—Tim Keesling, Director, Office of Veteran Services Coordination, Texas Health and Human Services*

When considering how to ask about military service, it is important to ask the question in different ways. Some variables include how a Veteran may see themselves as such regardless of their characterization of discharge or deployments. It can also be beneficial to place the question in different parts of the initial assessment or intake as well as provide specific training on how to ask the question in different ways. *—Angela Eberle, MBA, Vice President of Integration & Program Development, Volunteers of America, Massachusetts*

When developing safety plans, it is important to be familiar with specialized and nuanced safety planning for the SMVF population as well as inequities in care that this population often encounter as barriers to engagement in treatment. Give weight to counseling on access to lethal means and engaging social supports as a part of the process while joining with the individual to give them ownership in the plan development. Additionally, in lieu of or in addition to a traditional suicide prevention safety plan, consider opportunities for Wellness Recovery Action Plans, psychiatric advance directives, and other self-directed crisis recovery plans. Whenever possible, incorporate Veteran peer specialists/persons with lived experience as part of the intervention and follow-up services.*—Kristin Sauerbier, LCSW, Senior Project Associate, Policy Research Associates, Inc.*

After confirming that a client is a current or former service member or a family member, an excellent follow-up question to continue the conversation is, “What was your job?” That’s a separate question from their occupational specialty because the circumstances of particular duty stations or deployments may require service members to take on different roles to accomplish their mission. While answering that question, the client may provide much of the additional information needed (e.g., when and where they were stationed; whether they were active duty, Reserve, or National Guard; whether they deployed). *—Blake Chaffee, PhD, ABPP, Vice President, Integrated Healthcare Services, TriWest Healthcare Alliance*

One way to ensure that military service is included during intake or coded in a CCBHC's electronic health record (EHR) is to make use of the International Classification of Diseases (ICD)-10 code Z91.85 Personal History of Military Service. This can assist in identifying and tracking clients with military service for data use purposes. *—Ashley Delehanty, LSCSW, Community Engagement and Partnership Coordinator, VA Eastern Kansas Health Care System-Topeka*

It can be beneficial for CCBHC staff to review resources available for community providers, such as the VA Welcome Kit or other introductions to the various functions of the Department of Veterans Affairs. CCBHC staff may have limited awareness that Veteran Benefits Administration disability benefits and Veterans Health Administration health care benefits are distinct and have different eligibility criteria and determination processes. Gaining insight into these differences can enhance rapport and provide better support for SMVF clients. *—Kerry Bond, LSCSW, DBT-C, Community Engagement & Partnerships Coordinator, Robert J. Dole VA Medical Center*

Our leadership celebrates employees who served in the military in a number of different ways. Several programs provide service member, Veteran, and military spouse staff with a pin that can be worn on an ID card lanyard that demonstrates their connection to the military. The agency also hosts a luncheon every year around Veterans Day as well as producing a video highlighting staff who served in the military. This video was separated into segments and shared with all staff throughout the month of November as well as played during the luncheon. *—Sarah Strang, LPC, Mobile Crisis Outreach Team and Resiliency Team Director, The Harris Center for Mental Health and IDD*

Access to and use of behavioral health services within the military has changed, and it is likely that younger Veterans have engaged with treatment while in the military, and older Veterans might have attempted to access services prior to their current engagement with CCBHCs. Given this fact, it could also be helpful to include an assessment on prior history with mental health and substance use disorder services; including but not limited to, years, time frames, if they found treatment helpful, diagnosis, or reasons they entered treatment or resisted treatment. *—Mindy Miller, LMHC, LADC1, Chief Operating Officer, Volunteers of America of Massachusetts*

It is important to note that the CCBHC certification criteria for "community care for uniformed service members and Veterans" is in addition to the other CCBHC Certification Criteria, not separate from it. These are additional services that may be available to this population beyond the other scopes of service, which are also available to the Veteran. We have previously heard some confusion about whether this service means that Veterans should receive only a specific service array that is separate from other people receiving care. We have had to explain that Veterans are eligible for any service anyone else is eligible for, but there may also be unique services or unique service delivery for Veterans. *—Sarah Melecki, Director of System Integration, Texas Health and Human Services*

Notes From the Field

VOAMASS | Jamaica Plain, MA

Volunteers of America—Massachusetts (VOAMASS) identifies SMVF through a centralized intake process. Clients complete an initial intake and comprehensive assessment with a licensed clinician, which includes a section dedicated to military service. This section tracks and logs military and family affiliation.

VOAMASS employs military and Veteran case managers who work exclusively with Veteran clients. The organization offers seven Veteran programs covering housing, employment, education and training, transitional living, and VA connections and disability claims. Referrals to these programs go through a specialized email handled by the program manager.

To explore military backgrounds, VOAMASS requires proof of service such as DD214 (Discharge Papers and Separation Documents), Status Query and Response Exchange System (SQUARES), or other credentialed military documentation. Case managers assist Veterans in obtaining their military records if needed. Additionally, one staff member who is a national service officer has access to the records database for any Veteran who entered service in Massachusetts. For screening unique behavioral health, medical, and community needs, Veteran clients complete the Massachusetts Standardized Documentation Project (MSDP) questionnaire with an intake clinician, which covers all relevant information and includes a comprehensive assessment tailored to factors that influence health.

Community Counseling Center | Ashtabula, OH

Community Counseling Center of Ashtabula, Ohio, identifies SMVF by asking clients about their military status at the point of entry and during the initial assessment. This approach ensures that SMVF are recognized early in the process.

While the organization does not currently have military and Veteran case managers on staff, it refers clients to the local Veterans Service Commission (VSC) for additional support. This collaboration helps ensure that Veterans receive the specialized assistance they need.

Standard procedures for exploring military backgrounds include assessments with clients; care coordination with the VSC, VA, or both; and involvement of other providers identified by the client as part of their support and treatment team. Staff conduct ongoing assessments to screen for behavioral health and medical and community needs unique to SMVF, ensuring continuous and comprehensive care.

Berks Counseling Center | Reading, PA

Berks Counseling Center identifies SMVF by screening clients at admission. This initial screening helps determine if a client is part of the SMVF community, ensuring they receive appropriate support from the start.

While the organization has case managers on every team, it does not have case managers specifically dedicated to military and Veteran clients. However, it does have standard procedures for exploring military backgrounds, which involve detailed assessments and coordination with relevant services.

Family Service of Rhode Island | Providence, RI

Family Service of Rhode Island (FSRI) identifies SMVF during the intake process. When potential clients contact the intake department to request services, staff ask if the client or someone in their household has served in the military, which is recorded in the electronic medical record. Additionally, when clients begin receiving services, their treatment team asks about military service as part of the clinical or program assessment.

FSRI has military and Veteran case managers. Staff should inform SMVF clients about the services provided by the case manager and ask if they would like a call from them. The staff then share the client's information with the case manager. The case manager also regularly reports on SMVF status and proactively reaches out to new clients to explain available services.

The organization uses "Ask the Question" training to explore military backgrounds. Once the SMVF client is meeting with the military case manager, they engage in conversation to learn about their experiences and share their own military background, fostering a supportive and understanding environment.

High Plains Mental Health Center | Hays, KS

High Plains Mental Health Center identifies SMVF by asking every individual seeking services about their military status, including whether they are active duty, Reserves, or National Guard, as well as their branch of service. This ensures appropriate recognition and support for SMVF from the beginning.

The organization has a navigator specifically assigned to assist military and Veteran populations, providing a single point of contact to help locate services. This role facilitates seamless referrals and support for SMVF clients.

High Plains Mental Health Center has standard procedures in place for exploring military backgrounds, ensuring comprehensive assessments for all individuals seeking services. Its robust screening process at entry and throughout treatment covers various aspects, including physical health (biometric data, body mass index [BMI], diabetes and cardiovascular risk, medical history, screenings for human immunodeficiency virus [HIV], hepatitis, blood-borne conditions, current medications, primary care provider, and referrals), behavioral health (emotional problems, patient and family history, trauma history, comprehensive assessments, ongoing depression and anxiety screenings), substance misuse (alcohol, drug, and tobacco screenings), and community needs. This thorough approach ensures continuous monitoring and addressing of the unique needs of SMVF clients.

Valley HealthCare System | Morgantown, WV

Valley HealthCare System identifies SMVF through a comprehensive intake process that asks clients about their military service. This initial screening helps ensure appropriate recognition and support of SMVF from the start.

The organization offers case management services provided by staff trained in Veteran and military experiences. Terry Vance and Shane Laws, who serve under the Veterans Program as peer support specialists, can make referrals to case management through internal systems. Additionally, Valley HealthCare System has two Veteran therapists, one male and one female, who assist in managing cases. Any department can make referrals internally using its Electronic Medical Record (EMR) Staffing and Referral System, which connects clients to appropriate services based on individual needs.

Standard procedures for exploring military backgrounds during the intake process include asking clients about their military status and branch of service as well as whether they are active duty, National Guard, or Reserves. Clients can share their military experiences through peer support, individual and group therapy, and counseling sessions. Proof of military service such as a DD-214 (Certificate of Release or Discharge from Active Duty) is only requested if applying for emergency relief funding. The staff screen for unique behavioral health, medical, and community needs through trained health professionals and the Veterans Program through peer support sessions, individual therapy, group therapy, past medical history, and community needs assessments. Valley also organizes a monthly Veteran's Coalition meeting with 80 organizations to discuss available resources and needs.

Community Fairbanks Behavioral Health | Indianapolis, IN

Community Fairbanks Behavioral Health identifies service members, veterans, and their families (SMVF) using the Adult and Child Needs and Strengths Assessments (ANSA/CANS), completed for all clients and documented in the EMR. A Weekly Veterans Report, generated by the IT/Analytics team, is reviewed by the Veteran Care Coordinator (VCC), who then works with primary caregivers to determine if veteran-specific support is needed.

The VCC role, created in November 2023, connects Veterans to resources, partners with the VA, and provides community outreach. Staff can refer clients to the VCC through the EMR or secure email, and a brochure was developed to promote available services. During intake, military service history is gathered, and the VCC may request documentation like a DD214 when appropriate. The VCC also trains staff to identify and address Veteran-related needs.

Throughout treatment, SMVF clients are offered additional support from the VCC, who collaborates with caregivers to assess and address military-specific needs. Internal referrals ensure unique behavioral health, medical, and community concerns are met with specialized services tailored for Veterans and their families.

Ideas for Action

EMBED SCREENING QUESTIONS:

Incorporate the question, “Have you or a family member ever served in the military?” into all intake forms, EHRs, and assessment tools to systematically identify SMVF clients.

TRAIN STAFF:

Provide training for all staff on the different branches of the military, types of service, and the unique needs of SMVF to improve understanding and support.

CREATE A WELCOMING ENVIRONMENT:

Display military branch emblems and other military-related images in the clinic to make SMVF clients feel recognized and welcomed.

DEVELOP A REFERRAL SYSTEM:

Establish a process to refer identified SMVF clients to military/Veteran liaisons or case managers and connect them with county Veteran service officers for benefits and support.

PROMOTE AWARENESS:

Use social media, websites, and printed materials to communicate that the clinic values and honors military service, encouraging SMVF clients to self-identify and access available resources.

Resources

NH ATQ Website

The “Ask the Question” (ATQ) campaign encourages providers across various sectors to ask if individuals or their family members have served in the military. This initiative aims to improve services and support for Veterans and their families in New Hampshire.

Have You Ever Served Pocket Card

The “Have You Ever Served?” 2023 pocket card helps clinicians ask Veterans about their military service to better understand their health needs. It covers topics such as combat exposure, PTSD, military sexual trauma, and suicide risk.

ACMF Risk Reduction Framework

The Arizona Coalition for Military Families’ Risk Reduction program supports SMVF through a public health approach. It focuses on prevention, crisis response, and treatment, addressing factors that influence health to enhance overall well-being.

Maine Veteran Suicide Prevention Toolkit

The Maine Veteran Suicide Prevention Toolkit provides strategies for preventing Veteran suicide, emphasizing community-based approaches, mental health screenings, and support services. The kit includes sample workflows and scripts to use when screening for SMVF in a clinical setting.

Military Family Research Institute Measuring Communities Database

Measuring Communities is an online project providing military-specific data from over 30 sources to support military and Veteran families. It offers interactive maps and data on employment, demographics, and other issues to help community leaders make informed decisions.

Finding and Using Policy-Relevant Data About Veterans

The RAND report examines the availability and accessibility of policy-relevant data about U.S. Veterans. It highlights gaps in data access and interpretability, offering recommendations to improve data collection and usage for better Veteran support and policy-making.

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MODULE 2

MILITARY AND VETERAN EXPERIENCES

Overview

When engaging service members, Veterans, and their families (SMVF), it is necessary to recognize that military background and experience foster unique characteristics, attitudes, and worldviews that form a distinct set of values, attitudes, and behaviors. Shared experiences, common knowledge and terminology, and a deeply ingrained set of values contribute to strong bonds among SMVF, often regardless of location, era, or type of service. Simultaneously, military service is inherently stressful, potentially dangerous, and may create both risk and protective factors related to mental health. When providing mental health or substance use disorder treatment to this population, Certified Community Behavioral Health Clinics (CCBHCs) are encouraged to develop experiential awareness, knowledge, and sensitivity to these unique characteristics to offer responsive care that meets SMVF's needs.

In this section, we will share the importance of alignment with the SMVF population, explore specific aspects of SMVF experiences, and examine how access to care is influenced by a service member's characterization upon leaving the military. We will also share insights from subject matter experts on military experiences, highlights from CCBHCs that demonstrate responsivity to SMVF needs, and provide resources to support further learning.

Fact Sheet: Military and Veteran Experiences

Overview

Military Service Awareness and Responsiveness	Aspects of Military and Veteran Experiences	Access to Care and Eligibility for Benefits
» Creating an environment that recognizes and respects the unique experiences of service members, Veterans and their families is essential to CCBHCs. » Behavioral health professionals must understand the military and Veteran community as a distinct group shaped by shared values and experiences. » This knowledge supports trust-building, enhances peer support, and improves Veteran-specific outreach—key elements of effective care aligned with CCBHC Criteria 4.J and 4.K.	» When CCBHC staff and volunteers are trained in military and Veteran experiences, they are better equipped to build trust, reduce stigma, and engage SMVF clients in meaningful care. » This training supports responsive assessments, targeted case management, and person-centered planning—especially Veterans who may have been overlooked. » Understanding military values like resilience, camaraderie, and confidentiality helps staff foster connection and promote long-term engagement.	» Service Members, Veterans, and their Families (SMVF) have access to a range of care options, including CCBHCs, VA Medical Centers, and Vet Centers. » To ensure continuity of care, CCBHCs should build partnerships with these agencies and understand the benefits landscape, including how discharge status affects eligibility. » This supports Criteria 3.B, 3.C, and 4.G by promoting coordination, accurate screening, and responsive care.

Insights from Experts

Supporting SMVF clients effectively requires CCBHCs to address both visible and invisible barriers to care. For example, CCBHC experts emphasize the importance of asking about discharge status during intake—not to exclude, but to connect Veterans with the most appropriate resources. Similarly, one CCBHC expert in Texas highlights how some Texas CCBHCs assist Veterans in navigating discharge upgrades, especially when behavioral health issues contributed to their separation.

Building rapport also means understanding the nuances of military experiences. Experts note that humor and camaraderie among Veterans can foster connection, while others note how rank and role during service may influence how SMVF clients engage with providers. It is also important to proactively discuss firearm and medication safety, which can help staff navigate sensitive topics before a crisis occurs. These insights reinforce the need for responsive, person-centered care that respects the complexity and resilience of the SMVF community.

Fact Sheet: Military and Veteran Experiences

Notes from the Field

CCBHCs across the country are demonstrating success in serving SMVF by investing in understanding military services and experiences and addressing barriers to care. At VOAMASS, 80% of Veteran program staff are Veterans themselves, and quarterly VA trainings ensure staff stay current. Their in-house national service officer helps navigate discharge upgrades and VA eligibility challenges. Similarly, Community Counseling Center in Ohio offers ongoing access to Relias training and STAR certification to deepen staff understanding of military experiences.

Other centers, like Berks Counseling Center and Family Service of Rhode Island, require all staff to complete foundational military experiences training, with additional VA and SAMHSA training for those working directly with Veterans. High Plains Mental Health Center uses the Veteran Ready Organization Pathway to train staff on the experiences of military families, Veterans, and caregivers. Valley HealthCare System in West Virginia integrates monthly coalition meetings and statewide partnerships into its training model, ensuring all staff—Veteran and civilian—are equipped to support SMVF, regardless of discharge status or eligibility barriers.

Ideas for Action

- **Provide military experiences training:** Ensure all staff and volunteers complete training on unique experiences and values of SMVF.
- **Enhance visual representation:** Display military branch flags, emblems, and images of Veterans throughout the clinic to create a welcoming environment for SMVF clients.
- **Develop trust-building protocols:** Train staff on privacy policies and effective communication strategies to build trust with SMVF clients, emphasizing confidentiality and the importance of understanding past experiences in seeking care.
- **Facilitate peer support:** Establish peer support programs that connect Veterans with other Veterans, fostering empowerment and self-determination through shared experiences and mutual support.
- **Collaborate with Veteran organizations:** Partner with local and national Veteran-serving organizations to provide comprehensive support for SMVF clients, including referrals to specialized services and community-based support groups.

Resources

- PsychArmor
- Worried About a Veteran Website
- Working Effectively With Military Families: 10 Key Concepts All Providers Should Know
- VA's Training for Community Providers
- Exemplary Practices for Counseling Military Populations
- Nevada Military Care Pocket Card
- Utah Military Playbook
- VA's Veterans Experience Office
- Community Toolkit for Safe Firearm Storage

Military Service Awareness and Responsiveness

Behavioral professionals in CCBHCs and crisis response services must create comprehensive care environments that consider the unique experiences of those they serve. Staff should learn about clients' experiences to provide effective support. For service members and Veterans, this means recognizing distinct common identities shaped by shared experiences and common values. Understanding these experiences supports Criteria 4.J (Peer Supports and Counseling) and Criteria 4.K (Community-Based Mental Health Services for Veterans) by enhancing connection with peer supports and Veteran-specific outreach.

CCBHCs may be difficult for SMVF to engage with because of fear, stigma, or crisis. Strategies to reduce these barriers include identifying staff who are Veterans or family members and ensuring that roles frequently interacting with SMVF—such as case managers and peer navigators—are representative of this population. Care that is responsive to military experiences includes building rapport and trust, which can directly affect client engagement. This supports Criteria 2.A (General Access Requirements) by fostering a responsive environment that encourages trust and improves service engagement. Nonmilitary staff can improve their understanding of military and Veteran experiences to create a more welcoming atmosphere and provide individualized care. In this section, we will discuss some aspects of military experiences to consider. However, flexibility and responsivity, along with individual client characteristics, history, and presenting concerns, should always be considered.

Building Trust by Being Responsive to Military Experiences

Trust is a key factor in whether individuals seek and engage in behavioral health services. For service members and Veterans, building trust is particularly important. Recent studies have shown that concerns about confidentiality and mistrust of mental health professionals are significant barriers for active-duty personnel seeking treatment (Wong et al., 2024).

The transition from military to civilian life presents substantial challenges for SMVF. These may include navigating postmilitary education or employment, adapting to nonmilitary settings, and finding purpose in life after service. Research has also shown an increased risk of suicidal thoughts and behaviors during this period (Sokol et al., 2021). Understanding these challenges and risks gives CCBHCs a valuable opportunity to engage the SMVF population. Veterans receiving care in community settings may be reluctant to engage if providers lack a basic understanding of military experiences. Although staff with lived experience are helpful, all personnel can take steps to build a better understanding of military service in order to provide responsive, informed, and trust-based care.

Some SMVF clients hesitate to seek behavioral healthcare because of negative consequences experienced during military service. These may include time away from duties, disqualification from specific roles, or perceived stigma—such as being viewed as weak, untrustworthy, or ineffective by leaders or peers. These consequences can be both real and perceived.

Establishing trust involves asking clients about their experiences with care—whether they sought it—and exploring the reasons behind those decisions. The Department of War (DOW) has recently promoted mental health help-seeking by adopting phrases such as "mental health is health" and encouraging SMVF to seek help early to reduce the risk of suicide and other crises. However, many still fear repercussions for seeking help because attitudes evolve slowly. Being responsive to military experiences can support trust-building with SMVF. Collectively, these strategies support Criteria 3.A (General Care Coordination Requirements) through enhanced communication protocols, Criteria 6.B (Governance) and Criteria 1.A (Needs Assessment) through inclusive staffing, and Criteria 4.C (Crisis Behavioral Health Services) by supporting suicide prevention and safety planning during acute risk. The strategies include the following:

- Train staff and volunteers on your clinic's privacy and confidentiality policies and how to explain those policies clearly. Assure clients that confidentiality and privacy are prioritized. Ensure your SMVF clients understand their rights regarding consent for sharing records or coordinating care with providers such as the U.S. Department of Veterans Affairs (VA).
- Ensure visual representation of the military and Veteran community. Display flags and emblems from all military branches.
- Highlight military service among staff and volunteers through name badges, photos, personal stories, or a "story of impact" feature that includes both Veterans and civilians working with SMVF.
- Review how VA engages with Veterans to assess their trust and consider incorporating surveys and other methods to capture data on trust levels among your SMVF clients.
- Learn about the importance of firearms in military service, training, and readiness; understand issues related to firearm accessibility; and emphasize the importance of securely storing firearms and other lethal means when working with SMVF.

Firearms are the leading method of suicide among SMVF, and there are various options for transferring firearms during a time of crisis. CCBHCs should familiarize themselves with local resources as well as the jurisdictional laws and regulations related to firearm transfers. Because state and federal firearm safety laws vary, CCBHCs may consider consulting local gun shop experts who can help staff and volunteers understand how to protect your clients' rights while mitigating risk.

Review Common Military and Veteran Definitions and Language

A basic aspect of learning about military experiences is understanding the distinction between the branches of the U.S. military. Because of the unique attributes associated with military service, providers are encouraged to learn about these experiences to effectively communicate with SMVF. Familiarize yourself with terms such as active duty, Reserves, National Guard, and Veterans. Ask clients, friends, and loved ones about their military service history. If you serve, have served, or have a family member who has served, consider sharing that with your colleagues. The U.S. military is the largest in the world, with a presence in more than 100 countries, yet only a small portion of the U.S. population serves (USA.gov, 2024). Although there are similarities across branches, each has important differences, including what its members are called. For example, many civilians may not realize that the term "soldier" refers only to Army personnel. Other branches use different terms, such as "sailors" in the Navy. However, the term "service member" is universal.

Another important distinction is understanding a client's era of service, such as the Vietnam era, Cold War era, Gulf War era, or Post-9/11. Familiarity with terms such as "pre-9/11" (referring to the period before the terrorist attacks of September 11, 2001), "post-9/11" (referring to the period after) and other U.S. periods of war and dates of recent conflicts helps staff engage more meaningfully with SMVF and understand initialisms such as OIF (Operation Iraqi Freedom) and OEF (Operation Enduring Freedom). Not all SMVF have been deployed to combat zones, and not all who deployed were traumatized by the experience. Conversely, military service itself is inherently stressful and dangerous. A lack of deployment does not mean someone avoided trauma. Engaging SMVF requires familiarity with common service experiences while recognizing that each client is a unique individual with their own history and worldview.

Military service emphasizes structured, predictable schedules. For many in the SMVF community, being on time is a sign of respect, arriving early is considered on time, and arriving on time is late. Clients may arrive early to appointments, and clinicians who are consistently behind schedule or who frequently reschedule appointments may damage rapport with those clients. Because timeliness is a deeply held value among many who served, this supports Criteria 2.B (Timely Access to Services) by emphasizing schedule reliability to build trust and improve perceived access to behavioral health support. Additionally, the U.S. military uses military time, a 24-hour clock system with no a.m. or p.m. reference. For example, an appointment at 4 p.m. would be referred to as 16:00 hours. Hearing military time may indicate that someone identifies as SMVF. Another aspect of military service is the use of formal titles based on a hierarchical rank of leadership when referring to others. Terms such as "ma'am" and "sir" are commonly used when addressing someone in the military. Learning various aspects of military service can help you build rapport with your SMVF clients.

CCBHCs should ensure that staff and volunteers have access to training related to military and Veteran experiences, which is available at no cost through TRAIN.org—a national online training catalog—and through the nonprofit organization PsychArmor. Clinical staff should be trained in the federal Clinical Practice Guidelines; understand the 24/7/365 Veterans Crisis Line, which is cobranded with the Military Helpline (accessible by dialing 9-8-8 and pressing 1 for service members and Veterans); and be knowledgeable about evidence-based practices for SMVF, such as suicide prevention safety planning and treatments for depression, posttraumatic stress disorder, and substance use disorders.

Aspects of Military, Veteran, and Family Experiences

When CCBHC staff and volunteers receive education and training on military and Veteran experiences, they are more likely to convey a sense of welcome and compassion and more effectively engage SMVF in meaningful treatment. When there is a sense of acceptance and belonging, it becomes easier for staff to engage clients in treatment, safety planning, and therapeutic goal setting. Participating in follow-up referrals, treatment sessions, outreach calls, and mood checks helps reduce periods of crisis and risk for SMVF. This aligns with Criteria 4.H (Targeted Case Management) by emphasizing coordinated follow-up care to reduce risk and promote continuity of services. Also, modeling this type of follow-through builds trust and encourages SMVF to follow through on safety and treatment plans.

Many Veterans display signs of military service through clothing, hats, or license plates. However, not all Veterans do so, and women Veterans often do not display visible indicators of their service. Women are frequently questioned about the legitimacy of their service and may avoid outward expressions of their military background to avoid such interactions. Women are often referred to as "invisible veterans" because they are less likely to be asked if they have served in the military. Establishing policies to ensure that all individuals at your CCBHC are asked about prior and current military service helps ensure that all who served—regardless of sex—are identified. This supports Criteria 4.D (Screening, Assessment, and Diagnosis) by promoting consistent inquiry into military history as part of a military experience informed assessment process.

Veterans represent a unique group spanning rural and urban geographies, sex, races, and ethnicities. Women represent the fastest-growing group of Veterans, and post-9/11 Veterans include a higher proportion of women compared to their pre-9/11 counterparts (Schuler, 2024).

Stigma Against Help Seeking Can Be a Barrier to Care

Working with SMVF can involve additional complexities. For example, Veterans who currently hold or previously held security clearances or sensitive military positions may face more obstacles to engagement. Prior to recent changes in the security clearance process, service members were required to disclose whether they had consulted a health care professional for an emotional or mental health condition or had been hospitalized for such a condition. Although such disclosures do not automatically disqualify someone from receiving security clearance, many service members and Veterans remain hesitant to acknowledge prior treatment—or may avoid treatment entirely—for fear it could jeopardize their security clearance and military career.

Mental health and substance use disorder treatment is sometimes perceived as a sign of weakness in the military. Concerns about how treatment may affect one's employment, responsibilities to family, or overall readiness are common. Veterans who continue to serve in the National Guard, Reserve, or both, may feel conflicted about disclosing symptoms or seeking help. Addressing these barriers and

creating a plan to support comfort and safety in sharing should be integrated into the treatment process when possible. This aligns with Criteria 4.E (Person-Centered Treatment Planning) by encouraging codeveloped strategies to overcome barriers and customize care.

Uncertainty about confidentiality policies and the consent needed to share information with friends, family, or the DOW or VA can further contribute to fear and stigma around seeking help. Additionally, alcohol use is prevalent in this client population, and those who seek mental and substance use disorder treatment may experience criticism or mistreatment from peers or supervisors. These issues can vary depending on the branch of service and further influence reluctance to engage in care. CCBHCs can reduce these concerns by using clear language to explain confidentiality and privacy policies, including where medical records are stored and who may access them—including the client. Transparency can significantly improve trust and engagement with SMVF. This supports Criteria 2.D (No Refusal Due to Inability to Pay) and Criteria 3.D (Care Treatment Team and Planning) by promoting trust and clear communication in care access and planning. In alignment with person-centered practices, clients should determine what information is shared and with whom—except in cases of mandated reporting. CCBHCs should address this clearly during the intake process.

Resilience and Competence Are Key Aspects of Military Values

Values commonly held among those who have served include a strong sense of duty, commitment to mission over self, loyalty, and resilience. Resilience, in particular, has been widely studied in military and Veteran populations. An article reporting findings from the National Health and Resilience in Veterans Study, which reviewed more than 80 studies, reported that "while a significant minority of Veterans screen positive for mental disorders, the majority are psychologically resilient" (Fogle, et al., 2020). All branches of the U.S. military integrate resiliency training into service members' development, which may help explain how many Veterans manage, adapt to, and overcome life challenges. The ability to maintain composure under pressure and respond constructively to adversity is often viewed as a core strength. However, it is essential to recognize that such resilience often emerges from repeated exposure to difficult, stressful, or traumatic experiences.

It is also important to note that service members receive extensive expert-level training and education. They are highly skilled and often entrusted with the responsibility of leading others and managing valuable equipment—sometimes at a young age. This experience fosters confidence in their own abilities and in others who have served. Many SMVF take pride in their problem-solving skills and capacity to persevere through difficult situations independently. Other core values, such as selfless service, teamwork, and commitment to the mission, typically remain strong after leaving the military. CCBHCs may need to help clients reframe their understanding of strength and resilience in the context of mental health. SMVF should be encouraged to view seeking help not as a weakness, but as a further demonstration of strength—one that highlights their connection to others and their ability to use available resources to overcome challenges.

Camaraderie and Connectedness Can Be Critical Protective Factors

Military service provides an opportunity for service members to form interpersonal relationships and emotional connections that often last a lifetime. Many Veterans retain a strong sense of responsibility and duty to those they served with. "Buddies" is a common term in the military, reflecting a sense of camaraderie that often continues into Veteran life. The shared commitment to serve the greater good, defend others over self, and make sacrifices creates powerful bonds among SMVF. These bonds may form between Veterans across different branches and can be especially strong among those who shared occupational specialties or served in the same locations. This aligns with Criteria 4.J (Peer Supports and Counseling) by highlighting the depth of shared experiences and mutual trust that form the foundation for effective peer support.

Social connection is a key protective factor for SMVF. It often becomes especially important during times of crisis and throughout the treatment and recovery process. However, building and maintaining these connections after military service can be challenging. CCBHCs can help by providing referrals to vetted Veteran Service Organizations (VSOs) and facilitating drop-in support groups for SMVF experiencing crisis or social isolation. This supports Criteria 3.C (Care Coordination Partnerships) by emphasizing external coordination with community-based SMVF resources.

National VSOs with local chapters include the following:

- Vietnam Veterans of America
- American Veterans
- Veterans of Foreign Wars (VFW)
- Disabled American Veterans
- The American Legion a U.S. Veterans Association
- Paralyzed Veterans of America
- Wounded Warrior Project
- Team Red, White & Blue
- Team Rubicon
- Student Veterans of America

Military and Veteran Families: Their Experiences

As a CCBHC, your staff will likely provide treatment and support to military and Veteran family members. It is necessary to understand the differing experiences of family members, how those experiences relate to the military, and how their family members' service impacts them individually and as a group. Although the term "family" can be broad and expanded to include nonrelational caregivers, the specific discussion here will focus on immediate familial relationships such as spouses, partners, and children. This relates to Criteria 4.E (Person-Centered Treatment Planning) and Criteria 4.K (Community-Based Mental Health Services for Veterans) by recognizing the interconnected needs of Veterans and their families.

It is commonly known that service members change duty stations frequently, requiring their families to be extremely flexible and adapt quickly to new environments. Although the length of time at a duty station varies branch and era of service, it is typical for moves to occur every 3 to 5 years. This frequent relocation involves leaving behind friends and established relationships and learning to create a new life in an unfamiliar community. It is also common for service members to be absent from their households for extended periods—ranging from

weeks or months for training and education to years for deployments. These absences often result in families functioning as single-parent households while striving to maintain connection with the absent service member. Reintegration after a long absence or repeated reintegration after frequent absences can be both a positive and stressful experience.

For many overseas assignments, families accompany service members and often live, work, and socialize within communities surrounding military installations. These families are exposed to a range of unique experiences that differ significantly from those of typical U.S. families. This experiential and physical separation from their original communities may result in a lack of stable structure and support for military spouses or partners. Military children, while attending school on military installations, may feel disconnected from a consistent home community. Many military children are born where their parents are stationed and attend multiple schools in various locations, which can contribute to a sense of not being "from" anywhere.

One valuable resource for understanding military and Veteran families is the *Blue Star Families Annual Military Family Lifestyle Survey* report. This report collects responses from over 100,000 military and Veteran families each year and provides insights into a wide range of issues affecting these families, including health care access, food insecurity, employment, and housing. The 2024 Survey demonstrated the following (Blue Star Families, 2025):

- The top concern for active-duty spouses continues to be military spouse employment, followed by military pay, time away from family due to service, housing affordability, and children's education.
- Time separated from family remains the central concern for National Guard and Reserve family respondents, as it has since 2020, followed by military pay, the impact of deployments on family, and access to health care.
- Access to military and VA health care systems was the top concern for both Veteran respondents and spouses of Veterans, highlighting its critical importance to their well-being.

Access to Care and Eligibility for Benefits

Because of their military service, SMVF have access to a variety of care options. CCBHCs are one key community-based option, and VA Medical Centers and VA Vet Centers provide additional avenues for care. State and federal benefits available to SMVF include financial support—such as disability pensions and home loans—education benefits, and other resources. Establishing partnerships with these agencies supports Criteria 3.B (Health Information Systems) by promoting coordinated data-sharing and communication among providers ensures continuity of care.

From October 2023 to September 2024, more than 9 million individuals were enrolled in VA health care, and over 6.5 million Veterans accessed services through VA (U.S. Department of Veterans Affairs, 2024). Each year, millions of VA Veterans receive referrals for community-based care, which may be covered by the VA. However, the degree of responsiveness among community-based clinicians to military experiences varies widely. Without such support, some Veterans may discontinue community care, drop out of that care, or request to return to VA, even if it means waiting for care. This gap in provider knowledge can be addressed through structured training and education. CCBHCs can apply the strategies discussed in this toolkit to ensure they are SMVF-ready, with staff and volunteers equipped to meet the population's unique needs.

As discussed in the previous module, family members of Veterans have fewer treatment options compared to when their family member was actively serving. Although Veterans have access to services through VA, the options for Veteran family members are more limited. Families of currently serving military members can obtain services from providers in the TRICARE network; however, this option is limited for families of retired service members. Many Veteran families must rely on alternative forms of insurance to cover their treatment needs, yet they still require clinicians who can respond to the unique experiences associated with military life. This supports Criteria 2.D (No Refusal Due to Inability to Pay) by acknowledging financial barriers that may limit access to care and by emphasizing the role of CCBHCs as a unique, inclusive resource for SMVF populations—including Veterans without VA benefits and their family members.

DD214 and Characterization of Discharge

When transitioning out of military service, service members are provided with a characterization of discharge (COD), which determines their type of discharge, verifies their military service, and provides various service details. This relates to Criteria 4.G (Primary Care Screening and Monitoring) by highlighting the importance of discharge status in understanding client eligibility and related health indicators. Documented on the DD214 Form, the recorded character of discharge partly determines the benefits available to the Veteran, their caregiver, and family. These benefits include services from the VA (e.g., health, disability, financial, educational, burial benefits) and eligibility for care through DOW facilities.

Types of the recorded characterization of discharge include the following:

- **Honorable Discharge:** Awarded for exemplary service; entitles Veterans to full benefits

- **General Discharge:** Issued for satisfactory service with minor issues; provides access to most benefits
- **Medical Discharge:** Granted for service-related medical conditions; allows access to medical benefits
- **Other Than Honorable:** Issued for misconduct-related separation; limits access to benefits
- **Bad Conduct Discharge:** Resulting from a court-martial or separation in lieu of court-martial for serious misconduct; bars most benefits
- **Dishonorable Discharge:** Issued for severe misconduct; bars most benefits
- **Entry-Level Separation:** Given to those who separate before completing 180 days of service; no benefits

"Generally, to receive VA benefits and services, the Veteran's character of discharge or service must be under other than dishonorable conditions" (U.S. Department of Veterans Affairs, June 2024). For many service members, the distinction between receiving a General Discharge, which grants access to most benefits, and an Other Than Honorable Discharge, which limits access, is determined by their chain of command at the time of separation. In recent years, there have been efforts to update policies and allow Veterans with other than honorable or bad conduct discharges to have their cases reexamined. VA encourages all Veterans to apply for benefits, regardless of discharge type.

CCBHC staff and volunteers do not need to be experts in SMVF benefits but should know who the local experts are. Referring SMVF to the enrollment office at their nearest VA medical center and to a county or local Veteran service officer is crucial for interpreting the changing landscape of benefits. This aligns with Criteria 3.C (Care Coordination Partnerships) by encouraging active coordination with VA and county-level support services to navigate benefits and care options.

Insights From Experts

Being able to discuss adjustment disorders and the way in which psychoeducation may be discussed with SMVF to align holistic approaches to care is important. Therapy, medication, etc., may not be forever, and that's important to convey as well as the alternatives for holistic treatments. It is also necessary to be aware of the difficulties of those who have specialized skills in potentially not being seen in the same way after discharge—for example, someone with high supervisory experiences in the military then looking for a job postmilitary only to find that they are told their experience isn't "transferable" to civilian employment opportunities. *—Kristin Sauerbier, LCSW, Senior Project Associate, Policy Research Associates, Inc.*

To me, a person who says they understand my military experiences, means they too have worn the boots, carried a rifle, packed their house on their back, survived the chaos of war, watched helplessly as their family struggles to understand the interpersonal changes postconflict, and been profoundly impacted by the totality of the experience. In my experience, many people use this word too much and have too little actual understanding. Many Veterans react strongly to the idea that someone who does not have lived experience in the military can truly "understand" them. *—Tim Keesling, Director, Office of Veteran Services Coordination, Texas Health and Human Services*

When supporting peer to peer engagement, lived experience is always the best route to go if you can employ staff who are Veterans themselves. Our Veteran team (80% are Veterans) has created a norm within the organization and have trained our nonveteran staff on the military lifestyle from lived experience. It is important to respect how time was spent in the military significantly affects each person who serves differently and understand the broad spectrum of experiences and backgrounds within the Veteran community itself. When a Veteran uses their own personal experiences to guide another Veteran toward resources and community while validating personal experience, trust and community are built. *—Angela Eberle, MBA, Vice President of Integration & Program Development, Volunteers of America, Massachusetts*

It's important to let the Veteran know that they can be served by CCBHCs, regardless of discharge and if their discharge were under less than honorable conditions. We actually ask about discharge status during our intake assessment and train our staff to ask the question. We reassure the Veteran that we will provide them services and treatment, but we ask about discharge in order to provide the most helpful resources to the individual. *—Sarah Strang, LPC, Mobile Crisis Outreach Team and Resiliency Team Director, The Harris Center for Mental Health and IDD*

Some CCBHCs in Texas have gotten good at helping Veterans with discharges under less than honorable conditions navigate paperwork to help upgrade their discharge status if they were discharged for a reason that could be seen differently with more context. This could be very helpful, especially if a mental health or substance use need was causing behavior issues that led to a less than honorable discharge. *—Sarah Melecki, Director of System Integration, Texas Health and Human Services*

Addressing firearm ownership and access to medications is crucial within the SMVF population, and it is essential for clinicians to feel at ease discussing these topics. Engaging all clients (SMVF or not) about how firearms and medications are stored at home, while documenting these conversations, serves multiple purposes: It equips clinicians with vital information, allows staff to discuss safety for both the individual and others in the household, provides a reference point for crisis situations, gives staff a chance to practice navigating challenging discussions in a noncrisis context, and ensures that the conversation about firearms and medications occurs proactively rather than reactively during a crisis. *—Kerry Bond, LSCSW, DBT-C, Community Engagement & Partnerships Coordinator, Robert J. Dole VA Medical Center*

One of the things that I found interesting when starting to work with Veterans was the number of inside jokes and banter. You can see the special relationships that Veterans have with one another regardless of branch. Understanding that humor is a common characteristic can help with rapport and relationship. *—Mindy Miller, LMHC, LADC1, Chief Operating Officer, Volunteers of America of Massachusetts*

Building rapport with SMVF can vary based on rank or pay grade during military service. Enlisted personnel, often instructed from a young age, may struggle with self-determination and perceive a power differential with mental health providers, affecting treatment outcomes. Officers, accustomed to making significant decisions for subordinates, may experience cognitive dissonance when seeking mental health support, as their leadership roles conflict with their need for assistance. *—Ashley Delehanty, LSCSW, Community Engagement and Partnership Coordinator, VA Eastern Kansas Health Care System- Topeka*

Notes From the Field

VOAMASS | Jamaica Plain, MA

Volunteers of America—Massachusetts (VOAMASS) ensures its staff members are well-versed in military and Veteran experiences through training at local VA facilities. Approximately 80% of the staff working on Veteran programs are Veterans themselves. VA training sessions are offered quarterly, ensuring staff remain updated on relevant issues and practices.

The presence of a national service officer on staff has significantly enhanced the ability of VOAMASS to manage barriers to care. Staff members are adept at handling issues related to eligibility for VA services and characterizations of discharge that may limit access to certain services. They have experience in performing discharge upgrades, appealing access decisions, and navigating the complexities associated with different discharge characterizations.

Community Counseling Center | Ashtabula, OH

Community Counseling Center of Ashtabula, Ohio, ensures its staff are trained in military and Veteran experiences through various resources. One staff member has completed three tiers of STAR training, and the organization maintains ongoing access to the training program which introduces participants the military experience and focuses on military structure, values, beliefs and other factors that may affect clinical work with military-connected clients. This training is always available, allowing staff to continually enhance their understanding and competency in serving the SMVF community.

Staff are also familiar with managing barriers to care, such as eligibility for VA services and characterizations of discharge that may limit access to some services. This knowledge helps them navigate and address the unique challenges that Veterans and their families face.

Berks Counseling Center | Reading, PA

Berks Counseling Center ensures that all staff receive specific training on military and Veteran experiences. Within 1 year of hire, all staff complete military-focused provider training through the Center for Deployment Psychology. This foundational training helps staff understand key aspects of military experiences.

Additionally, staff members identified to work directly with Veterans in counseling receive further training from VA. This additional training equips them with the skills and knowledge needed to effectively support Veteran clients.

Staff at Berks Counseling Center are also familiar with managing barriers to care, such as VA eligibility and characterizations of discharge that may limit service access. This expertise ensures that Veterans receive needed support despite potential challenges.

Family Service of Rhode Island | Providence, RI

Family Service of Rhode Island (FSRI) ensures that all staff receive specific training on military and Veteran experiences. Upon hire, all employees are required to complete Relias training focused on understanding military experiences. Additionally, military case managers attend federally hosted trainings, keeping them current on relevant issues.

Military case managers at FSRI are well-versed in managing barriers to care, such as VA eligibility characterizations of discharge that may limit access to some services. Through Fox Grant implementation training, VA trainings, and their military experiences, they are well-equipped to support Veterans and their families.

High Plains Mental Health Center | Hays, KS

High Plains Mental Health Center ensures its staff are well-versed in military and Veteran experiences through the Veteran Ready Organization Pathway. This series of five trainings covers the general military experience, the experiences of military families and caregivers, and the unique experiences of women who serve. These trainings are available through Relias, providing ongoing access to essential knowledge and skills.

The staff are also familiar with managing barriers to care, such as VA eligibility and characterizations of discharge that may limit access to some services. They frequently coordinate with the local VA and are sensitive to potential treatment barriers, ensuring that Veterans receive the support they need.

Valley HealthCare System | Morgantown, WV

Valley HealthCare System has implemented a comprehensive Veterans Program, staffed by Veterans who engage in annual training webinars and in-person seminars. These trainings focus on mental health, suicide prevention, social awareness, reintegration into civilian life, and other aspects of military and Veteran experiences. All employees are required to complete training on military experiences and the behavioral health needs of Veterans, ensuring a well-rounded understanding across the organization.

Training is facilitated through the Veteran Coalition established by the Veterans Program, with monthly meetings featuring presenters from organizations across the state. VA provides an annual S.A.V.E. training during the July meeting. Valley HealthCare System partners with organizations such as the VFW, American Legion, National Guard, Veterans Upward Bound, and the Marine Corps League to provide additional training and information. Internally, all employees are required to take Veteran and military Relias trainings.

Staff at Valley HealthCare System are familiar with managing barriers to care, such as VA eligibility and characterizations of discharge that may limit access to some services. Importantly, discharge status does not affect whether an individual can receive services at Valley HealthCare System, ensuring all Veterans in need are supported.

Community Fairbanks Behavioral Health | Indianapolis, IN

Community Fairbanks Behavioral Health trains staff on military and veteran experiences through Relias courses, VA partnerships, and program-specific presentations. Trainings cover military structure, terminology, behavioral health stigma, Veteran services, referral processes, and the COMPACT Act. The Veteran Care Coordinator (VCC) collaborates with the training department to meet various educational requirements. Each year, the VCC coordinates with the VA Compact Office to provide SAVE Training. This office manages emergency intervention services while the training itself teaches staff how to recognize and respond to suicide risks.

The VCC stays current by attending trainings, webinars, and conferences, and by reviewing new research. Regular meetings with VA partners ensure updates on client care are shared with leadership and staff. The VCC also serves as a resource, responding to staff, client, and partner questions as needed. Staff screen for military-related needs during intake and review these regularly in treatment planning. Person-Centered Treatment Plans and assessments help ensure that behavioral health, medical, and community needs for SMVF are met.

Ideas for Action

PROVIDE MILITARY EXPERIENCE TRAINING:

Ensure all staff and volunteers complete training on military and Veteran lifestyle, including the unique experiences and values of SMVF.

ENHANCE VISUAL REPRESENTATION:

Display military branch flags, emblems, and images of Veterans throughout the clinic to create a welcoming environment for SMVF clients.

DEVELOP TRUST-BUILDING PROTOCOLS:

Train staff on privacy policies and effective communication strategies to build trust with SMVF clients, emphasizing confidentiality and the importance of understanding past experiences in seeking care.

FACILITATE PEER SUPPORT:

Establish peer support programs that connect Veterans with other Veterans, fostering empowerment and self-determination through shared experiences and mutual support.

COLLABORATE WITH VETERAN ORGANIZATIONS:

Partner with local and national Veteran-serving organizations to provide comprehensive support for SMVF clients, including referrals to specialized services and community-based support groups.

Resources

PsychArmor

PsychArmor provides over 250 educational products focused on the military experience for health care providers, Veterans, employers, military family members, and caregivers. Their mission is to transform national engagement with the military and veteran community through education and training.

Worried About a Veteran Website

The Worried About a Veteran website provides resources and guidance for supporting Veterans at risk of suicide. It offers practical steps for making homes safer, recognizing warning signs, and starting conversations about mental health and firearm safety.

Working Effectively With Military Families: 10 Key Concepts All Providers Should Know

This resource from the National Child Traumatic Stress Network outlines 19 key considerations when working with military families, including family separation, stigma about mental health care, access to programs, and involving peers and civilian providers.

VA's Training for Community Providers

This PDF provides healthcare professionals with core competencies for understanding SMVF. It covers military ethos, organization, stressors, and treatment tools to improve clinical practices and therapeutic alliances with military patients.

Exemplary Practices for Counseling Military Populations

The document provides counselors with foundational principles and practices for working with military-connected clients. It serves as a guide for clinical and ethical decision-making, training, and supervision to enhance counseling services for military populations.

Nevada Military Care Pocket Card

This Nevada Veterans Service Officers pocket card includes questions for assessing suicide risk among Veterans. It also provides contact information for VA health care systems in Nevada and offers guidance for connecting Veterans and their families to benefits and support services.

Utah Military Playbook

This *Live On Utah Military Playbook* provides tailored strategies to prevent suicide among service members and Veterans. It offers practical tips, training, and resources to help individuals recognize warning signs and support those at risk.

VA's Veterans Experience Office

The Veterans Experience Office (VEO) at VA focuses on improving the overall experience for Veterans, their families, caregivers, and survivors. By utilizing customer experience data, advanced tools, and innovative technology, VEO aims to streamline and enhance service delivery.

Community Toolkit for Safe Firearm Storage

This Community Toolkit for Safe Firearm Storage from VA emphasizes safe firearm storage as a crucial suicide prevention measure. It provides best practices and guidelines for securing firearms to reduce risk among Veterans and their families.

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MODULE 3

KEY PARTNERSHIPS FOR SMVF SUPPORT

Overview

Effective partnerships are crucial for Certified Community Behavioral Health Clinics (CCBHCs) to provide comprehensive and coordinated care for service members, Veterans, and their families (SMVF). By collaborating with various organizations, including the U.S. Department of Veterans Affairs (VA), the Department of War (DOW), and community organizations such as Veteran Service Organizations (VSOs) and Veteran-serving nonprofits, CCBHCs can enhance their ability to address the specific needs of SMVF clients and ensure seamless access to essential services. This directly supports Criteria 3.A (General Care Coordination Requirements) because it highlights the importance of interagency collaboration to ensure seamless and holistic care delivery for SMVF populations.

This section outlines strategies for establishing and maintaining strong partnerships, highlighting the importance of formal agreements, community engagement, and mutual support. By leveraging these collaborative efforts, CCBHCs can create a robust network that supports SMVF clients and fosters their well-being.

Fact Sheet: Key Partnerships for Service Members, Veterans, and their Families Support

Overview

The Department of Veterans Affairs

- The U.S. Department of Veterans Affairs (VA) offers a wide range of services through its three branches—VHA, VBA, and the National Cemetery Administration—making it a vital partner for CCBHCs serving SMVF.
- By building formal and informal partnerships with local VA offices, joining the Community Care Network, and referring clients to VA enrollment offices or Veteran Service Officers, CCBHCs can enhance access, coordination, and informed care.

The Department of War

- The U.S. Department of War (DOW) oversees all branches of the military and plays a vital role in supporting SMVF through health care, benefits, and community partnerships.
- CCBHCs can enhance care by collaborating with DOW programs like TRICARE and Military OneSource, especially when serving National Guard, Reserve, or active-duty families.
- These partnerships support coordinated, experientially informed care across multiple CCBHC criteria.

Veteran Serving Organizations

- CCBHCs can strengthen SMVF care by partnering with vetted Veteran-serving organizations, nonprofits, and state agencies.
- Collaborations with networks like Cohen Veterans Network and Headstrong Project offer no-cost behavioral health services, while local VSOs provide housing, employment, and benefits support.
- These partnerships enhance care coordination, experiential competence, and access to holistic, community-based resources.

Insights from Experts

CCBHCs can strengthen SMVF care by leveraging VA programs and building collaborative partnerships. For example, One CCBHC expert highlights the VA's Military2VA (M2VA) teams, which help newly discharged Veterans and their families navigate health care. Designated office hours at VA facilities allow programs like Supportive Services for Veteran Families (SSVF) grants to engage Veterans directly and connect them to wraparound services.

Formal agreements like MOUs ensure continuity despite staff turnover. Experts note that reciprocal shadowing between CCBHC and Veteran organizations enhances mutual understanding and referral processes. Other strategies include embedding clinicians in trusted organizations and promoting state-level leadership to foster successful partnerships. These strategies promote consistent, coordinated, and responsive care.

Fact Sheet: Key Partnerships for Service Members, Veterans, and their Families Support

Notes from the Field

CCBHCs across the country are building strong, innovative partnerships to better serve SMVF. For example, VOAMASS collaborates with all three VA facilities in Greater Boston and hosts office hours with HUD-VASH teams, while also engaging in community outreach through events and podcasts. Community Counseling Center in Ohio has formal MOUs with its VA Medical Center and participates in the VA's Community Care Network, enhancing service access.

Berks Counseling Center and Family Service of Rhode Island maintain strong ties with local Veterans Affairs offices and National Guard units, participating in events and initiatives like the Governor's Challenge. High Plains Mental Health Center formalized its VA partnership with an MOU and works closely with the Kansas National Guard. Valley HealthCare System in West Virginia leads a 150-member Veteran Coalition and partners with organizations like Wounded Warrior Project and Military OneSource, demonstrating how local collaboration and community engagement can significantly expand support for SMVF.

Ideas for Action

- **Establish formal agreements:** Develop MOUs or MOAs with local VA facilities to ensure clear roles and responsibilities and enhanced coordination of care for SMVF clients.
- **Join community care networks:** Become a member of VA's CCN, TRICARE, and Military OneSource to provide timely, high-quality care and facilitate smooth transitions for Veterans needing specialized treatment.
- **Facilitate staff engagement events:** Attend open houses; community events; and mutual meet-and-greet opportunities with local VA, DOW, and VSO personnel to foster relationships, enhance collaboration, and improve coordination of care for SMVF clients.
- **Engage with local Veteran organizations:** Partner with local VSOs and nonprofits to offer comprehensive wraparound services, bidirectional referrals, and collaborative community events.
- **Participate in community collaboratives:** Actively engage in community Veteran engagement boards, local coalitions, and advisory groups to strengthen partnerships, share best practices, and improve access to resources for SMVF clients.

Resources

- VA Community Care Network Information for Partners
- TRICARE Network Providers
- Department of Veterans Affairs Community Veterans Engagement Boards (CVEBs)
- VA/Substance Abuse and Mental Health Services Administration Governor's Challenge to Prevent Suicide Among SMVF Teams
- VetResources Community Network
- Veteran Experience Office (VEO) Community Partnerships
- National Resource Directory
- America Serves Coalition Locations
- Got Your 6 Network
- VA Online Location Directory

Key Partnerships for SMVF Support

Partnering With VA

VA is the federal agency dedicated to providing lifelong health care and benefits to eligible Veterans and their families. With medical centers and outpatient clinics nationwide, VA offers comprehensive health care to eligible Veterans and a variety of benefits, including disability compensation, vocational rehabilitation, education assistance, home loans, and burial benefits. Partnerships between CCBHCs and VA are crucial for serving SMVF clients effectively. This directly aligns with Criteria 4.K (Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans), which provides important context for the collaboration between CCBHCs and the VA, and it also supports Criteria 3.C (Care Coordination Partnerships) by highlighting the value of intentional partnerships with federal agencies to enhance access and outcomes for the SMVF population. These collaborations expand access to care that is responsive to military experience, ensuring Veterans receive the support they need in their communities. By working together, CCBHCs and VA can enhance treatment outcomes, reduce crisis periods, and improve overall well-being for Veterans and their families.

VA has three branches: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA). Understanding these three VA branches and how SMVF may engage and interact with them can benefit CCBHC staff.

- **Veterans Health Administration (VHA)** is the largest integrated health care system in the United States, with more than 170 medical centers and nearly 1,200 community-based outpatient clinics (CBOCs). It provides care to more than 9 million Veterans nationwide.
- **Veterans Benefits Administration (VBA)** is the branch of the VA responsible for providing benefits to SMVF. Regional offices and VBA staff are spread out across the country and provide expertise on what benefits are available and how to apply for them. VBA is also responsible for processing benefit applications.
- **National Cemetery Administration** manages national cemeteries across the country. These cemeteries are meant to honor the life and legacy of those who are serving or have served in the military as well as their families. More information about burial benefits can be found by contacting the nearest national cemetery: Find a Cemetery—National Cemetery Administration.

Because of their military service, Veterans can access VA federal health care in addition to community care, private insurance, and other forms of health care. CCBHCs should refer Veterans to either the enrollment and eligibility office at their nearest VA Medical Center or to their county or local VSO, who can meet and help the CCBHC's clients determine eligibility for VA care and all VA benefits. The VA also provides financial support and benefits to caregivers who apply and are eligible through its Program of Comprehensive Assistance for Family Caregivers: VA Caregiver Support Program.

Additional benefits and services available from the VHA and VBA include housing resources, educational benefits, financial benefits, resources for substance use disorder treatment and serious mental illness support, and resources for SMVF who may be involved with the criminal legal system.

Key Personnel and Organizations

When exploring partnerships with the local VA office, there are key personnel or organizations that specifically focus on mental health and wellness and are good collaborative partners for CCBHCs. Engaging these partners supports Criteria 4.C (Crisis Behavioral Health Services) and Criteria 2.C (24/7 Crisis Services) by emphasizing collaboration with VA personnel dedicated to suicide prevention and crisis response, while also supporting Criteria 4.E (Person-Centered Treatment Planning) through individualized care planning and workforce development in recovery-oriented, SMVF-informed practices. These key partners include the following:

Suicide prevention program manager and coordinators: The suicide prevention program manager within VA provides leadership and oversight for the development and implementation of suicide prevention initiatives. This role ensures alignment with national policies while tailoring programs to meet the needs of local Veteran populations. By coordinating clinical and community-based efforts, the program manager enhances access to care, monitors Veterans at risk for suicide, and drives evidence-based practices to reduce suicide rates and improve overall mental health outcomes.

Suicide prevention coordinators: Suicide prevention coordinators work with the suicide prevention program managers and coordinators to manage outreach and case management for Veterans at high risk for suicide. They work closely with both the VA and community partners to enhance crisis intervention and safety planning.

Local recovery coordinator: The local recovery coordinator within VA promotes recovery-oriented care for Veterans with serious mental health conditions. This role provides clinical expertise, program development, and staff education to ensure services are person-centered and focused on long-term wellness and independence. By advocating for recovery principles and collaborating across VA and community systems, the local recovery coordinator helps shape policies and practices that assist Veterans to achieve meaningful, self-directed lives.

Vet centers: Vet centers provide community-based counseling and support services to combat Veterans, service members, and their families. Focused on readjustment and mental health, vet centers offer confidential care, including individual and group therapy, marital and family counseling, and trauma-focused services. Operating outside traditional VA medical centers, these centers reduce barriers to mental health care and promote long-term well-being.

VA community engagement and partnerships coordinator (CEPC): CEPCs play a critical role in advancing suicide prevention efforts. This position fosters collaboration between VA and community-based organizations and supports effective coalition building and community-driven public health strategy implementation.

CEPCs employ defined priority areas to help state and local community coalitions adapt evidence-informed approaches aimed toward ending Veteran suicide. CEPCs also develop and implement public health strategies within local communities that align with VA, DOW, and Centers for Disease Control and Prevention guidelines for effective suicide prevention. Further, CEPCs help bridge gaps in care, ensuring Veterans have access to timely, comprehensive mental health and crisis resources beyond the VA system.

Veterans mental health council (VMHC): The VMHC is a Veteran-led advisory group that collaborates with VA to enhance mental health services. Acting as a bridge between Veterans

and VA leadership, the council provides valuable insights on the needs and experiences of those receiving care. By promoting Veteran-centered policies and recovery-oriented practices, the VMHC helps shape programs that foster empowerment, engagement, and improved mental health outcomes. Not all VA facilities have a VMHC; therefore, when staff are engaging the local VA mental health services office, they should inquire if the VA facility has a VMHC.

Support for Native and Tribal Veterans: VA partners with Tribal governments to designate Tribal Veteran Representatives (TVRs), who serve as trusted cultural liaisons and advocates, guiding Native Veterans through VA benefits and services. To strengthen these efforts, the VA Office of Tribal Government Relations (OTGR) fosters collaboration with Tribal nations by providing outreach, education, and technical assistance that ensures Veterans understand and access available resources.

In addition to VA efforts to support Native and Tribal Veterans, VA and the Indian Health Service (IHS) maintain a longstanding memorandum of understanding (MOU). This agreement promotes collaboration in key areas such as sharing health information, coordinating treatment plans, and resource sharing between VA and IHS facilities to improve access and reduce service duplication. Additionally, VA reimburses IHS and Tribal Health Programs for care provided to eligible Veterans, supporting financial sustainability for Tribal health systems.

CCBHCs can strengthen care for Native and Tribal Veterans by partnering with both VA and IHS. Through care coordination agreements, CCBHCs can align with VA and IHS efforts to share health information, integrate responsive practices, and support treatment planning. Leveraging telehealth and mobile services in collaboration with these agencies expands access in rural and Tribal communities while honoring traditions and incorporating traditional healing practices into a holistic care model that honors Tribal sovereignty.

VA Faith-Based Program Support: VA collaborates with faith-based and community organizations through its Center for Faith. This program educates faith leaders on VA benefits, mental health resources, and suicide prevention, enabling them to assist Veterans in accessing care. VA also partners with faith groups to provide outreach in underserved communities, promote spiritually sensitive care, and connect Veterans to both VA services and local support networks.

CCBHCs can act as a bridge between local faith-based organizations and the VA's Center for Faith. By fostering collaboration, CCBHCs help faith leaders connect with VA resources and integrate spiritual supports into care coordination. This role strengthens community networks and ensures SMVF clients receive holistic, spiritually responsive care.

Opportunities for Partnership and Collaboration

Some CCBHCs may already be closely and consistently collaborating with elements of VA. If a CCBHC is also a Supportive Services for Veteran Families (SSVF) provider, its staff likely work closely with homelessness prevention specialists within VA. If staff members from a CCBHC are involved in a local Veteran Treatment Court, those who are supporting those initiatives are likely engaged with local Veteran Justice Outreach staff from VA.

When exploring VA partnerships, there are a range of options for CCBHCs to consider. Effective formal partnerships include establishing MOUs/memorandums of agreement (MOAs) or becoming part of the VA's Community Care Network. Informal partnerships can be created through a simple connection between clinical colleagues, membership or attendance at the

same care meetings, or even extending an invitation to local VA staff to attend an open house of the CCBHC, or conversely, a request for the CCBHC staff to visit local VA facilities. Whether there is a formal partnership or not, informal activities offer opportunities for collaboration and engagement, including professional connections between VA and CCBHC staff. This relates to Criteria 6.B (Governance) by reinforcing the value of organizational relationships and responsiveness to partner needs beyond formal mechanisms.

Memorandums of Understanding/Agreement

MOUs/MOAs create formal partnerships that outline clear mutual benefits for each agency and require both legal and administrative review and signatures. While these memorandums are not necessary to provide or receive referrals, some CCBHCs have found that this type of formal partnership ensures a lasting connection between the two organizations and the leadership's familiarity with both organizations. Further, MOUs/MOAs allow providers to share relevant and timely protected health information (PHI) while protecting their clients' rights to privacy. MOUs/MOAs can also support Criteria 6.A (Organizational Authority and Finances) because they support structured administrative frameworks for sustainable care partnerships. It is important to note that not all VA medical facilities are able to enter into formal agreements with CCBHCs, and partnership policies vary between medical centers.

MOUs/MOAs between the VA and CCBHCs can be highly beneficial for several reasons:

- **Establish clear roles and responsibilities:** MOUs/MOAs outline specific roles and responsibilities for each party, ensuring clarity and reducing misunderstandings.
- **Enhance coordination:** MOUs/MOAs facilitate effective coordination of care and services, improving the overall efficiency and effectiveness of support provided to SMVF clients.
- **Facilitate resource sharing:** MOUs/MOAs enable the sharing of resources, such as training materials and best practices, enhancing the quality of care.
- **Improve communication:** Establishing formal agreements fosters regular communication channels, ensuring that both organizations are aligned in their goals and strategies.
- **Ensure accountability:** MOUs/MOAs include mechanisms for reporting and documentation, which helps with tracking progress and ensuring accountability.

To explore the establishment of this type of formal partnership with the local VA health care entity, it is recommended that staff connect with the key personnel mentioned in the previous section. To support the development of MOUs/MOAs, examples of documents used by various CCBHCs are included in the appendix to this module.

Community Care Network

VA's Community Care Network (CCN) is meant to ensure that Veterans have access to timely, high-quality care within their community. This is VA's preferred network of community providers where eligible Veterans can receive their care. Contractors divide the network of providers by region and manage it through Optum Serve or TriWest Healthcare Alliance. A national map where CCBHCs can locate providers in their corresponding region is available at Community Care Network—Information for Providers—Community Care. Contact information varies based on the provider's state and associated region.

Through the CCN, SMVF may access expanded and specialized behavioral health care options. Veterans can get an explanation about possible

treatment options, including options outside of a VA Medical Center, by calling the CCN phone numbers themselves, or CCBHCs could assist their clients with those calls. This aligns with Criteria 2.B (Timely Access to Services) because it ensures Veterans have help navigating urgent care options in both crisis and noncrisis situations. Emergency suicide crisis care is also covered under the COMPACT Act, under which eligible Veterans in a suicidal crisis have their emergency room visit and subsequent hospitalization, as well as associated follow-up, covered.

It is recommended that CCBHCs know who the CCN providers in their area are and, if possible, consider joining the CCN. A formal partnership with local VA health care facilities may be unnecessary if a CCBHC is already a member of the CCN because membership goes beyond the requirements for a care coordination agreement.

Transition Support Resources

Each year more than 200,000 people are transitioning out of the military and into civilian life. It is important for clinics to understand these transitions and what resources are available to support the transition. Employment, financial, childcare, and behavioral health resources are vital to share with service members preparing to leave the military, as well as those within the first 12 to 18 months after transitioning to civilian life. This supports Criteria 4.I (Psychiatric Rehabilitation Services) because transition resources play a crucial role in stabilizing individuals during reintegration and improving long-term recovery outcomes. VA provides several transition resources. VSOs, including state and county-level VAs, can provide additional support. CCBHCs should ensure that resources are properly vetted before sharing them with SMVF clients. In addition, CCBHCs can refer to the resources highlighted in this toolkit.

Some transition support resources include the following:

- **VA Transition Assistance Program (TAP)** provides information, resources, and tools to help prepare for the transition process. SMVF can learn about TAP either through a 1-day, in-person course or through an online course.
- **VA transition events** provide a list of VA-related events taking place across the country. Events include benefits fairs; claims clinics; hiring fairs; and workshops on housing assistance, employment strategies, financial literacy, and access to VA benefits. Upcoming events are available online as well as printable reference guides.
- **VA Solid Start** program places three outreach calls from qualified representatives to Veterans who have recently transitioned out of the military. This program is meant to inform Veterans on what to expect with their transition and can also offer information on accessing VA benefits and health care.
- **Warriors to Workforce Program** is a training and development program that helps Veterans transition into federal government careers by applying their military skills and experiences to the federal workforce.
- **Warrior Training Advancement Course** is open to transitioning service members who have 180 days or fewer left in service and allows them to complete a national-level VBA training program so they can access long-term, high-quality career opportunities in the federal government after their transition.

Partnering With the U.S. Department of War

The DOW is the federal agency responsible for coordinating and supervising the U.S. armed forces, including the Army, Navy, Marines, Air Force, Space Force, and Coast Guard. The DOW also oversees the Army National Guard and Air National Guard, which serve both federal and state missions. Additionally, each branch has its own reserve components: Army Reserve, Navy Reserve, Marine Corps Reserve, Air Force Reserve, and Coast Guard Reserve. These reserve forces provide trained units and personnel ready for active duty in times of war or national emergency. Partnerships between CCBHCs and the DOW are necessary to serve SMVF clients effectively because they enhance access to particular care and resources, ensuring comprehensive support for service members and their families.

If a CCBHC has a military installation within its service area, it is likely that active-duty family members are within the client population. If a clinic provides specialized services, such as Intensive Outpatient Programs, Partial Hospitalization Programs, or inpatient services, clients could possibly include active-duty service members. Otherwise, clients connected to the DOW are probably serving in the National Guard or a reserve component of the different branches.

Each of the different duty statuses has different eligibility for health care. When partnering with different parts of the DOW, it is necessary for CCBHCs to identify which component of the military branch they will be engaging with.

Differences in Duty Status Within the DOW

Active-duty military service refers to full-time service members who are permanently assigned to their respective branches and serve under Title 10 of the U.S. Code. These personnel are fully funded and controlled by the federal government and are always available for immediate deployment or assignment. Active-duty members undergo continuous training, readiness activities, and operational assignments, ensuring they are always prepared for global missions. They receive full benefits, including pay, health care, and retirement, and are stationed at bases or deployed based on mission needs. They receive care through their military branch treatment facilities, and their families receive care through TRICARE. Additionally, care can be coordinated for the service member through their military branch treatment facility via TRICARE authorizations and referrals.

The **National Guard's Active Guard Reserve (AGR) and Active-Duty Operational Support (ADOS)** programs provide full-time support through both state and federal authorities. **Title 32 Active Guard Reserve** (T32 AGR) personnel serve under their state governor's command but are federally funded and regulated, maintaining a federal-state status. Similarly, **Title 32 Active-Duty Operational Support** (T32 ADOS) members serve temporarily under state command for specific missions like training, operational readiness, or disaster response, receiving active-duty pay and benefits without long-term commitments. While **Title 10 Active Guard Reserve** (T10 AGR) personnel serve on full-time active duty under federal jurisdiction, they are fully controlled and funded by the federal government.

Title 10 **One Time Occasional Tour** (T10 OTOT) offers short-term federal assignments, typically tied to specific missions or projects, with no guarantee of follow-on assignments. These roles may involve domestic or international deployments, providing crucial support for mission-specific needs. Together, these programs enhance the National Guard's readiness and operational capacity. National Guard service members under these designations are TRICARE beneficiaries, meaning they have access to a

provider on a military installation or can see a community provider that accepts TRICARE.

Mobilization Day (M-Day) Soldiers in the National Guard are part-time service members who typically drill 1 weekend a month and 2 weeks a year, maintaining readiness for active duty when needed. Most serve under Title 32 status, operating under state governor command with federal funding, while **State Active Duty (SAD)** places them under state control and funding for missions such as disaster response.

Unit Training Assemblies (UTAs) are scheduled training periods that ensure units remain prepared for mobilization and mission readiness. M-Day service members are only covered under TRICARE during their UTA (drill time) and travel directly to and from the training. SAD service members are state employees and are covered by state health insurance; injuries incurred during this type of duty are not eligible for VA disability claims.

The **Reserve's Active Guard Reserve (AGR)** members serve full-time under Title 10 of the U.S. Code, federally funded and controlled, providing year-round support for training, administration, and operational readiness. The **Reserve's ADOS** offers temporary, full-time active duty for short-term missions such as training, exercises, or operational support, addressing immediate needs without requiring long-term commitments.

Part-time service is the foundation of the Reserve force, with each branch having a designation for these members. In the Army Reserve, these are **Troop Program Units**; in the Air Force Reserve, **Traditional Reservists**; and in the Navy Reserve, **Selected Reservists**. These service members typically drill 1 weekend a month and 2 weeks a year, participating in **UTAs** or similar training periods to maintain readiness for mobilization and operational demands.

Key Personnel and Programs

Establishing individual partnerships with those who support mental health and wellness in SMVF can help CCBHCs receive or provide referrals for a service or family member who qualifies. Below are some of those key individuals CCBHCs can connect with, including potential contacts for active-duty, National Guard, or Reserve Component service members. Engaging with these key partners aligns with multiple CCBHC criteria by illustrating how DOW roles contribute to coordinated care: supporting Criteria 4.C (Crisis Behavioral Health Services) through suicide prevention efforts; Criteria 4.F (Outpatient Mental Health and Substance Use Services) by offering family-inclusive, community-based care; Criteria 3.D (Care Treatment Team and Planning) via direct client support and personalized care planning; Criteria 3.C (Care Coordination Partnerships) and Criteria 4.G (Primary Care Screening and Monitoring) through collaborative preventive education and integrated care approaches; and Criteria 3.B (Health Information Systems) by demonstrating the importance of secure, coordinated connections between military and civilian systems.

Active-Duty Military

- **Installation/base suicide prevention coordinator or violence prevention specialist:** Most installations have a designated person responsible for overseeing and implementing suicide prevention and violence reduction programs at military installations. This position works closely with service members, leadership, and community partners to develop and deliver training, awareness campaigns, and support resources. By identifying risk factors, providing intervention strategies, and promoting resilience, the coordinator or specialist helps create a safe environment and ensures that service members have access to timely, comprehensive mental health support.

- **Substance abuse treatment programs:** Military substance abuse treatment programs focus on prevention, education, and rehabilitation to maintain readiness and support service members' well-being. The Army Substance Abuse Program, Navy's Substance Abuse Rehabilitation Program, Air Force Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program, and Marine Corps Substance Abuse Program provide assessment, counseling, and treatment, emphasizing early intervention and recovery. These programs collaborate with command leadership and behavioral health providers to ensure effective support and mission readiness.
- **Military hospitals and behavioral health clinics:** Active-duty military installations in a CCBHC's service area have hospitals, clinics, and facilities that provide mental health services, including integrated mental health services with primary care clinics. Staff can locate treatment facilities in the area by searching the Military Treatment Facility location database.
- **Military family life counselors** offer confidential counseling services to both active Reserve members and their families, focusing on mental health, stress management, and coping strategies. They also provide educational workshops on suicide prevention and overall well-being.

National Guard

- **Public affairs officers (PAOs)** can help connect community organizations with the appropriate program or individual within the Army or Air National Guard. PAOs do not work specifically in the mental health field but have a wide network of connections and typically work directly for the Office of the Adjutant General. PAO contact information is publicly available.
- **Resilience, risk reduction, and suicide prevention specialists (R3SPs)** are responsible for the training and education of service members regarding suicide prevention, intervention, and postvention, and substance abuse prevention. R3SPs work in conjunction with behavioral health staff to promote organization and community resources and connect service members with those resources. This is not a clinical role.
- **Director of psychological health (DPH)** is instrumental in the care and welfare of National Guard service members. This is a clinical role that provides assessment and referrals, advocacy, intervention, case management, and recommendations for policy development. The DPH typically has a limited support staff of clinicians, but this varies by state or territory.
- **Integrated primary prevention (IPP)** staff are responsible for the research, analysis, and development of training, education, and promotional materials for the Army and Air National Guard's Primary Prevention Program. IPP covers domestic violence, interpersonal violence, nonsuicidal self-inflicted injury, suicide prevention, substance abuse, and sexual assault and harassment.

Reserve Components

- **Psychological health programs:** Each branch of the U.S. military has dedicated psychological health programs for their reserve components, including the Army Reserve Psychological Health Program, Navy and Marine Corps Reserve Psychological Health Outreach Programs, Air Force Reserve Psychological Health Program, and Coast Guard Reserve Behavioral Health Program. These programs enhance mission readiness by offering confidential counseling, crisis intervention, and referrals to community-based mental health services. Through outreach, education, and collaboration with military and civilian providers, these programs help reduce

stigma, promote resilience, and ensure service members receive timely, effective care for mental health and well-being.

- **Unit behavioral health providers** are mental health professionals, often embedded within Reserve units, who provide direct behavioral health care and support to soldiers. They collaborate with leaders and provide community resources to promote mental well-being, identify those at risk, and offer counseling and intervention services.
- **Chaplain:** Reserve chaplains provide spiritual guidance and mental health support to service members and their families. They are often the first point of contact for soldiers seeking help, offering confidential counseling and crisis intervention and connecting individuals to appropriate behavioral health and suicide prevention resources.

Opportunities for Partnership and Collaboration

Unlike partnerships with VA, partnerships with DOW are more likely to be restrictive. The DOW's health care system, the Defense Health Agency (DHA), is a joint, integrated health-care agency that enables the U.S. Army, Navy, and Air Force medical services to provide a medically ready force in both peace and wartime. The primary clients for DOW medical facilities are service members, retirees, and their families. The DHA manages military hospitals and clinics worldwide; oversees the TRICARE health plan; and supports various medical capabilities, including pharmacy services, health information technology, medical logistics, and public health. The two primary opportunities for partnership with the DOW are by becoming a TRICARE service provider and being familiar with, and possibly a provider for, Military OneSource.

TRICARE

TRICARE is a health care coverage plan for service members, retirees, and their families around the world and includes medical, dental, and pharmacy services. TRICARE is available to active-duty service members, National Guard and Reserve members, retirees, their families, survivors, and certain former spouses. This connects with Criteria 2.A (General Access Requirements) by highlighting access to a federally funded system of care that CCBHCs must integrate and navigate for service delivery.

TRICARE offers several plans to meet different needs, including TRICARE Prime, TRICARE Select, TRICARE For Life, TRICARE Reserve Select, and TRICARE Retired Reserve. TRICARE covers a wide range of services, such as preventive care, emergency care, mental health services, prescription medications, and more. TRICARE is divided into two regions in the United States—TRICARE East and TRICARE West. Each region is managed by a different contractor with their own networks—Humana Military in the east region and TriWest Healthcare Alliance in the west region. CCBHCs that become TRICARE network facilities can serve beneficiaries enrolled in all TRICARE plans as well as those not enrolled through the TRICARE Select option.

Learn more about the different TRICARE plans and eligibility on the TRICARE website.

Military OneSource

Military OneSource offers free resources to SMVF, including confidential counseling; financial and legal advice; relocation assistance; and information about installations, program benefits, and contacts. Partnering with Military OneSource can significantly enhance the support, services, and resources CCBHCs provide to SMVF clients.

Additionally, CCBHCs can become a Military OneSource provider and receive referrals to provide behavioral health services and

other resources. This supports Criteria 3.A (General Care Coordination Requirements) by showing the value of joining established referral networks to support SMVF care. To participate in Military OneSource, providers are required to complete a training program before joining the network and then annually, in accordance with the Military OneSource contract. The Military OneSource behavioral health provider program is managed by a DOW contractor, and CCBHCs must be credentialed with this contractor to receive referrals. As of this publication, the current contractor is Carelon Behavioral Health, and interested CCBHCs can review the provider handbook.

Partnering With Community Organizations, Veteran Serving Organizations, and Nonprofits

The landscape of Veteran nonprofits can be complicated and confusing because there are thousands of nonprofits across the nation that claim to serve the SMVF population. Additionally, providing referrals for SMVF to receive high-quality care and services without out-of-pocket costs can be a challenge. This section provides information on some well-established and nationally recognized resources and organizations. As CCBHCs establish their own partnership network, they should have a standard protocol for vetting organizations to determine their quality of care or resources. CCBHCs should consider engaging a local community Veteran task force, board, or group to assist with the vetting process. This supports Criteria 6.B (Governance) by promoting SMVF inclusion in decision-making and service quality oversight.

Forming partnerships with VSOs across multiple sectors can position a CCBHC as a trusted and reliable resource with SMVF. Partnership opportunities with these organizations include the following:

- Partnering for bidirectional referrals
- Providing comprehensive, wraparound services when a client has been in crisis
- Networking at in-person events and across social media
- Gaining potential partners to collaborate on applications to fund new projects

Many of these partnerships will be informal, although there may be a time when an MOU or MOA is appropriate.

State and Territory-Level Resources

In addition to VA at the federal level, there are state and territory-funded departments across the country that support Veterans. Separate from VA, these agencies or departments may have different designations and may be aligned differently within their state or territory government. They are commonly managed by appointed staff and are responsible for carrying out services and programming for Veterans. This supports Criteria 3.C (Care Coordination Partnerships) because it reinforces cross-sector collaboration across systems for Veteran care. State and territory-level departments and agencies typically have an appointed director with employees, many of whom are SMVF, and provide key resources to anyone currently living in or planning to reside in their jurisdiction after transitioning out of the military. The National Association of State Directors of Veterans Affairs provides a national map of each department within a state or territory and includes contact information.

Partnering with local organizations or the relevant state department or agency that supports SMVF can provide additional training support and actionable resources for a CCBHC's SMVF clients, including assistance with applying for and appealing

benefits, disability compensation, pensions, and education benefits; employment support; housing assistance; and advocacy and outreach.

Veteran Care Networks

Mental health and wellness for SMVF has always been a priority for communities and organizations that support this population. However, the conflicts in Iraq and Afghanistan, as well as the wider efforts of the Global War on Terror, have resulted in numerous behavioral health-specific care networks managed by national nonprofits. When considering partnerships and referral sources, it might be beneficial to explore whether the organizations listed below have resources in a CCBHC's service area or might be open to partnering with the CCBHC to support SMVF.

- **Wounded Warrior Project's (WWP) Warrior Care Network** is a partnership between WWP and four academic treatment centers: Emory Healthcare Veterans Program (Atlanta, Georgia), Massachusetts General Hospital—Home Base, Veteran and Family Care (Boston, Massachusetts), Rush University Medical Center—Road Home Program (Chicago, Illinois), and UCLA Health—Operation Mend Program (Los Angeles, California). These programs provide onsite intensive outpatient treatment for 2 weeks primarily focused on traumatic brain injury, posttraumatic stress disorder, and major depression, with follow-up recommendations and referrals for long-term care needs. All treatment is provided at no cost to the Veteran.
- **Avalon Action Network** connects Veterans and first responders across the country to a range of retreats and treatment settings to address invisible wounds such as traumatic brain injury, posttraumatic stress disorder, and substance use disorders (SUD).
- **Veterans Wellness Alliance** combines best-in-class treatment providers with peer support organizations to offer SMVF vetted resources that improve social connection and provide behavioral health treatment. This alliance also supports the **CheckIn program**, which allows anyone to submit basic information and be contacted by a trained mental health screener who can provide direct referrals for Veterans who need behavioral health treatment and social connection.
- **Cohen Veterans Network** is a national network of outpatient mental health clinics providing free care to SMVF across 20 states. This network does not charge SMVF for care and typically has strategic partnerships with universities and other VSOs.
- **Headstrong Project** provides SMVF with free evidence-based behavioral health care for people who have posttraumatic stress disorder or have had exposure to trauma. Headstrong Project partners with a national network of providers and connects and pays for SMVF care.

Additional Opportunities for Partnership and Collaboration

In addition to the VSOs and treatment providers already mentioned, there are still many other national and local VSOs that can provide support to SMVF. If a CCBHC is engaging in community outreach, consider contacting the nearest County Veteran Service Officer to find out what community groups or committees are in the area that focus on the health and well-being of SMVF. Find the local county VSO at The National Association of County Veteran Service Officers.

Here are additional recommendations for strategically expanding a CCBHC's network of SMVF-serving partnerships in its community.

National Nonprofits Serving SMVF

- Blue Star Families promotes thriving among military families during and after service. Its reach is international, and it provides direct resources, social connection, and research.
- Organizations establish Community Veteran Engagement Boards across the country to engage community VSOs with VA health care. Consider reaching out to the nearest board in a CCBHC's service area.

Local Nonprofits Serving SMVF

Many organizations that support SMVF in a community are likely to be 501(c)(3) nonprofits. A potential starting point to find a state's nonprofits that serve SMVF is by researching and contacting the state's Secretary of State or other equivalent nonprofit accrediting body. The state's charitable or nonprofit database can also provide insight into whether an organization is active, inactive, or suspended. Other local nonprofits that could become potential partners include congressionally chartered VSOs that have been mentioned in previous modules of this toolkit, such as the Veterans of Foreign Wars or the American Legion.

One advantage of partnering with local organizations is that they are usually familiar with the unique needs of the SMVF in the local area and have the understanding and expertise to meet those needs sufficiently. They may also be able to provide peer services, case management, opportunities for social connection and engagement, and overall holistic wellness services for SMVF.

Local nonprofits are typically connected to one another, either as a part of a local coalition or through professional relationships, and one local partnership could provide a CCBHC with the opportunity to engage with a broader network of support.

Peer Input and Advisory Boards

Another potential opportunity for community partnership and collaboration is to develop advisory groups and boards of local Veterans, similar to the VMHC described earlier in this module. Separate from formal peer support specialists providing services in a CCBHC, these groups could help ensure the CCBHC remains responsive to military experiences and supports SMVF effectively by contributing to continuous quality improvement and responsive service design.

Insights From Experts

VA's Post 9/11 Transition and Case Management is a great asset. There are personnel at VA to establish health care for transitioning service members or those newly discharged—every VA Medical Center has a specialized Post-9/11 Military2VA (M2VA) team ready to welcome individuals as they transition from service member to Veteran. The post-9/11 M2VA team will assist the Veteran, their family, and caregivers in navigating the VA health care system and support them in achieving health and wellness goals. *— Ashley Delehanty, LSCSW, Community Engagement and Partnership Coordinator, VA Eastern Kansas Health Care System Topeka*

It's important for CCBHCs to know that VA Community Care goes far beyond the scope of behavioral health and substance use disorder services. Community Care can be holistic in nature, incorporating multiple factors that have direct and indirect impacts on the health and well-being of SMVF. *— Tim Keesling, Director, Office of Veteran Services Coordination, Texas Health and Human Services*

Another significant advantage of MOUs/MOAs between the CCBHC and local VA medical centers is consistency. When there is turnover at a CCBHC or at the VA, having a formalized agreement ensures that the activities last beyond the period of a professional relationship between staff members. *—Sarah Melecki, Director of System Integration, Texas Health and Human Services*

Establishing office hours at your local VA is a great way to gain presence and provide more resources and services to SMVF. For instance, our Homeless Veterans Reintegration Program/Incarcerated Veterans Transition Program (IVTP) and SSVF programs have designated office hours/days that they are at the local VA for Veterans to walk in and enroll or learn about services. We are able to engage Veterans in Massachusetts Behavioral Health Services as well as our Veteran programs for wraparound services. *—Angela Eberle, MBA, Vice President of Integration & Program Development, Volunteers of America, Massachusetts*

Our CCBHC has established Care Coordination agreements with Veteran organizations that include a reciprocal shadowing experience. Employees from these organizations spend a shift shadowing our Mobile Crisis Outreach Team, and all our employees spend a shift at their organization. For new employees joining our team, the shadowing experience is part of the onboarding process for each agency. This initiative not only fosters a strong collaborative relationship but also provides employees from both organizations with firsthand knowledge of the referral process and the services offered. *—Sarah Strang, LPC, Mobile Crisis Outreach Team and Resiliency Team Director, The Harris Center for Mental Health and IDD*

For both nonprofits and Veteran-serving organizations, the CCBHC could discuss agreements in which they provide an embedded clinician or case manager to provide services onsite at the trusted organization. This model can also be replicated with a crisis counselor for immediate crisis response, outreach, and consultation. *—Kristin Sauerbier, LCSW, Senior Project Associate, Policy Research Associates, Inc.*

In CCBHCs where partnerships were most successful, state leadership and collaboration between the state Department of Mental Health and the state Department of Veterans Services were critical. Staff at the state level were able to make introductions and encourage partnership at the local level. *—Monika Witt, MSW, Senior Project Associate, Policy Research Associates, Inc.*

CCBHCs are well-positioned to connect Service Members and Veterans to a broad network of care and support services. By working with the local Vet Center and VA facility, CCBHCs can also be well-prepared to support Service Members and Veterans as they apply for benefits and services, as well as specific services available. *Kerry Bond, LSCSW, DBT-C, Community Engagement & Partnerships Coordinator, Robert J. Dole VA Medical Center*

At VOAMASS, we also partner closely with the Homeless Veterans Reintegration Program (HVRP) and the Incarcerated Veterans Transition Program (IVTP), programs through the U.S. Department of Labor Veterans Employment and Training Service. HVRP typically supports Veterans experiencing or at risk of homelessness by offering job training, employment services, and case management to help them achieve stable housing and employment. IVTP generally assists incarcerated or recently released Veterans with reentry planning, including access to housing, behavioral health care, and employment support. *—Mindy Miller, LMHC, LADC1, Chief Operating Officer, Volunteers of America of Massachusetts*

At Community Counseling Center, we have leveraged resources from the CCBHC-E National Training and Technical Assistance Center to develop Designated Collaborating Organization Agreements instead of Memorandums of Agreement or Understanding. A DCO Agreement is intended to be more than a care coordination or referral partner, designed to include regular intensive collaboration between CCC and the Erie VA Medical Center. *Joleen V. Sundquist, MA, LPCC-S, Chief Clinical Officer, Community Counseling Center*

Notes From the Field

VOAMASS | Jamaica Plain, MA

Volunteers of America—Massachusetts (VOAMASS) has established strong partnerships with all three VA facilities in Greater Boston. This collaboration began with the opening of their grant-per-diem (GPD) program for Veterans, which led to referrals from VA. As VA recognized the comprehensive services offered by VOAMASS, the partnership expanded to include programs such as HVRP, SSVF, and IVTP. The SSVF and Veterans Affairs Supportive Housing programs work closely together, with the HUD Veterans Affairs Supportive Housing team holding office hours at VOAMASS facilities and vice versa. The key to this successful partnership has been maintaining open communication and VOAMASS demonstrating how its services complement those of the VA.

Currently, VOAMASS is not credentialed with TRICARE or the VA's Community Care Network. However, it does accept referrals from active National Guard members and Veterans, supported by a state-funded program.

VOAMASS collaborates with other Veteran-serving organizations through regular interactions and shared initiatives. Staff members participate in a local podcast that highlights Veteran services and organizations. It also hosts events at its Plymouth Veteran Center and provides office space for other organizations. By working with agencies that share funding sources, it avoids overlap and ensures comprehensive support for Veterans. This collaborative approach enhances outcomes for the Veteran community.

Community Counseling Center | Ashtabula, OH

Community Counseling Center of Ashtabula, Ohio, has established MOUs with its local VA Medical Center. It recommends building and maintaining relationships through ongoing communication and including Veterans on advisory boards to strengthen these partnerships. This approach ensures that the collaboration remains effective and responsive to the needs of Veterans.

The organization is paneled with TRICARE and is part of the VA's Community Care Network, which allows it to provide a broader range of services to Veterans. Partnerships with Veteran-serving organizations in the area are fostered through community collaboratives, trainings, and ongoing communication. These efforts help create a network of support and resources for Veterans, enhancing the overall effectiveness of their services.

Berks Counseling Center | Reading, PA

Berks Counseling Center has developed a strong relationship with Berks County Veterans Affairs, although it has not established MOUs with its local VA Medical Center. This partnership has been built through active participation in community crosswalk meetings and events organized by Berks County Veterans Affairs. Consistent involvement in these activities has been key to developing and maintaining this relationship.

The organization is paneled with TRICARE and is part of the VA's Community Care Network, which allows it to provide a range of services to Veterans. However, it is not currently connected to its state National Guard or providing support to currently serving National Guard members.

Berks Counseling Center partners with Veteran-serving organizations in its area by actively participating in community events centered around Veterans. This consistent engagement has helped strengthen the organization's relationship with Berks County Veterans Affairs and enhance its support network for Veterans.

Family Service of Rhode Island | Providence, RI

Family Service of Rhode Island (FSRI) has established a partnership with its local VA Medical Center through its CCBHC initiative. This collaboration has been instrumental in enhancing its services for Veterans. It recommends leveraging initiatives such as CCBHC to build and strengthen partnerships with VA.

FSRI has clinical staff who are paneled with TRICARE, allowing them to provide services to a broader range of Veterans. The organization is also connected to the state National Guard, with its military outreach specialist actively engaging with National Guard units to inform them about available services. This specialist collaborates with National Guard members who are part of the Governor's Challenge to Prevent Suicide Among SMVF, ensuring comprehensive support.

The organization partners with Veteran-serving organizations in its area by attending the Governor's Challenge meetings on serving SMVF. Its military case manager and outreach specialist participate in various Veteran events across Rhode Island, fostering strong community connections and support networks for Veterans.

High Plains Mental Health Center | Hays, KS

High Plains Mental Health Center established an MOU with the Robert J. Dole VA Medical Center in January 2024. Prior to this, there were some initial challenges in establishing MOUs, and the center found it helpful to engage congressional representatives in the discussion. As a result of the MOU, leadership at its local VA Medical Center is much more knowledgeable about CCBHCs and their collaborative potential.

The organization is paneled with TRICARE and has TRICARE providers, ensuring it can offer services to a broader range of Veterans. It is also connected to the Kansas National Guard, working with the director of psychological health to streamline communication and support for currently serving National Guard members.

High Plains Mental Health Center partners with local Veteran-serving organizations through its Prevention, Education, and Outreach department. This department actively engages with local Veteran organizations to educate and reduce stigma regarding mental health, fostering a supportive community for Veterans.

Valley HealthCare System | Morgantown, WV

Valley HealthCare System has not yet established MOUs with its local VA Medical Center. However, it is working with the VA Community Engagement & Partnership Coordinator to achieve this.

The organization is in the process of being added to the VA's Community Care Network and is also working toward Commission on Accreditation of Rehabilitation Facilities accreditation. This will enable it to receive referrals for its detox and SUD residential programs.

Valley HealthCare System is connected to the state National Guard and provides support through various initiatives, including quarterly retirement briefings, new enlistee briefings, unit presentations, Gold Star Family weekends, and mental health deployment briefings both before and after deployment.

The Veterans Program at Valley HealthCare System has established a Veteran Coalition with over 150 members and around 80 organizations that meet monthly, followed by a Veterans Walk the next day. They have partnerships with numerous Veteran-serving organizations, such as the WWP, VFW, American Legion, ActiVet, Veterans Upward Bound, Disabled American Veterans, American Red Cross, Military OneSource, Stars & Strides, Patriot Guard Riders, National Guard, and VA. These partnerships involve regular meetings, events, and referrals, leveraging the system's extensive network to share information and resources.

Community Fairbanks Behavioral Health | Indianapolis, IN

Community Fairbanks Behavioral Health has established a VA procedure outlining expectations for shared clients, including care coordination, EMR documentation, referrals, and compliance with privacy and CCBHC standards.

The Veteran Care Coordinator (VCC) role was created to strengthen VA partnerships, promote services through brochures, and connect with staff on military-specific needs. The VCC engages in roundtables, stand-downs, and community events to build relationships and improve Veteran care.

The organization is credentialed with TRICARE through the Community Health Network and supports National Guard clients. It also partners with Veteran-serving organizations through initiatives like the Homeless Initiative and Work One, while the VCC expands collaboration through conferences and summits to enhance Veteran support.

Ideas for Action

ESTABLISH FORMAL AGREEMENTS:

Develop MOUs or MOAs with local VA facilities to ensure clear roles and responsibilities and enhanced coordination of care for SMVF clients.

JOIN COMMUNITY CARE NETWORKS:

Become a member of VA's CCN, TRICARE, and Military OneSource to provide timely, high-quality care and facilitate smooth transitions for Veterans needing specialized treatment.

FACILITATE STAFF ENGAGEMENT EVENTS:

Attend open houses; community events; and mutual meet-and-greet opportunities with local VA, DOW, and VSO personnel to foster relationships, enhance collaboration, and improve coordination of care for SMVF clients.

ENGAGE WITH LOCAL VETERAN ORGANIZATIONS:

Partner with local VSOs and nonprofits to offer comprehensive wraparound services, bidirectional referrals, and collaborative community events.

PARTICIPATE IN COMMUNITY COLLABORATIVES:

Actively engage in community Veteran engagement boards, local coalitions, and advisory groups to strengthen partnerships, share best practices, and improve access to resources for SMVF clients.

Resources

VA Community Care Network Information for Partners

The VA Community Care Network connects Veterans with community providers to ensure timely, high-quality care. It uses industry-standard approaches for service administration, prompt payments, and network management, enhancing Veterans' access to care through regional networks.

TRICARE Network Providers

The TRICARE Network Providers page explains how to find and use TRICARE-authorized network providers. It details the benefits of using network providers, such as lower out-of-pocket costs, claims filing, and negotiated rates, ensuring comprehensive care for TRICARE beneficiaries.

Department of Veterans Affairs Community Veterans Engagement Boards (CVEBs)

CVEBs are local collaborations that address Veteran issues by integrating local stakeholders and VA resources. They focus on outreach; community engagement; and leveraging collective impact to improve services for Veterans, their families, caregivers, and survivors.

VA/Substance Abuse and Mental Health Services Administration Governor's Challenge to Prevent Suicide Among SMVF Teams

The Governor's and Mayor's Challenges aim to prevent suicide among SMVF by implementing state and community-wide suicide prevention strategies. The Substance Abuse and Mental Health Services Administration provides technical assistance to support these initiatives.

VetResources Community Network

The VetResources Community Network enhances community engagement for Veterans by connecting local partners, sharing best practices, and improving access to VA services. It aims to build trust; bridge service gaps; and support Veterans, their families, caregivers, and survivors.

Veteran Experience Office (VEO) Community Partnerships

The VEO fosters partnerships to enhance services for Veterans. By collaborating with public and private organizations, the VEO aims to improve access to resources; streamline services; and support Veterans, their families, caregivers, and survivors.

National Resource Directory

The National Resource Directory is a database of validated resources supporting recovery, rehabilitation, and reintegration for SMVF and caregivers. It connects users to national, state, and local services and programs.

America Serves Coalition Locations

AmericaServes is a coordinated network connecting SMVF to local resources. It aims to streamline access to services, reduce service fragmentation, and enhance care coordination across various communities.

Got Your 6 Network

The Got Your 6 Network, part of the Bob Woodruff Foundation, connects local organizations nationwide to support Veterans, service members, and their families. It fosters collaboration, shares resources, and strengthens community-based efforts to improve SMVF well-being.

VA Online Location Directory

The VA Online Location Directory is a national locator that allows users to search by location to find the nearest medical center, urgent care/emergency care, Vet Center, VA Benefits contact, and Community Care providers in the VA Community Care Network.

APPENDIX I: VA/CCBHC MEMORANDUM OF UNDERSTANDING EXAMPLE

Disclaimer: *This appendix and the examples contained herein it are for informational and example purposes only and do not constitute legal advice. Agreements, memoranda of understanding, and other legally binding arrangements should be developed in consultation with qualified legal counsel and designed for an agency's specific operations, legal responsibilities, and other relevant factors.*

The **memorandum of understanding** between VOAMASS and its local Veterans Affairs Medical Center formalizes a long-standing partnership focused on supporting Veterans through housing, employment, and reintegration services. VOAMASS, a provider of Veteran-specific programs across several counties, will collaborate with VA to offer walk-in services, referrals, and shared meeting spaces. Both parties commit to monthly coordination meetings and joint efforts to identify eligible Veterans in need of services, maintaining a shared goal of improving access to permanent housing and support for Veterans at risk of experiencing homelessness.

Volunteers of America MASSACHUSETTS | VOAMASS

Phil Chadwick
Chair

Charles E. Gagnon
Chief Executive Officer

MEMORANDUM OF UNDERSTANDING

BETWEEN
Volunteers of America of Massachusetts, Inc.

AND
Boston VA Healthcare

Volunteers of America Massachusetts (VOAMASS) is the current recipient of the Department of Labor VETS Homeless Veteran Reintegration Program (HVRP), Incarcerated Veteran Transition Program (IVTP), Department of Veteran Affairs, Supportive Services for Veterans and Families (SSVF), and Massachusetts Bay Veteran Center (MBVC). Specializing in workforce, education, rapid rehousing, and transitional housing for male veterans. VOAMASS has successfully run Veteran programs since 2011 and continues to expand veteran services across Middlesex, Essex, Suffolk, Plymouth, and Bristol counties.

The VA Boston Healthcare System provides healthcare services at eight locations, serving Norfolk, Middlesex, and Plymouth counties, ranging from healthcare, social programs and services, specialty care and mental health care.

The VA Boston Healthcare System and Volunteers of America Massachusetts (VOAMASS) have collaborated for over ten years to further improve the availability of services for eligible program participants assisting veterans in securing permanent housing and employment, homelessness prevention and rapid rehousing services to at-risk homeless veterans. The continued partnership will entail;

- VA Boston healthcare will provide access to space within the VA healthcare facility for VOAMASS staff for the purpose of providing walk in services and referrals for services for eligible participants.
- VOAMASS will provide access to space within the Massachusetts Bay Veteran Center (MBVC) grant per diem program for the purpose of HUD VASH caseworkers to meet with the clients in the facility.
- Participate in monthly partnership meetings via Zoom
- VA Boston Healthcare will work alongside VOAMASS to identify and recruit eligible participants in need of eligible services.

The intent to provide the above outlined resources and/or services is hereby affirmed and agreed to by representatives of the applicant and partnering organization. Together, we agree that the services shall be provided for the benefit of the VA Boston Healthcare System and Volunteers of America Massachusetts (VOAMSS)

AGREED TO AND SIGNED this (xx) day of (month), (year)

Signature

_____

Signature

_____

APPENDIX II: VA/CCBHC MEMORANDUM OF UNDERSTANDING EXAMPLE 2

Disclaimer: *This appendix and the examples contained herein it are for informational and example purposes only and do not constitute legal advice. Agreements, memoranda of understanding, and other legally binding arrangements should be developed in consultation with qualified legal counsel and designed for an agency's specific operations, legal responsibilities, and other relevant factors.*

This **memorandum of understanding** was developed in partnership with VA Medical Centers in Kansas to establish a collaborative care coordination framework with CCBHCs. The agreement outlines joint responsibilities for screening Veterans, facilitating referrals, coordinating treatment planning, and sharing information in a manner that supports person-centered care. It emphasizes HIPAA compliance, integration of services, respect for Veteran choice, and coordinated follow-up, while maintaining the independent operations of each party and providing clear terms for modification or termination.

MEMORANDUM OF UNDERSTANDING BETWEEN «CCBHC» AND «VA MEDICAL CENTER» REGARDING CARE COORDINATION FOR BEHAVIORAL HEALTH SERVICES

I. Purpose:

This Memorandum of Understanding (MOU) is between «VA Medical Center_Physical_Address», «City», Kansas «Zip_Code» and «CCBHC», «CCBHC_Physical_Address», «City», Kansas «Zip_Code» collectively referred to as the "Parties." This MOU sets for a structure for collaboration between «CCBHC» and the VHA Facility for the purpose of care coordination under the Department of Health and Human Services (HHS) two-year demonstration program (the Demonstration Program) required by Section 223 of the Protecting Access to Medicare Act (PAMA) (Public Law 113-93).

II. Authority and Background:

Section 223 of PAMA requires the Secretary of HHS to establish Certified Community Behavioral Health Clinics (CCBHCs) as part of the Demonstration Program to improve community mental health services. In order for a clinic to be certified as a CCBHC, the clinic must meet a certain criterion, which include meeting care coordination requirements, which include "partnerships or formal contracts" with certain entities to include facilities of the Department of Veterans Affairs (VA). This MOU is an agreement between «CCBHC» and «VA Medical Center» made pursuant to the requirement in section 223(a)(2)(C) for a CCBHC to establish "partnerships or formal contracts" as part of a CCBHC's requirements for care coordination.

III. Nature of the Relationship:

This MOU constitutes a written expression of the mutual understanding between «CCBHC», and «VA Medical Center» regarding services to be provided and shall not bind either Party, create any future ongoing legal or other obligations.

IV. Screening for Military Service and Referrals:

a. For individuals with former service in active military, naval, or air service, as defined in 38 U.S.C. § 10 1(24), «CCBHC» will work with «VA Medical Center» to determine eligibility for VHA care.

b. Depending upon the desire of the individual and contingent upon the availability of resources, «CCBHC» will work to arrange transition to VHA care for any individual identified as a Veteran eligible for VHA care, provide the needed behavioral health services through «CCBHC», or coordination care between «CCBHC» and VHA if both entities will be providing care. A Veteran is not prohibited from receiving a portion of their services from VHA (e.g., primary care, specialty care, etc.) while continuing to be served by «CCBHC» for their behavioral health care.

c. «CCBHC» will develop protocols to guide management of Veterans eligible for VHA care who present at a CCBHC with emergent or urgent behavioral health care needs.

V. Overall Responsibilities:

A. «CCBHC» agrees to:

a. Provide coordination between the care of all mental health and substance use disorders for Veterans eligible for VHA care who experience both, to the extent those services are appropriately provided by «CCBHC».

b. Provide for integration and coordination of care for behavioral health conditions and other components of health care for all Veterans eligible for VHA care, to the extent those services are appropriately provided by «CCBHC».

c. Assign a Principal Behavioral Health Provider to every Veteran eligible for VHA care seen, unless VHA has already assigned a Principal Behavioral Health Provider.

d. Provide care and services to Veterans eligible for VHA care, independent of VA's duties to provide care, that are recovery-oriented and adhere to the guiding principles of recovery.

e. Develop a behavioral health treatment plan for all Veterans eligible for VHA care receiving behavioral health services.

f. Include military and Veteran-focused education as a component of staff training

g. Meet all other program requirements as specified in and defined in section 3.c.4 and 4.k.1-4.k.4 of the CCBHC program criteria document as provided and updated by Substance Abuse and Mental Health Services Administration (SAMHSA).

B. «VA Medical Center» agrees to:

a. Provide assistance with determining the Veteran's eligibility for VHA care.

b. Provide assistance with the transition of care to all Veterans eligible for VHA care upon the Veteran's request.

VI. Additional Care Coordination Responsibilities for Certain Facilities:

CCBHCs are required to have agreements that establish care coordination expectations with certain entities in the area served by the CCBHC. Per guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA) of HHS, when those entities include inpatient psychiatric facilities, ambulatory and medical detoxification facilities, post-detoxification step-down services, residential programs, inpatient acute care hospitals, emergency departments, hospital outpatient clinics, urgent care centers, or residential crisis settings, among other things. The agreement must provide for: Transfer of medical records of services received from those providers, including prescriptions; Tracking of admission and discharge; Active follow-up after discharge; Coordination of specific services if the consumer presented as a potential suicide risk, and, to the extent necessary to carry out other requirements related to care transitions. See https://www.samsha.gov/section-223/care-coordination/agreements-transitions

A. Transfer of medical records of services received from those providers, including prescriptions

«CCBHC» will work with «VA Medical Center» to ensure that when referrals are provided or received, all applicable medical records for the consumer, including key health indicators for medical and behavioral health, prescription information and appointment dates are transferred to the appropriate parties. Sharing of the information with the necessary authorizations allows for coordination of care and will continue throughout a Veteran's treatment with «CCBHC» and/or "VA Medical Center».

B. Tracking of admission and discharge

«CCBHC» and "VA Medical Center» will track admission and discharge dates for all Veterans referred as a function of the CCBHC to coordinate care and meet the goals of the project. "VA Medical Center» will provide the data required to meet the reporting requirements of the CCBHC standards as defined by SAMHSA.

C. Active follow-up after discharge

«CCBHC» and "VA Medical Center» will collaborate to provide the highest quality treatment for individuals who experience transitions of care to and from each agency, as well as for Veterans who have experienced acute hospitalizations. As members of the treatment team, representatives from both agencies will participate in information sharing activities to the extent that consent is provided to ensure community safety and re-engage with appropriate treatment of the Veteran's choice.

D. Coordination of specific services if the Veteran presented as a potential homicide and/or suicide risk

"VA Medical Center» agrees to participate in coordination of services for shared individuals who are identified through the use of standardized, evidenced-based screening and clinical evaluation tools as being at increased risk for homicide and/or suicide and subsequently placed on the suicide care pathway. For individuals designated as high risk, care is adjusted to provide increased clinical screenings and interventions and for higher intensity outreach/engagement, and care consultations.

E. Other expectations necessary to carry out other requirements related to care transitions

"VA Medical Center» will participate in shared patient-centered care as an active member of the treatment team, along with «CCBHC», the Veteran, family members (to the extent determined by the Veteran), and any other person the Veteran chooses. The treatment team is responsible for directing, coordinating, and managing care and services for the Veteran according to the treatment plan throughout the individual's length of treatment, including transitions in care.

VII. HIPAA Compliance and Confidentiality

«CCBHC» and "VA Medical Center» shall be in compliance with all applicable aspects of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) and the Administration Simplification Section, title II, Subtitle F, regarding standards for privacy and security of PHI (Protected Health Information) as outlined in the Act and all other applicable laws. «CCBHC» and the

VHA facility shall appropriately safeguard any protected health information received from or created by "VA Medical Center» on behalf of each Veteran eligible for VHA care served in accordance with all applicable policies and state, federal and tribal laws.

VIII. Limitations:

a. This agreement is not intended to address the participation, or not, of «CCBHC» in the Veteran's Community Care Program, as authorized by the VA's Mission Act of 2018, or any other program that facilitates referrals from VA for reimbursable services.

b. This MOU does not imply that «CCBHC» and "VA Medical Center» are liable for either Party's obligations, Neither Party is responsible for debts, contractual obligations, or conduct, tortious or otherwise, of the other Party. This agreement does not create any rights or contractual obligations between the Parties or on any third party's behalf.

c. «CCBHC» will not use this MOU to sell or promote any products or services.

d. «CCBHC» will not use the name of the Department or any of its components, except in factual publicity and with prior approval of VA. Factual publicity includes announcements of programs, initiatives or delivery systems developed under this MOU. Such factual publicity shall not imply that the involvement of VA serves as an endorsement of the general policies activities, or products of «CCBHC». Where the publicity references the Department, publicity will be accompanied by a disclaimer to the effect that no VA endorsement is intended.

e. «CCBHC» may use VA's logo seals, flags, and other symbols only pursuant to a written consent specifically in reference to the proposed use and with the goal that is advances the aims, purposes, and mission of the Department. VA approval is not guaranteed.

f. VA will not use and does not obtain any ownership interests in «CCBHC»'s Services, or other of «CCBHC»'s names, logos, and/or trademarks (the Marks). VA will obtain «CCBHC»'s prior written approval to use the Marks.

g. This MOU is not intended to be an exclusive arrangement. The relationship established in this MOU does not limit «CCBHC» or VA from establishing similar relationships with any other entity.

h. Any publicity released by either Party concerning this MOU, the services or supports providing within, or any resulting outcomes, will be subject to prior approval of the other Party.

i. Each Party shall bear its own costs, risks, and liabilities incurred in accordance with its obligations and efforts written in this MOU. Neither Party can commit any cost, expense, or obligations without prior written consent from that Party. Neither party may commit the other to any transfer of funds under this MOU absent a formally negotiated agreement.

j. This MOU may not be assigned or otherwise transferred by any Party, in whole or in part, without the expressed prior written consent of the other Party, which shall not be reasonably withheld.

MEMORANDUM OF UNDERSTANDING BETWEEN «CCBHC» AND «VA MEDICAL CENTER» REGARDING CARE COORDINATION FOR BEHAVIORAL HEALTH SERVICES

IX. Termination:

This agreement is effective when signed by both parties and will remain in effect until such time as «CCBHC» cease to operate, unless terminated according to the terms of this agreement. Amendments must be bilaterally executed in writing, signed by authorized representatives of both Parties, no oral or unilateral amendments will be effective. Terminations are executed in accordance with the terms of this agreement and may be done unilaterally.

This agreement will be reviewed annually for compliance and its effectiveness.

This agreement may only be terminated in writing with a thirty (30) days' notice sent from the authorized representative of the terminating Party to the authorized representative of the other Party. An oral termination is unauthorized, nor will any terminations be attempted outside of the written requirements in the agreement.

X. Approvals:

«VA Medical Center»	«CCBHC»
X _____	X _____
VA Medical Center Director Name, Credentials CEO/Medical Center Director	CCBHC Director Name, Credentials «Signor»

APPENDIX III: VA/CCBHC CARE COORDINATION AGREEMENT EXAMPLE

Disclaimer: *This appendix and the examples contained herein it are for informational and example purposes only and do not constitute legal advice. Agreements, memoranda of understanding, and other legally binding arrangements should be developed in consultation with qualified legal counsel and designed for an agency's specific operations, legal responsibilities, and other relevant factors.*

The **Care Coordination Agreement** between The Harris Center for Mental Health & IDD and its local VA Medical Center establishes a collaborative framework to coordinate behavioral health and substance use services for Veterans. The agreement outlines mutual responsibilities for referrals, intake, treatment planning, recordkeeping, and crisis intervention, all grounded in person- and family-centered care. Both parties commit to respecting Veteran choice, maintaining privacy under Health Insurance Portability and Accountability Act (HIPAA) and 42 Code of Federal Regulations (CFR) Part 2, and independently managing services and billing. The partnership allows for regular coordination while affirming the independent status of each organization, with provisions for amendment or termination as needed.

CARE COORDINATION AGREEMENT
BETWEEN
The Harris Center for Mental Health & IDD
AND
Michael E. DeBakey VA Medical Center

This Care Coordination Agreement (the Agreement) serves to confirm the mutual understandings of The Harris Center for Mental Health and IDD (The Harris Center) and Michael E. DeBakey VA Medical Center a referral partner for those individuals who receive community-based mental health and/or substance use disorder services from The Harris Center, in accordance with the terms set forth below. The purpose of this Agreement is to set forth the parties' understanding regarding their collaborative treatment planning and care coordination activities.

I. Referral Activities

1. The Harris Center is committed to providing integrated and coordinated care across a spectrum of services in a manner that is both person-centered and family-centered, consistent with Section 2402(a) of the Patient Protection and Affordable Care Act (ACA).
2. Michael E. DeBakey VA Medical Center agrees to make and/or accept referrals to/from The Harris Center subject to the restrictions of the federal rules and laws governing VA in order to assist individuals in accessing needed services and resources to facilitate. If accepting referral, Michael E. DeBakey VA Medical Center agrees to notify The Harris Center if at any time it becomes unable to accept new referrals. The Harris Center agrees to notify Michael E. DeBakey VA Medical Center of the same.

II. Care Coordination Processes

1. The parties will collaborate to conduct treatment planning and care coordination activities in a manner that is person and family-centered.
2. The Harris Center agrees to provide initial screening, intake, and, as capacity permits, appropriate treatment to clients referred to The Harris Center for the provision of community-based mental health and substance use disorder services, and to establish and maintain records of such individuals' healthcare.
3. If such screening and/or treatment indicate the need for referral to Michael E. DeBakey VA Medical Center for services, as determined in the sole discretion of The Harris Center consistent with requirements of privacy, confidentiality, and consumer preference and need, The Harris Center will assist clients and/or their families to obtain an appointment with Michael E. DeBakey VA Medical Center. The Harris Center will confirm with Michael E. DeBakey VA Medical Center that the appointment was kept, consistent with the Referral and Communication Protocol described below in Section II.S.
4. The Harris Center will ensure that clients' preferences and those of their families, as applicable, for shared information will be adequately documented in the applicable clinical records, consistent with the philosophy of person and family-centered care. The Harris Center will make reasonable efforts to obtain necessary consent for release of information from clients of The Harris Center.

5. The Harris Center and Michael E. DeBakey VA Medical Center agree to coordinate care for individuals served, making/accepting timely referrals, incorporating consumer preferences and needs for care, allowing The Harris Center and Michael E. DeBakey VA Medical Center to track clients and the services they receive, coordinating the transfer of medical records for services, coordinating The Harris Center's active follow-up and other activities necessary for effective management of care transitions.
6. The Harris Center will make and document reasonable attempts to screen all clients who are referred for outpatient services within 24 hours and to schedule intake for individuals in need within 10 business days. The Harris Center will make all reasonable efforts respond to requests for mental health crisis within 1 hour of request. For all The Harris Center clients who present as a potential suicide risk, The Harris Center will provide crisis intervention services, emphasizing smooth transitions to and from emergency department care or psychiatric hospitalization, as indicated. The Harris Center will coordinate consent and follow-up services with the consumer within twenty-four (24) hours of discharge, which shall continue until the individual is linked to services or assessed to be no longer at risk.
7. The Harris Center and Michael E. DeBakey VA Medical Center agree that, to the extent that clients receive care from either Party pursuant to this Agreement, such individuals are considered clients of the Party furnishing the services. Accordingly, each Party agrees to be solely responsible for billing and collecting all payments for such services from appropriate third-party payors, funding sources, and, as applicable, clients, observing the Party's customary billing, collection, and discount/charity care policies.

III. Lack of Financial Responsibility

Nothing in this MOU shall be deemed to be a commitment or obligation for future payment of money from any of the Parties. This MOU does not prohibit a Party from obligating funds for or designating employees to assist with the delivery of services.

IV. Amendments

The MOU may not be modified, altered, or amended except by written agreement by both parties.

V. Nondiscrimination

Each party to this MOU agrees that no person on the basis of race, color, national origin, religion, sex, age, handicap or political preference will be excluded from services be denied benefits of or be subject to discrimination in connection with the services provided hereunder.

VI. No Implied Authority

Any authority delegated by one Party to another Party is limited to the terms of this MOU. No Party shall rely upon implied authority or any authority not specifically

delegated under this Memorandum of Understanding to create, amend, or disregard any Party's programs or policies.

VII. Ownership of Records

All records created by The Harris Center during the performance of this MOU including clinical records of people evaluated at The Harris Center facilities, shall remain the property of The Harris Center. All records created by Michael E. DeBakey VA Medical Center during the performance of this MOU shall remain the property of Michael E. DeBakey VA Medical Center.

VIII. Assurance of Patient and Clinician Choice

1. The Harris Center and Michael E. DeBakey VA Medical Center acknowledge and agree that all health and health-related professionals employed by or under contract with either The Harris Center or Michael E. DeBakey VA Medical Center retain sole and complete discretion, subject to any valid restriction(s) imposed by participation in a managed care plan and consistent with Section II above, to refer clients to any and all providers who best meet the medical needs of such clients.
2. The Harris Center and Michael E. DeBakey VA Medical Center acknowledge that all clients have the freedom to choose (and/or request referral to} any provider of services, and the parties will advise clients of such right, subject to any valid restriction(s) imposed by participation in a managed care plan.
3. The Harris Center and Michael E. DeBakey VA Medical Center acknowledge and agree that they have freely negotiated the terms of this Agreement and that neither Party has offered or received any inducement or other consideration in exchange for entering into this Agreement. Nothing in this Agreement requires, is intended to require, or provides payment or benefit of any kind (directly or indirectly) for the referral of individuals or business to either Party by the other Party, subject to Section II above.
4. The Harris Center and Michael E. DeBakey VA Medical Center remain separate and independent entities. No provision of this Agreement is intended to create, nor shall any provision be deemed or construed to create a relationship between the parties other than that of independent contractors. The Harris Center and Michael E. DeBakey VA Medical Center retain the authority to contract or affiliate with, or otherwise obtain services from, other parties, on either a limited or a general basis.

IX. Term and Termination

1. The term of this Agreement shall commence on , and continue until — — — — — — — — ' unless terminated at an earlier date in accordance with Section V. This Agreement will automatically renew for additional one (1) year term unless written notice of intent not to renew is provided by one Party to the other Party no less than thirty (30) days prior to the expiration of the then-current Agreement.
2. This Agreement may be terminated, in whole or in part, at any time upon the mutual

agreement of The Harris Center and Michael E. DeBakey VA Medical Center with ninety (90) days prior written notice to the other Party.

4. This Agreement may be terminated for cause upon written notice by either The Harris Center or Michael E. DeBakey VA Medical Center. "Cause" shall include, but is not limited to when the life, health, welfare, or safety of individuals served, or its employees is endangered or could be endangered either directly or through the Parties willful or negligent discharge of its duties under this Agreement.

X. Privacy and Confidentiality of Consumer Information

1. The Harris Center and Michael E. DeBakey VA Medical Center will coordinate care, as set forth in this Agreement, in a manner that complies with privacy and confidentiality requirements, including but not limited to those of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. No. 104191, 110 Stat. 1936 {1996)), 42 CFR Part 2, and other federal and state laws, including privacy requirements specific to the care of minors.
2. Each Party agrees it shall request clients' consent for disclosure of their health information, in accordance with state and federal law and regulations. Each Party shall follow clients' preferences for shared protected health information, consistent with the philosophy of person and family-related consent.
3. This Section X shall survive termination of this Agreement.

Michael E. DeBakey VA Medical Center TheHarris Center for Mental Health & IDD

DATE _

NAME
Director, Michael E. DeBakey VA Medical Center
2002 Holcombe Blvd.
Houston, TX 77030

DATE

NAME
Chief Executive Officer, The Harris Center for Mental Health and IDD
9401 Southwest Fwy
Houston, TX 77030

MODULE 4

CLINICAL CONSIDERATIONS AND LIFE CIRCUMSTANCES FOR SMVF

Overview

Certified Community Behavioral Health Clinics (CCBHCs) play a vital role in addressing the clinical and personal needs of service members, Veterans, and their families (SMVF). In this section, we explore a comprehensive framework for supporting SMVF clients, emphasizing the importance of understanding their mental health, alcohol and drug use, and life circumstances. By integrating specialized knowledge and evidence-based practices, CCBHCs can provide holistic care that addresses both clinical diagnoses and the situational factors affecting SMVF's well-being. This aligns with Criteria 4.E (Person-Centered Treatment Planning) because it emphasizes tailored, comprehensive care that addresses the full range of a client's needs, not only clinical symptoms.

Through targeted interventions and collaborative efforts, CCBHCs can enhance their ability to respond to the complex challenges SMVF clients face. In this section, we will describe key considerations for crisis services, screening and assessment, treatment planning, outpatient services, primary care, case management, psychiatric rehabilitation, and peer support. By leveraging these insights, CCBHCs can foster resilience and promote recovery among SMVF clients.

Fact Sheet: Clinical Considerations and Life Circumstances for Service Members, Veterans, and their Families

Overview

Common Clinical Conditions	Transition Stress	Life Circumstances and Community Concerns
» Community-based clinicians play a vital role in assessing and treating SMVF, especially when familiar with military-specific conditions like PTSD, TBI, and substance use disorders. » Understanding how these conditions affect not only Veterans but also their families supports more inclusive care. » This section emphasizes the importance of clinical competency, timely assessment, and evidence-based treatment planning aligned with CCBHC certification standards.	» In addition to clinical diagnoses, SMVF often face psychological and relational challenges such as moral injury, relationship concerns, and loss of purpose—issues deeply rooted in military service and transition stress. » These concerns, while not always diagnosable, can significantly impact well-being and require informed care. » Addressing them supports CCBHC Criteria 1.A and 1.C by promoting needs-based, military service experience informed service planning.	» SMVF face life challenges—like housing instability, chronic pain, justice involvement, and suicide risk—that can intensify mental health conditions. CCBHCs play a key role by building trust, coordinating care, and addressing other factors that influence health. » Supporting connection, reducing isolation, and ensuring access to services aligned with their experiences and values that conforms with Criteria 3.A and 4.K, promoting stability and long-term recovery.

Insights from Experts

This module emphasizes a biopsychosocial approach to assessment, integrating factors that influence health and life stressors into care planning. VA's Whole Health model can be used as a guide for managing chronic pain through integrative therapies and personalized care planning.

Understanding emotional dysregulation, especially anger, is essential, particularly for Veterans from combat arms roles. Experts stress the importance of recognizing behavioral health needs beyond combat exposure. Pre-release planning and Veteran-specific outreach—like food pantry days—can reduce stigma and improve engagement. Tools like PRAPARE® and trauma-informed screening help uncover unmet needs and guide early intervention.

Fact Sheet: Clinical Considerations and Life Circumstances for Service Members, Veterans, and their Families

Notes from the Field

CCBHCs across the country are demonstrating success in equipping staff to meet the clinical and community-based needs of SMVF. For example, VOAMASS and High Plains Mental Health Center train staff in trauma-informed care, suicide prevention, and Veteran-specific assessments like PCL-5 and C-SSRS. Community Counseling Center and FSRI also use Zero Suicide and STAR training to strengthen suicide risk response.

To address broader needs, organizations like Valley HealthCare System and Community Health Network partner with local VA offices and community providers to support housing, employment, and justice-involved Veterans. Berks Counseling Center and FSRI use comprehensive screening tools—such as PHQ, WEMWS, and ISEL-12—to monitor SMVF well-being. These examples show how targeted training, coordinated partnerships, and responsive practices enhance care for SMVF across multiple settings.

Ideas for Action

- **Implement Comprehensive Screening Protocols:** Develop and utilize detailed screening, assessment, and diagnostic tools tailored to the full range of clinical needs and life circumstances of SMVF clients.
- **Create Inclusive Treatment and Safety Plans:** Design person- and family-centered treatment plans that integrate military identity and address the full spectrum of behavioral health, substance use, and life circumstances.
- **Coordinate Case Management:** Establish focused case management services that coordinate care across providers, reducing the burden on clients to manage their care independently.
- **Develop Training to Address Biopsychosocial Concerns:** Provide ongoing training for staff on the clinical concerns specific to SMVF, including the effects of trauma, substance use, and transition stress.
- **Build a Referral Network to Support Life Circumstances:** Develop a robust referral network with local organizations and agencies to address life circumstances such as housing instability, financial insecurity, and legal issues, ensuring comprehensive support for SMVF clients.

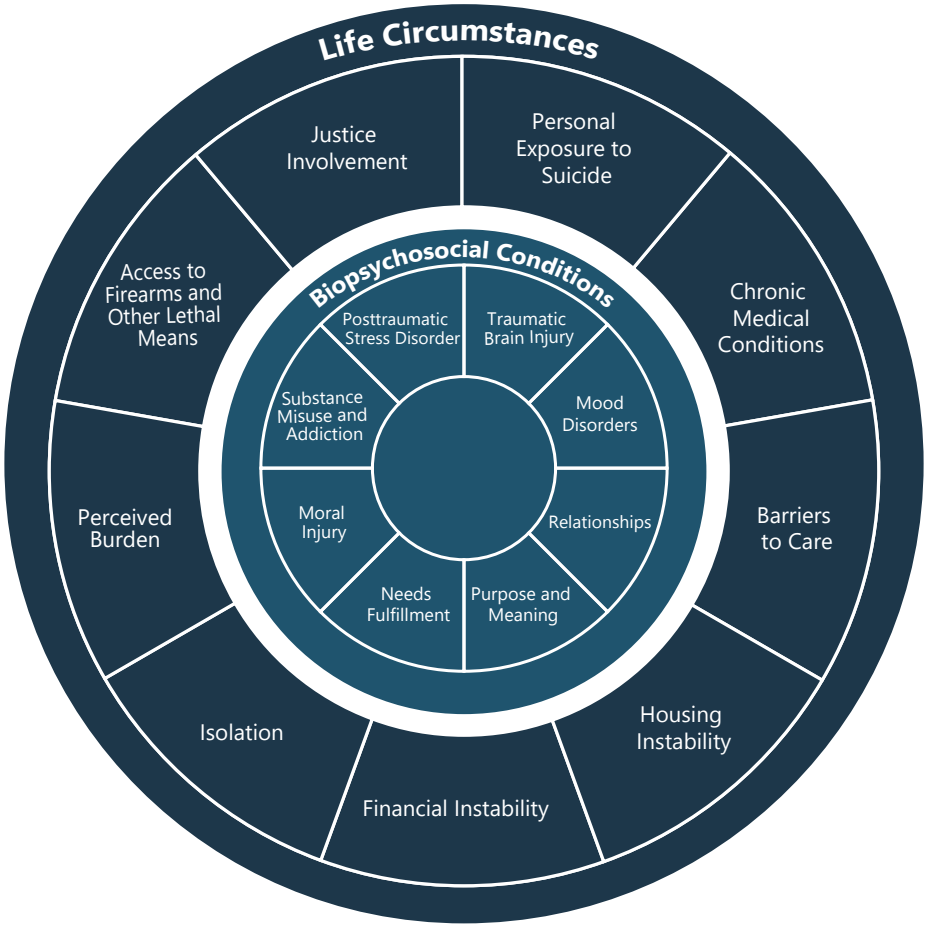
Resources

- RAND Resources for Service Members, Veterans, Families and Caregivers
- STAR Behavioral Health Providers Training Program
- Strong Star Training Initiative
- Justice for Vets: Veteran Court Resources
- Veteran Housing Programs: Supportive Services for Veteran Families
- National Veterans Financial Resource Center
- Department of Labor Veterans Employment and Training Service (VETS)
- VA Health Care Provider Resources
- Uniformed Services University Center for Deployment Psychology
- Supporting People with Brain Injury through CCBHCs

The concept of "invisible wounds of war" describes the psychological effects of combat exposure, frequent successive deployments, and the adaptive demands placed on service members during the critical Iraq and Afghanistan conflicts. These effects include increased prevalence of traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), and other mental and substance use disorders. Although these conditions are often difficult to observe, diagnose, and treat, they are not limited to those who have deployed to a combat zone. Military service itself is inherently dangerous and stressful.

In addition to combat-related exposures, routine aspects of military service can also contribute to significant stress and psychological strain. This can include frequent relocations, extended training exercises, and non-combat deployments. These ongoing disruptions can interfere with family cohesion, create challenges in maintaining social support networks, and elevate the risk of mental health conditions among SMVF. Military families, particularly spouses and children, often experience elevated levels of stress, anxiety, and emotional burden related to separation, uncertainty, and caregiving responsibilities. According to a study on military families by RAND, these stressors can negatively affect emotional well-being, parenting practices, and family functioning (Ramchand et al., 2024). Recognizing the cumulative effect of stressors related to military service is essential for developing comprehensive support systems for the entire military-connected community.

Figure 1: Mental Health and Wellness in Service Members and Veterans: Biopsychosocial Conditions and Life Circumstances

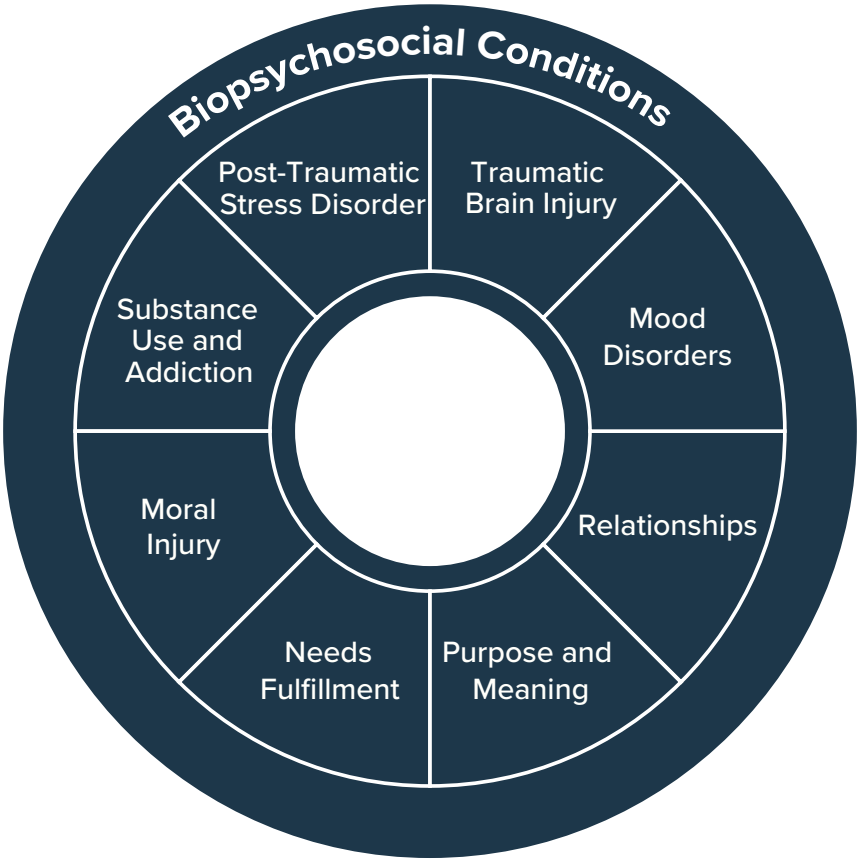


This graphic presents a conceptual model illustrating the range of circumstances and conditions that SMVF may experience (France & Davis, 2025). The model highlights two categories that influence SMVF mental health and wellness: biopsychosocial and clinical factors, which have a direct effect, and broader life circumstances—such as housing, employment, and legal issues, which exert an indirect influence on overall well-being. Mental health providers may observe biopsychosocial conditions in clinical settings, which are necessary to assess, diagnose, and treat clients. This connects with Criteria 4.D (Screening, Assessment, and Diagnosis) as it highlights the need to assess complex, layered conditions to inform treatment. Additionally, Criteria 4.B (Person-Centered Treatment Planning) emphasizes the importance of person-centered and family-centered care in the CCBHC model, ensuring that treatment plans are tailored to the specific needs and goals of each patient and their family. This holistic approach is crucial for effective mental health care. Meanwhile, life circumstances can be addressed by CCBHCs or other partners, and their non-clinical staff.

Although these areas are presented separately, they are not discrete or disconnected. SMVF may face numerous challenges across multiple circumstances, and comorbid or chronic conditions can exacerbate one another. However, according to the *National Health and Resilience in Veterans* study (Fogle et al., 2020), a meta-analysis of more than 80 studies found that "although a significant minority of Veterans screen positive for mental disorders, the majority are psychologically resilient." This model is not intended to pathologize military service or imply that SMVF are universally impaired or affected by their service because not all—nor even most—will experience the challenges discussed in this section.

Common Clinical Conditions

Figure 2: Common Clinical Concerns in Service Members and Veterans



Community-based clinical care providers can assess SMVF and recommend treatment within their CCBHC or refer them to another community healthcare provider or to VA for care. Clinicians familiar with common clinical conditions and effective evidence-based treatments are better equipped to assess, educate, and treat SMVF. This supports Criteria 1.B (Licensure and Credentialing) because it highlights the necessity of ongoing education to ensure competency in treating this population.

This discussion primarily focuses on the presence of these conditions in service members and Veterans; however, it's important to recognize their multifaceted effect on family members as well. Thomson (2021) highlighted how both military members and their families often feel unprepared for the emotional and behavioral challenges of PTSD, citing stigma, lack of understanding, and difficulty navigating the mental health system as key barriers to seeking help. Creech and Misca (2017) showed that PTSD can impair parenting, resulting in emotional unavailability and inconsistent discipline, which negatively affect child development and family cohesion. Powling et al. (2024) described how the partners of individuals with PTSD often experience a mix of loss and gain as they adapt to their loved one's changes while managing their own psychological struggles. Collectively, these studies underscore the profound ripple

effects of PTSD on family dynamics and call for more inclusive interventions and accessible mental health support (Creech & Misca, 2017; Powling et al., 2024; Thomson, 2021).

Posttraumatic Stress Disorder

PTSD is classified in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; DSM-5-TR) as a trauma and stressor-related disorder that can occur after someone experiences a life-threatening traumatic event (American Psychiatric Association, 2022). Most people who experience a traumatic event don't develop PTSD. However, a PTSD diagnosis relies on clinically indicated symptoms that last for more than 1 month and cause distress or functional impairment. On average, about 6 out of every 100 people in the United States will develop PTSD in their lifetime (Goldstein et al., 2016).

According to Tolin and Foa (2006), Veterans deployed to combat zones are at greater risk of developing PTSD than civilians, and women are more likely than men to develop the disorder. Among those serving in the military, women face a higher risk of PTSD because of an increased risk of sexual trauma, which is more strongly correlated with PTSD than other events (Tannahill et al., 2020). However, military sexual trauma occurs in both men and women. A thorough assessment of SMVF should consider exposure to combat and other traumatic events during their military service. This aligns with Criteria 2.B (Timely Access to Services) because it supports early and accurate identification of trauma exposures to guide treatment planning.

For SMVF, best practices in PTSD assessment include comprehensive screenings that evaluate trauma exposure before, during, and after military service, including combat and other potentially traumatic events. Assessments inform referral decisions and help identify appropriate evidence-based treatment options. Clinical assessment tools include structured, provider-led evaluations, whereas self-report tools allow clients to document their symptoms, which providers can then score.

The PTSD Checklist for DSM-5 (PCL-5) is a self-report questionnaire that uses a 20-item scale to measure the severity and likelihood of PTSD symptoms based on DSM-5 criteria. In contrast, the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) is a structured clinical interview conducted by trained professionals to diagnose PTSD, evaluate symptom severity, and assess functional impact, making it the gold standard for PTSD diagnosis.

Although research is ongoing, there have been advancements in effective clinical interventions for PTSD. The following three evidence-based therapies are particularly effective for the SMVF population. It is essential that providers are trained and certified in these modalities. This connects with both Criteria 1.B (Licensure and Credentialing) and Criteria 4.F (Outpatient Mental Health and Substance Use Services) because it emphasizes the importance of trained clinicians delivering high-quality outpatient services.

- Prolonged Exposure Therapy (PE) is a specialized form of cognitive behavioral therapy in which trained providers help clients confront and process traumatic experiences, gradually reducing PTSD symptoms.
- Cognitive Processing Therapy (CPT) involves 12 structured sessions focused on reframing thoughts and emotions related to trauma, often incorporating writing exercises to facilitate healing.
- Eye Movement Desensitization and Reprocessing (EMDR) integrates talk therapy with guided eye movements to help clients reprocess traumatic memories and develop new perspectives, leading to a reduction in PTSD symptoms.

Traumatic Brain Injury

TBI has emerged as a significant concern for SMVF over the past 30 years. Improvements in medical treatments, rapid response to catastrophic events, and protective equipment designed to increase survivability have led to decreased mortality. As advances in medical care and protective equipment have reduced fatalities, more individuals are surviving with catastrophic injuries, resulting in an increased need for treatment and support for conditions such as TBI. The Centers for Disease Control and Prevention defines TBI as "a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head or penetrating head injury." Falls and vehicular accidents are the most common causes of TBI (U.S. Department of Veterans Affairs, 2022).

Although TBI can be classified as mild, moderate, or severe, these classifications are based on the duration of lost consciousness rather than the impact on an individual's physical and psychological functioning. Therefore, an SMVF client who experienced a mild TBI with a brief loss of consciousness and associated mental status changes may still experience significant long-term effects (Centers for Disease Control and Prevention, 2024). Repeated TBI of any classification, particularly when they occur in close succession, can have serious long-term consequences. Additionally, whether a client was assessed by medical personnel after a TBI—and the timing of that assessment—may influence their TBI categorization, treatment, and recovery. Chronic TBI exposure has been linked to cognitive decline, memory impairments, and an increased risk of neurodegenerative diseases such as chronic traumatic encephalopathy (LoBue et al., 2019).

Determining whether SMVF were deployed to a conflict zone or experienced blasts or accidents is crucial in evaluating potential TBI. Clients with a history of TBI should consult a primary care physician for assessment, diagnosis, and medical evaluation, including imaging. This relates to Criteria 4.G (Primary Care Screening and Monitoring) because it emphasizes the need to address physical and neurological health within behavioral health settings. TBI increases the risk of polytrauma and is often accompanied by substance use disorders, mood disorders such as PTSD or major depression, and increased suicidality. Veterans receiving VA care can access the Polytrauma/TBI System of Care, which offers interdisciplinary treatment, including occupational therapy, physical therapy, and mental health support.

Clinicians utilize tools to screen and assess TBI. The *Checklist to Assess for and Manage Mild Traumatic Brain Injury (mTBI) and Concussion* evaluates symptoms such as headache, dizziness, and memory issues, guiding clinicians through a series of questions to determine whether further evaluation or referral is needed. Another valuable tool is the *Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID)*, a structured interview tool used in clinical and research settings to assess an individual's lifetime history of TBI and evaluate long-term effects.

As a physical injury that affects psychological, emotional, and cognitive processes, clinical mental health professionals can identify and assess SMVF for TBI. They can also coordinate care with appropriate resources, such as brain injury programs that specialize in TBI recovery and rehabilitation. One such resource is the National Institute for State Head Injury Administrators (NASHIA), a nonprofit organization that supports state and federal efforts to improve brain injury services by providing resources, technical assistance, and guidance in TBI policy and program development.

NASHIA has developed TBI resources for CCBHCs that include recommendations for establishing partnerships with brain injury

programs, implementing TBI screenings and supports, and improving access to TBI resources. CCBHC clinical staff can address the challenges their SMVF clients face because of TBI, such as communication difficulties, cognitive limitations, physical health comorbidities, varying verbal abilities, and differences in social skills (NASHIA, 2025). This aligns with Criteria 4.I (Psychiatric Rehabilitation Services) by addressing functional and life-skills recovery post-injury. Additionally, Criteria 3.C (Care Coordination Partnerships) emphasizes the importance of fostering care coordination across a variety of providers, community resources, and supports for TBI. This collaborative approach ensures comprehensive and effective care for SMVF clients.

Substance Use Disorders and Addictions

The 2023 National Survey on Drug Use and Health: Veteran Adults (SAMHSA, 2024) found that 1.3 million Veterans (6.2%) had a diagnosis of a substance use disorder (SUD), and among those with an SUD, 26.9% struggled with illicit drugs, 80.8% with alcohol use, and 7.7% with both illicit drugs and alcohol. Alcohol misuse is a major concern for active-duty service members. Service members are not only part of the heaviest drinking demographic by both sex and age group, but binge drinking and heavy drinking occur at higher rates among service members than civilians (Meadows et al., 2023). Opioid use disorder (OUD) is another significant concern in the SMVF population. The prevalence of OUD among Veterans increased from 0.60% in 2005 to a peak of 1.16% in 2017, then declined to 0.97% by 2022 (Gorfinkel et al., 2024). Assessing, diagnosing, and offering treatment and resources for SMVF with SUD can be life-changing.

Other behaviors that could qualify as an addiction or a disorder among SMVF include gambling and compulsive pornography consumption. Although more research is needed, some studies associate military sexual harassment or assault as a risk factor for compulsive sexual behavior in men (Blais, 2021). Gambling addiction disproportionately affects SMVF; recent studies found that military service members scored double for problem gambling compared to their civilian participants, even after adjusting for demographic and behavioral factors. Additionally, the association between military service and problem gambling was significantly stronger for women than men (van der Maas & Nower, 2021). As with other conditions discussed here, consider how to partner with other resources if treatment for these conditions is not available within your CCBHC.

When applying assessment and screening tools, it's important for clinicians to establish a collaborative rapport with SMVF to ensure accurate reporting. It is recommended that CCBHCs create a policy to determine which screening tools they will use. This supports Criteria 6.A (Organizational Authority and Finances) because it involves structured administrative planning and clinical quality-assurance practices. The federal Clinical Practice Guidelines for Substance Use is an excellent resource. The Alcohol Use Disorders Identification Test (AUDIT-C) is a tool with questions and scoring cards to assess viral hepatitis and liver disease. Additionally, the National Institute on Drug Abuse provides a *Screening and Assessment Tools Chart* that is highly recommended.

There are numerous evidence-based interventions for substance use disorders that trained providers can use in individual, family, or group counseling sessions. It can also be beneficial to screen for SUD and other compulsive disorders at multiple points of contact, such as at intake and after referral to a peer navigator or recovery coach. This connects with Criteria 3.D (Care Treatment Team and Planning) as it underscores the importance of continuous monitoring and adaptable

treatment strategies. Additionally, Criteria 4.F (Outpatient Mental Health and Substance Use Services) emphasizes the importance of providing comprehensive outpatient mental health and substance use care to everyone. Cognitive behavioral therapy (CBT) helps clients identify, confront, and recover from substance misuse and addiction. Certified alcohol and drug counselors and certified peer support specialists are invaluable for screening, referring, and treating SMVF. Social and peer support programs, such as 12-step programs like Alcoholics Anonymous, Al-Anon Family Groups, SMART Recovery, and Narcotics Anonymous, are also available to SMVF.

Some adults struggling with substance misuse may require medically supervised inpatient detoxification. It is essential to consult addiction medicine providers and encourage clients to be honest about their substance use because detox and withdrawal can become life-threatening. Building relationships with the nearest VA Substance Use Treatment Program, emergency departments, detox centers, and inpatient and outpatient addiction treatment programs that offer evidence-based treatment is highly recommended. Medication-assisted therapies allow SMVF to meet experts who treat SUDs with specific medications used to initiate detox and withdrawal and to help decrease symptoms in the early stages of sobriety and recovery. This supports Criteria 4.F (Outpatient Mental Health and Substance Use Services) because it promotes the use of specialized, evidence-based outpatient treatment interventions. It can be especially important to implement systems to identify Veterans at risk of opioid overdose and provide comprehensive education and training to both healthcare providers and Veterans on naloxone use and administration.

Mood Disorders

The development of mood and emotion-related disorders in SMVF can stem from contributing factors including genetics, adverse childhood experiences, exposure to trauma, a clinical diagnosis prior to military service, and a history of substance misuse. Experiences during military service—such as exposure to combat or other traumatic events—can contribute to the onset or worsening of these conditions. Anxiety and depression are among the most common diagnoses in SMVF, often presenting with symptoms such as anger, irritability, and emotional dysregulation. Additionally, noncombat stressors such as harassment, prolonged separation from family, and military occupational demands can further impact emotional well-being.

Anger and irritability can be symptomatic of clinical diagnoses and should be addressed with clients. Providing resources, encouraging interventions to improve coping skills, and recommending the therapies discussed in this section should all be considered. In addition to anger management, it is important to understand how the stress of military service or adaptation to life after the military can lead SMVF to develop depression, anxiety, or both.

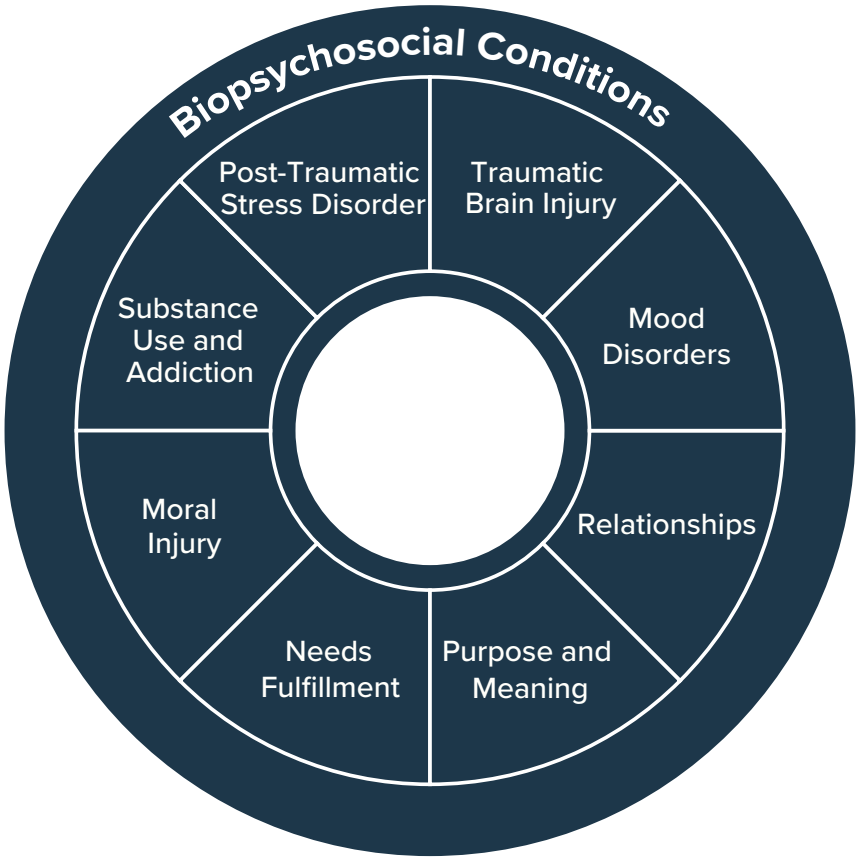
Providing comprehensive screening, assessment, and treatment interventions to SMVF is important. CCBHCs should ensure their providers are trained in referencing the federal Clinical Practice Guidelines for the Management of Major Depressive Disorders as well as other mental health-related CPGs that provide training aligned with evidence-based military and Veteran protocols. They should also establish clear policies regarding which clinical assessments and screening tools are provided to clients.

The Patient Health Questionnaire (PHQ-9 and PHQ-2) offers two versions to aid in recognizing and diagnosing depression. According to the CPGs, the PHQ-2 functions as a screening tool for depression, whereas the PHQ-9 serves as an indicator of depression severity or response to treatment for patients with a depressive disorder. Additionally, the General Anxiety Disorder Scale (GAD-7) and the Beck Anxiety Inventory (BAI) are commonly used tools to assess anxiety alongside depression screens. The State-Trait Anger Expression Inventory-2 (STAXI-2) is a psychological assessment tool designed to measure aspects of anger, including its intensity, expression, and control.

There are evidence-based therapies for treating depression, anxiety, and dysregulated mood. CBT for anxiety is a talk therapy provided by trained therapists in individual, family, or group sessions. This therapy focuses on processing thoughts and feelings and developing new, more positive skills. CBT for depression is a time-limited talk therapy conducted by trained providers to improve skills and reduce symptoms of depression. Trained medical providers may prescribe antidepressants and other medications to support mood stabilization and enhance overall emotional well-being. This aligns with Criteria 4.G (Primary Care Screening and Monitoring) because it emphasizes the integration of medical and behavioral health services. Additionally, Criteria 3.C (Care Coordination Partnerships) highlights the importance of coordinating with physical health providers to ensure comprehensive care. Furthermore, Criteria 4.F (Outpatient Mental Health and Substance Use Services) underscores the need for providing comprehensive outpatient care, and Criteria 1.B (Licensure and Credentialing) emphasizes the necessity of having medical and licensed staff to prescribe medication to the people they serve. These medications have the best outcomes when combined with talk therapy and in the absence of substance use.

Transition Stress

Figure 3: Transition Stress in Service Members and Veterans



Although it is critical that clinicians working with SMVF are aware and capable of addressing the common clinical conditions discussed in the previous section, it is also necessary to consider other psychological, social, and relational factors that affect this population. Conditions such as moral injury, relationship concerns, and struggles with purpose, meaning, and meeting needs in post-military life are not DSM diagnoses but are associated with higher levels of distress and dysfunction in service members and Veterans (Bond et al., 2022). These conditions are more prevalent in the military because of high levels of self-identification within the military, a dedication to service, deeply held common values, and an interdependent communal structure (Demers, 2011; Litz et al., 2009). This supports Criteria 1.A (Needs Assessment) as it draws attention to the unique factors of military service that informs service planning. Ensuring that staff are equipped to understand and address the unique needs and experiences of the military community helps support the delivery of effective and tailored services. Collectively, these conditions fit within a framework of stress related to life changes and transitions, generally classified as Transition Stress (Mobbs and Bonanno, 2018).

One clinical condition not included in the model is adjustment disorder. According to the *DSM-5-TR*, adjustment disorder is an unhealthy emotional or behavioral response

to identifiable stressors, producing significant distress or impairment. It is a common condition among military populations, particularly during transitions. Morgan et al. (2022) found that adjustment disorder is frequently diagnosed in active-duty service members and is associated with reduced performance and increased health care use, although often without consistent follow-up or standardized care. Romaniuk et al. (2024) reported that a structured reintegration program for Veterans was feasible, well received, and showed early benefits for psychological well-being and adjustment, underscoring the need for targeted, scalable interventions.

Although these conditions are not formally diagnosable, clinicians can rely on theoretical orientations and interventions to address the distress related to each condition. In the following section, we will provide a brief overview of each condition, common assessments or screening tools to consider, and how theoretical orientations may be applied.

As with the common clinical conditions section, these transition stress conditions primarily focus on service members and Veterans. When supporting clients who are family members, consider how these conditions can disrupt relationships or create added stress. When a Veteran struggles to find meaning or purpose after military service, it can lead to emotional distress, identity confusion, and difficulty forming new relationships, which may strain family dynamics. Experiences of moral injury, such as deep shame or guilt, can lead to withdrawal, mistrust, and spiritual distress, often disrupting emotional intimacy and communication with loved ones. Moreover, unmet psychological and practical needs in post-military life can result in frustration, lowered self-esteem, and a sense of instability, which may affect a family's overall sense of security and cohesion.

Purpose and Meaning

The satisfaction and sense of purpose that service members gain from their military service is one reason many develop strong connections to their experiences as well as to others who have served. Their deep identification with military service serves as a protective factor during service-related hardships and remains a source of pride in post-military life. Yalom (1980) noted that people are "extraordinarily comforted by the belief that there is some... coherent pattern to life and that each individual has some particular role to play in that design." He suggested that the presence of a clear goal, a role in achieving that goal, and guidelines for living are deeply meaningful and provide a strong sense of satisfaction.

Unfortunately, when service members transition out of the military, many encounter situations they do not find as meaningful or fulfilling. Although the concepts of purpose and meaning are often used interchangeably, they can also be viewed as distinct. Purpose refers to something to do—an external activity one engages in. Meaning, on the other hand, is a sense of satisfaction or coherence expressed by an individual. For many who served, military service satisfied both innate needs: something to do (a sense of purpose) that was meaningful or satisfying (a sense of meaning). However, in post-military life, it is uncommon to find both conditions in the same activity; one might find employment that serves a purpose but is not meaningful or participate in an activity that is satisfying but lacks purpose. This disconnect can cause distress (Castro et al., 2015; Stebnicki, 2020).

This struggle with purpose and meaning often manifests as a loss of identity, dissatisfaction with post-military life, and difficulty reintegrating after service. Some Veterans maintain a rigid connection to their military identity, which can make it difficult to build relationships with nonmilitary colleagues and peers and can

hinder social connection (Edwards et al., 2022; Flack & Kite, 2021). Length and type of service also play roles in the difficulty of transition. Service members who leave after a significant period, typically at a higher rank with greater responsibility, often enter the civilian workforce at a relatively young age. As Veterans, they may not move into positions with similar levels of accountability and leadership potential, which can be challenging. Prolonged distress related to purpose and meaning can lead to conditions such as depression and anxiety and may also affect relationships and self-image.

Clinicians can use several assessments to evaluate the quality of life of SMVF clients. The Meaning in Life Questionnaire, developed by Steger et al. (2006), assesses the presence of meaning and the search for meaning. It has been used with SMVF to explore how meaning and purpose relate to mental health outcomes, suicidal ideation, and life functioning (Bryan et al., 2013a, 2013b; Kumar et al., 2024). This connects with Criteria 4.E (Person-Centered Treatment Planning) because it supports individualized approaches rooted in the client's values and identity. The Satisfaction With Life Scale (SWLS) assesses judgments about life satisfaction and personal well-being. This tool explores the relationship between career transition and life satisfaction as well as perceptions of well-being among SMVF who have experienced TBI (Martin & Campbell, 2019).

Existential and humanistic treatment modalities are well suited to support SMVF struggling with purpose, meaning, and identity. These modalities address concerns that go deeper than symptom-focused conditions while also acknowledging that both may be present (Guigno, Miranda, & Hallmark, 2017). Addressing concerns related to purpose and meaning in a group setting may also be beneficial, offering opportunities for mutual support, shared experience, and interpersonal connection (Cowden et al., 2021). This supports Criteria 4.J (Peer Supports and Counseling) and Criteria 4.I (Psychiatric Rehabilitation Services) because group work fosters connection, emotional regulation, and functional skill building.

Moral Injury

Moral injury is a construct that has emerged in the military and Veteran mental health community to describe unique responses of guilt, shame, avoidance, and grief related to past experiences. Moral injury has been defined as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009; Maguen & Litz, 2012). First introduced by Jonathan Shay (1994) to describe maladaptive thought patterns and self-referential narratives in Vietnam Veterans, shame and guilt related to actions taken—or not taken—during traumatic events have been documented in military literature as far back as Euripides in 416 BCE.

Moral injury is related to exposure to traumatic events but is distinct from trauma-related conditions such as PTSD. It relates more to how SMVF perceive their experiences than to the experiences themselves. Self-directed guilt and shame related to being unable to prevent harm to others, harming others in ways that conflict with deeply held beliefs, and being exposed to atrocities are frequent examples of situations that may lead SMVF to develop moral injury.

Moral injury can be significant among SMVF. It may include self-directed moral injury, in which the client experiences shame, guilt, or blame over their actions, as well as other-directed moral injury, where blame and anger are related to others' actions. Many who experience moral injury feel they are not worthy of forgiveness, whereas others who engage in morally injurious acts may be forgiven. SMVF experiencing moral injury may suffer from intense self-condemnation, severe loss of trust in others, difficulty establishing new trust, and even spiritual distress or struggles with faith and hope (Koenig & Al Zaben, 2021).

This relates to Criteria 4.F (Outpatient Mental Health and Substance Use Services) because it underscores the importance of treating moral injury within ongoing therapeutic settings.

Several assessments and scales have been developed to determine the presence of moral injury. These include the Moral Injury and Distress Scale (MIDS), the Expressions of Moral Injury Scale–Military Version (EMIS-M), and the Moral Injury Questionnaire–Military Version (MIQ-M) (Currier et al., 2019; Braitman, et al., 2018; Norman et al., 2024). These assessment tools are designed to assess exposure to potentially morally injurious events, evaluate emotional and cognitive dimensions of moral injury, and identify the condition within military and Veteran populations.

Interventions that support SMVF with moral injury include cognitive-behavioral strategies adapted specifically to address reactions to morally injurious events. Adaptive disclosure, designed to help SMVF integrate and resolve moral injuries from combat (Litz et al., 2017), uses emotion-focused cognitive-behavioral strategies to challenge dysfunctional cognitions related to moral transgressions. Acceptance and Commitment Therapy (ACT) has been shown to help SMVF recognize their reactions to morally injurious events, develop psychological flexibility regarding self-perception, and work toward integrating personal values that may have been violated during military service (Walser et al., 2024). Several additional interventions have been developed for specific types of moral injury. For example, Impact of Killing therapy is a cognitive-behavioral intervention that addresses the psychological and moral challenges faced by Veterans who have killed in combat (Maguen et al., 2022). This supports Criteria 3.D (Care Treatment Team and Planning) by providing targeted, team-based interventions for a highly specific clinical concern.

Needs Fulfillment

The transition from military to post-military life has the potential to be a positive experience but can also be a critical time for the psychological well-being of SMVF. Clinicians should be aware of how any significant life changes can affect this population. Although we will discuss life circumstances such as housing instability, financial insecurity, and other concerns below, this section is intended to show how some SMVF experience distress and discomfort adjusting from the highly regimented, communal, and well-resourced military life to the less-defined, individualistic, and less clearly resourced life they encounter post-military (Castro et al., 2015; Stebnicki, 2020).

Although Maslow's hierarchy of needs outlines the basic human requirements for fulfillment, it does not explain how to meet those needs. This relates to Criteria 4.H (Targeted Case Management) because it recognizes that support services must help clients address fundamental unmet needs to promote recovery. In the military, service members learn to meet these needs with structure and support from the military, but after leaving service, they must learn how to meet these needs in different ways—largely on their own.

Table 1: Needs Adaptation in Post-Military Life

Hierarchy of Needs	During Military Service	Post-Military Life
Physiological (food, water, shelter, clothing)	These needs are met at no cost as part of military service.	Basic needs must be obtained with limited or no support from others.
Safety (health, employment, family, personal security)	Safety and stability are core aspects of military service.	Safety and stability are no longer automatically provided and must be developed.
Love and Belonging (friendship, intimacy, family, connection)	Social groups are closely interrelated to fellow service members and military families.	SMVF must learn to engage others in unfamiliar social settings and establish relationships based on mutual interest rather than mutual occupation.
Esteem (respect, self-esteem, status, recognition)	The hierarchical and meritocratic structure of the military allows service members to regard themselves as accomplished and capable and to be seen that way by others.	After achieving a level of competence and skill in the military, some struggle to equate that competence and skill to nonmilitary situations, experiencing challenges in esteem and respect.
Self-Actualization (morality, creativity, achieving maximum potential)	Military service balances a challenging environment with support to achieve significant personal attainment while supporting others to do the same.	SMVF must develop alternative ways to express their full authentic selves and often explore their full potential apart from their SMVF identity.

As seen in the table above, a service member who was provided with the basic necessities of housing and stability in the military and who achieved high levels of occupational skill might be frustrated to find that they struggle to negotiate a rental contract or relocate to a new community where they have no support. During military service, social connections were established with other service members and within the communities where they were stationed, most likely with individuals who shared similar backgrounds and experiences.

Clinical mental health professionals can support the substantial psychosocial adjustment required by military transitions, especially when that adjustment results in significant distress. Although other community organizations are available to assist in meeting some needs, clinicians can support SMVF with their adjustments using well-known evidence-based interventions.

CBT helps SMVF reframe negative thoughts, develop coping strategies, and improve emotional regulation. Solution-Focused Brief Therapy (SFBT) emphasizes goal setting and problem-solving to support SMVF in adapting to post-military life. Mindfulness-based therapies, such as mindfulness meditation and ACT, assist in managing stress and distressing emotions.

Relationships

Military service creates a contained social network that surrounds service members immediately and completely. From basic training to duty assignments, technical training, education, and deployments around the country and the world, the mission-focused military

network can feel familial. Strong and healthy relationships, both intimate and social, serve as protective factors for SMVF during crisis. Conversely, disrupted relationships and a lack of connection may become risk or precipitating factors for a mental health crisis.

Military relationships are inherently different from civilian relationships because of the unique nature of service. The stress and danger of military service, frequent separations, and the effects on both the active and reserve components contribute to relationship challenges for SMVF—alongside the typical interpersonal dynamic challenges found in all relationships. When assessing the presence and strength of SMVF relationships, clinicians should consider the full range of interpersonal connections: intimate partners, family of origin, parental roles, and peer relationships.

Intimate relationships among SMVF can be both sources of support and stress. Many military families express pride in supporting their service members but also experience distress caused by recurrent moves, periodic separation, and the hazards of military life. During the high-risk deployments of the Iraq and Afghanistan conflicts, SMVF frequently reported marital strain. Several studies found increased rates of infidelity and divorce considerations among military couples during this period (Harvey et al., 2012; Riviere et al., 2012). Research comparing pre- and post-9/11 military population also showed an increased risk of divorce—especially for female service members and for couples married before 9/11 (Negrusa et al., 2014; Wang et al., 2015).

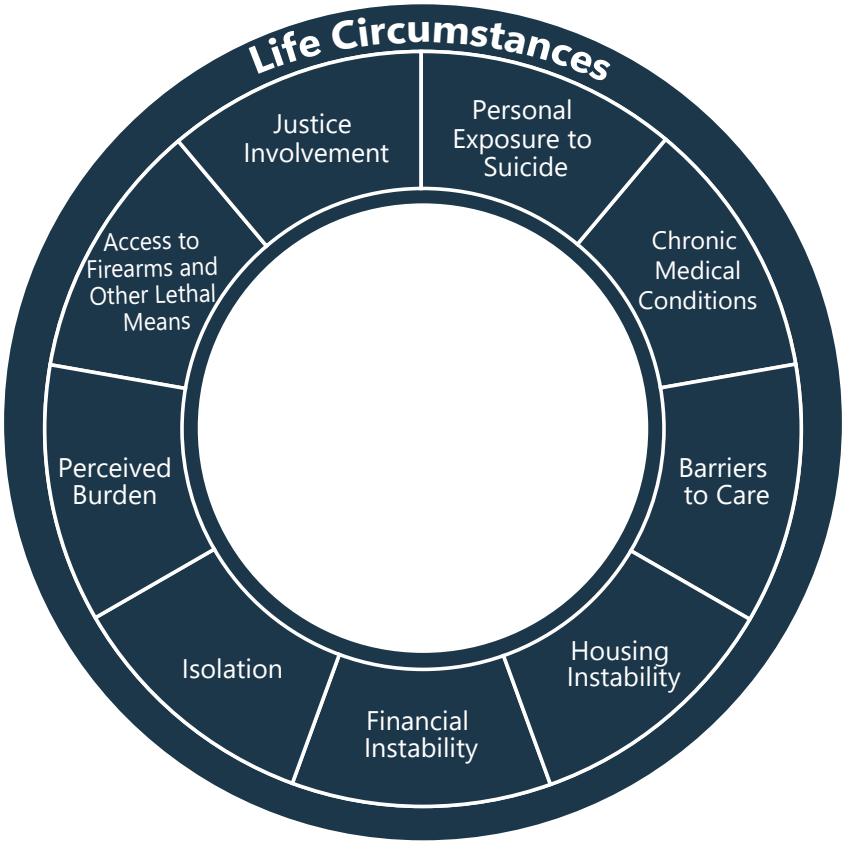
One important aspect of SMVF relationships is intimate partner violence (IPV). All SMVF should be screened for physical safety and interpersonal violence. CCBHCs should establish processes and protocols within their assessment tools and ensure staff receive training. This includes guidance on completing treatment plans specific to IPV and screening for IPV during crisis events. CCBHC staff and volunteers should have access to training resources, including IPV questions from the University of San Francisco, and guidance on establishing safety plans. This supports Criteria 2.C (24/7 Crisis Services) because it builds staff capacity to respond to domestic violence crises safely and effectively. Hotlines, such as the National Domestic Violence Hotline (1-800-799-7233), should be prominently displayed in visible locations, such as bathroom stalls, to ensure accessibility. Providers, staff, and community partners can utilize the VA Intimate Partner Violence Assistance Program to enhance support and intervention efforts.

Although SMVF are often separated from their family of origin, a common source of support, many find strong connections within military families. Given the transitory nature of service, military families often maintain long-distance relationships, both nationally and globally, with those they have served alongside. Concurrently, family-of-origin relationships may be strained by prolonged separation, changes in behavior and interests, or visible impacts of trauma. Unfortunately, many families express surprise at these changes and may wish for the service member or Veteran to "be like they were before."

Several evidence-based therapies effectively support SMVF relationship concerns. These include Cognitive-Behavioral Conjoint Therapy for PTSD, Integrative Behavioral Couple Therapy, Emotionally Focused Couples Therapy, Acceptance and Commitment Therapy for couples, and Gottman Method couples therapy (Christensen et al., 2020; Gottman & Gottman, 2015; Harris, 2019; Johnson, 2019; Monson & Fredman, 2012). These approaches help SMVF strengthen relationships by improving emotional connection, communication, and resilience. They focus on reducing stress, enhancing psychological flexibility, and addressing the unique challenges of military life, such as trauma, separation, and reintegration.

Life Circumstances and Community Concerns

Figure 4: Life Circumstances and Community Concerns that Impact Mental Health and Wellness



In addition to biopsychosocial conditions, SMVF can experience life circumstances that influence overall well-being. As CCBHC staff support Veterans with clinical diagnoses, they should also consider situational life circumstances that may influence or exacerbate these conditions. These may include community-based issues, such as barriers to effective mental health and substance use disorder care, involvement in the criminal legal system, lack of sustainable housing, or financial instability. Other risks may include stigma, personal exposure to suicide, isolation, and access to firearms and other lethal means.

Suicide among SMVF is a critical focus for VA, DOW, and other organizations supporting this community. In 2022, suicide rates varied notably among active-duty service members, National Guard and reserve members, Veterans, and the general U.S. population. The suicide rate for active-duty service members was 24.3 per 100,000, down from 28.7 in 2021. National Guard members had a suicide rate of 23.6, and reserve members had a rate of 21.2 per 100,000 (DOW, 2023). Veterans experienced a higher suicide rate of 33.9 per 100,000, an increase from 2021 (VA, 2024). Meanwhile, the general

population had an age-adjusted suicide rate of 14 per 100,000 (Curtin, Garnett, & Ahmad, 2023), highlighting the elevated risk among SMVF.

Suicidal thoughts, behaviors, and actions often reflect underlying and unresolved problems, such as the bio-psycho-social conditions mentioned earlier, and other life circumstances. As these conditions accumulate, SMVF may experience greater distress and require a strong support network. Although CCBHCs cannot address all life circumstances alone, they can play vital roles. As clinicians build trust and rapport with SMVF clients, they can become a source of stability, recovery, and hope. This aligns with Criteria 4.K (Community-Based Mental Health Services for Veterans) because it emphasizes how community-centered care supports both engagement and long-term recovery for Veterans. Additionally, Criteria 3.A (General Care Coordination Requirements) highlights the importance of relying on support from other professionals and providers to ensure comprehensive and coordinated care.

As with other clinical and transition stress conditions, the conditions in this section apply specifically to service members and Veterans. However, it is also important to consider how these conditions place significant emotional, psychological, and practical burdens on their families. Exposure to suicide and chronic pain can lead to prolonged stress and caregiver fatigue, often leaving families feeling helpless or emotionally overwhelmed. Mental health care barriers, combined with housing and financial instability, may create ongoing uncertainty and insecurity for the entire household. Feelings of isolation and burdensomeness can strain family relationships and erode support systems, whereas access to firearms or criminal legal system involvement may increase safety concerns and emotional trauma within the home.

Justice Involvement

Military and Veteran involvement in the civilian criminal legal system has become a growing concern during the Global War on Terror. To support justice-involved SMVF, specialized court programs such as Veteran Treatment Courts have been developed along with the broader establishment of military- and Veteran-specific cell blocks or pods in prisons.

It is estimated that between 100,000 and 180,000 Veterans are incarcerated each year. The Department of Justice's Bureau of Justice Statistics reported that more than 100,000 Veterans were sentenced to incarceration in state (96,300) or federal (9,100) prisons in 2016 (Lucas et al., 2022).

CCBHCs can better assist justice-involved Veterans by providing community-based resources. Veteran treatment courts in local jurisdictions provide rehabilitative alternatives to incarceration, focusing on substance use and mental health treatment. This supports Criteria 3.C (Care Coordination Partnerships) because it reflects community partnerships that promote alternatives to punitive approaches for justice-involved Veterans. Collaboration with public defenders and district attorneys can facilitate diversion programs and ensure Veterans receive appropriate legal representation. Guardian ad Litem and Court Appointed Special Advocate (CASA) agencies, along with local bar associations, can provide additional legal resources and advocacy services to support Veterans facing legal challenges.

VA's Veteran Justice Outreach (VJO) Program serves as a critical link, connecting justice-involved Veterans to VA health care, housing assistance, and mental health services. Another important VA program is the Health Care for Reentry Veterans (HCRV), which supports incarcerated Veterans transitioning back into the community. The program aims to prevent

homelessness and reduce the impact of medical, psychiatric, and substance misuse issues upon reentry. By leveraging these resources, CCBHCs can help Veterans access comprehensive support systems tailored to their needs.

Personal Exposure to Suicide

Research indicates that individuals exposed to suicide have significantly increased odds of dying by suicide or attempting suicide themselves. In this context, exposure to suicide refers to directly experiencing suicide loss or suicide attempts in oneself or others. It does not include asking someone whether they are considering suicide or self-harm. Inquiring about suicidal thoughts or behaviors does not increase suicidal ideation or self-harm; instead, it may encourage help-seeking and engagement in mental health treatment (Polihronis et al., 2022). Providing CCBHC staff with opportunities to attend suicide prevention training can increase familiarity with screening for suicidal ideation and help them learn how to ask about suicide directly.

Exposure to suicide attempts is linked to higher odds of subsequent suicide attempts when treatment is not provided or accessed (Hill et al., 2020). Given the suicide rates in the smaller SMVF population, they are more likely to have experienced suicide loss or been exposed to suicidal behaviors than the nonmilitary population.

CCBHCs can enhance suicide prevention efforts by leveraging local resources. Suicide prevention coalitions bring together key partners to develop focused strategies, whereas Local Outreach for Suicide Loss Survivors (LOSS) teams provide immediate support to those affected by suicide. This supports Criteria 6.C (Accreditation) because it highlights external partnerships that reinforce community collaboration and best practices in suicide prevention. Postvention initiatives offer structured support and education to reduce stigma and prevent further suicides. Additionally, assessing SMVF clients' exposure to suicide, including unit losses or personal experiences, can help providers identify risk factors and tailor interventions.

Chronic Medical Conditions

Chronic medical conditions, including chronic pain, insomnia, hearing and vision loss, and other persistent health issues, can significantly affect the mental health and overall well-being of SMVF. Chronic pain, defined as pain lasting longer than 3–6 months and beyond the normal healing period, is difficult to treat and is associated with numerous health problems and functional issues (Reilly et al., 2023). Dahlhamer et al. (2018) found that Veterans regularly experience a higher prevalence of chronic pain than the nonmilitary population (29.1% vs. 19.5%).

Similarly, insomnia and other sleep disorders are common among SMVF and may worsen symptoms of anxiety, depression, and irritability. According to Byrne et al. (2021), nearly 40% of U.S. Veterans experience clinical or subthreshold insomnia, which is associated with increased risks for depression, anxiety, suicidal ideation, and reduced psychosocial functioning.

Hearing and vision loss can lead to communication difficulties, social withdrawal, and a diminished sense of independence, all of which contribute to isolation and emotional distress. A retrospective analysis of injured U.S. military personnel deployed to Iraq and Afghanistan found a significant association between bilateral hearing loss and increased risk of PTSD. Among 1,179 male service members, PTSD rates were notably higher in those with bilateral hearing loss (29.2%) compared to those with unilateral (13.9%) or no hearing loss (9.1%) (Clifford & Ryan,

2022). Another study on U.S. military Veterans and service members found that those with vision loss are at increased risk for psychological distress, including higher rates of depression, anxiety, and PTSD (Hussain et al., 2021).

Many SMVF clients may also have been exposed to environmental hazards during military service. These exposures may be incidental or unintentional—such as burn pits, pesticides, or contaminated water—or may occur through occupational roles, including exposure to jet fuel, heavy metals, or traffic-related air pollutants. Such exposures can lead to long-term physical health conditions and contribute to psychological distress, uncertainty, and chronic stress (Hoisington et al., 2024)

By collaborating with medical providers, CCBHCs can ensure comprehensive and coordinated care that addresses both the physical and mental health needs associated with chronic medical conditions. This connects with Criteria 3.B (Health Information Systems) as it supports multidisciplinary care through improved communication across specialties. Additionally, Criteria 3.C (Care Coordination Partnerships) emphasizes the importance of developing partnerships with other providers to ensure seamless and coordinated care. Comprehensive assessments can identify the presence and effects of these conditions, enabling the development of customized interventions and treatment plans. Additionally, connecting SMVF with local and national organizations that offer adaptive engagement supports physical activity, social interaction, and mental well-being, enhancing overall quality of life.

Barriers to Care

SMVF may face numerous barriers to accessing and maintaining engagement in mental health treatment. External barriers include limited availability of providers familiar with SMVF experiences and needs, as well as difficulty affording care not covered by insurance or benefits. Other external barriers may involve scheduling conflicts with work or difficulty traveling to appointments. The *2019–2020 National Health and Resilience in Veterans Study* identified frequent relocations and deployments as challenges to maintaining consistent mental health care. Many also reported the limited availability of specialized mental health services, particularly in remote or rural areas, as a barrier (Kline et al., 2022).

The study also found that internal barriers, such as stigma surrounding treatment, real or perceived judgment from others, and feelings of guilt or shame based on self-perceptions of being "broken" or "weak," contributed to hesitancy in seeking care. Some SMVF expressed concerns about confidentiality and potential career implications, whereas others were unaware of available services or their need for them (Kline et al., 2022).

CCBHCs can help SMVF overcome barriers to mental health care by employing case managers with military-related backgrounds and experience. These professionals can assist clients in navigating external barriers and facilitating treatment engagement. Peer navigators and support groups can also play a crucial role in normalizing care and demonstrating its benefits. This aligns with Criteria 4.J (Peer Supports and Counseling) by leveraging shared experiences to promote acceptance and engagement in treatment. Their involvement promotes acceptance, strengthens engagement in treatment, and ensures care is responsive to the unique needs of the SMVF population.

Housing Instability

Veterans face a higher risk of homelessness when they lack strong social networks. Deployments and relocations often disrupt these connections, emphasizing the importance of community and family support during transitions to civilian life (Tsai & Rosenheck, 2015). SMVF experiencing

housing instability often report elevated levels of mental distress, including depression, anxiety, and suicidal ideation (Bossarte et al., 2013).

VA provides housing resources nationwide for Veteran families. Grant and Per Diem (GPD) programs offer transitional housing and supportive services to homeless Veterans through partnerships with community-based organizations. These programs aim to help Veterans achieve permanent housing by providing temporary housing, case management, employment assistance, and medical care. The program includes per diem funding for housing and services with a low-demand model to accommodate complex needs. Supportive Services for Veteran Families (SSVF) programs provide case management and supportive services to low-income Veteran families to prevent homelessness or rapidly rehouse homeless individuals. SSVF programs promote housing stability by helping with rental payments, utilities, security deposits, and related expenses. Similarly, VA's Health Care for Homeless Veterans (HCHV) program managers oversee outreach and services to reduce Veteran homelessness. HCHV coordinates community-based residential treatment, case management, and rehabilitative services focused on engaging and connecting unsheltered Veterans to VA care and supportive housing.

The U.S. Department of Housing and Urban Development (HUD)-Veterans Affairs Supportive Housing (HUD-VASH) program combines HUD's Housing Choice Voucher rental assistance with VA case management and clinical services. This collaborative program helps homeless Veterans secure permanent housing and access necessary health care, mental health services, and other supportive services. Additionally, local HUD Continuum of Care (CoC) programs promote a community-wide commitment to ending homelessness by funding nonprofit providers, states, and local governments to quickly rehouse homeless individuals and families while minimizing trauma and optimizing self-sufficiency. VA resources require eligibility screening and enrollment; however, other resources are available for SMVF who are not eligible for or enrolled in VA care. Collectively, these initiatives offer comprehensive support for CCBHC staff assisting SMVF experiencing housing instability.

Financial Instability

Studies have shown that there is a bidirectional relationship between financial stability and mental health symptoms, including suicidal ideation (Elbogen et. al., 2012). Financial stability has been found to be generally associated with fewer mental health symptoms, and improvements in depression symptoms increase the likelihood of finding and maintaining employment.

CCBHCs should provide SMVF clients with vetted resources and refer them to local VA benefits experts to determine eligibility for financial resources. Unemployment and underemployment can create stress, and referring clients to local employment resources or incorporating those resources into CCBHC services helps support SMVF.

CCBHC staff can connect SMVF clients with national employment support organizations that offer career development, job placement assistance, and skills translation services to help Veterans transition into civilian careers. Similarly, local and state workforce agencies provide job search support, vocational training, and access to unemployment benefits to help SMVF secure stable employment. The VA's Veteran Readiness and Employment (VR&E) program helps Veterans with service-connected disabilities prepare for, find, and maintain suitable employment or achieve greater independence if they are unable to work. Services include vocational counseling, training, job placement, and support for self-employment or independent living tailored to

individual needs. Additionally, VA's National Veterans Financial Resource Center (FINVET) equips Veterans and their families with financial literacy tools, including budgeting, debt management, and benefits navigation.

Joiner's Interpersonal Theory of Suicide

In his 2005 book, *Why People Die by Suicide*, Dr. Thomas Joiner proposed the interpersonal theory of suicide, which outlines specific life circumstances that contribute to the development of a suicidal crisis. This conceptual approach proposes that when three components—perceived burdensomeness, thwarted belongingness, and capability for suicide—are present together, the risk for suicidal behavior increases significantly.

- **Thwarted Belongingness:** The person feels socially disconnected, isolated, or alienated and believes they lack meaningful relationships.
- **Perceived Burdensomeness:** The person believes they are a burden to others and that their death would benefit those around them.
- **Capability for Suicide:** The person has the ability and means to enact lethal self-harm.

Isolation

SMVF are at greater risk of experiencing thwarted belongingness because of disruptions in social relationships, self-imposed disconnection, or perceived or actual ostracization. Leaving the military is a form of separation or social severance, marked by the loss of belonging to a team, unit, or group. Connectedness and belonging are significant protective factors against suicidal thoughts and behaviors, whereas isolation and lack of belonging are risk factors that increase the likelihood of crisis.

CCBHCs can support SMVF experiencing isolation by facilitating connections and engagement through peer groups. Peer support specialists can offer empathy and understanding through shared experiences. CCBHCs can also encourage SMVF to connect with organizations that align with their personal interests, such as fitness, outdoor activities, gaming, and civic engagement, to foster a sense of community and reduce isolation, promoting overall well-being.

Perceived Burden

SMVF clients may express a sense of burdensomeness—the belief that their existence is a burden to others or society—during discussions. Self-reliance, confidence, competence, and personal agency are core strengths of the military and Veteran community. The combination of personal and collective effort in military service often gives SMVF a sense of capability. A drawback of this mindset is that many SMVF feel they must do their part to "not let their buddies down" and be perceived as a "weak link." If life circumstances, including mental and physical health conditions, conflict with their sense of self-reliance, some SMVF may perceive themselves as a burden to others.

Veterans with physical or psychological disabilities resulting from their military service may hesitate to ask for support or disability compensation or may see themselves as a burden when accepting assistance. CCBHC staff can use supportive approaches to explore and address SMVF's feelings of burdensomeness. Facilitating peer groups and engaging peer specialists can offer understanding through shared experience, helping SMVF feel less isolated. Connecting SMVF with opportunities to contribute meaningfully to their community can help them recognize their value and capabilities, reducing feelings of burdensomeness.

Access to Firearms and Other Lethal Means

An aspect of military training is developing the ability to inflict harm and overcome the natural resistance to using potentially lethal force. Although this training is necessary for service members and Veterans to carry out combat missions, it can also increase their capacity for lethal self-harm. If an individual is experiencing isolation and perceived burdensomeness, access to firearms and other lethal means—combined with familiarity in their use—can elevate the risk of suicidal behavior.

Nearly half of all Veterans, approximately 44.9%, own one or more firearms and often exhibit risky firearm usage and storage behaviors, such as keeping firearms loaded and unlocked or storing them in unsecured locations (Theis et al., 2021). As an extremely lethal method, firearms accounted for 73.5% of Veteran deaths by suicide in 2022 (U.S. Department of Veterans Affairs, 2024). However, it is important to recognize that many Veterans are responsible firearm owners and view ownership as a protective measure. Firearm safety, including proper handling and storage, is a core value for many firearm owners. Understanding these nuances, appropriately assessing firearm access, and providing solutions that exclude weapon removal can lead to more successful outcomes in promoting safe storage. To support SMVF clients, CCBHCs can contact the local VA facility and collaborate with their suicide prevention teams. Many facilities offer storage solutions for lethal means, including medication lock bags and gun locks.

Firearms are not the only concern regarding lethal means in the SMVF population. According to the *2024 National Veteran Suicide Prevention Annual Report*, there were 1,200 overdose deaths among Veterans in 2022 with a significant portion involving prescription medications. The report emphasized the need for safe prescribing practices and effective substance use disorder treatment to reduce the risk of both accidental and intentional overdoses (U.S. Department of Veterans Affairs, 2024). Based on this, CCBHCs are encouraged to consider naloxone education and distribution for SMVF.

Counseling on Access to Lethal Means (CALM) is an evidence-based strategy aimed at reducing suicide risk by limiting access to lethal means. This supports Criteria 4.C (Crisis Behavioral Health Services) because it includes suicide prevention techniques that can be implemented during crisis intervention. CALM training equips healthcare providers, mental health professionals, and community members with skills to discuss safe storage options and develop plans to reduce access for individuals at risk of suicide. The VA's *Toolkit for Safe Firearm Storage in Your Community*, part of the VA's *National Strategy for Preventing Veteran Suicide*, provides resources and training to help healthcare providers talk with Veterans about secure storage of firearms and medications. The toolkit includes practical tips, social media materials, and long-form content to promote lethal means safety and reduce Veteran suicide rates.

Worried About a Veteran (WAV) is an initiative designed to empower loved ones to help prevent Veteran firearm suicide. Its website offers resources and guidance on supporting Veterans in crisis, securing firearms and medications, and recognizing suicide warning signs. WAV also provides practical steps and personal stories from Veterans, families, and friends who have experienced suicidal crises, helping others navigate similar situations. Together, these resources offer comprehensive support and actionable tools to reduce access to lethal means and prevent suicide among at-risk individuals, particularly Veterans.

Insights From Experts

VA's Whole Health program specifically emphasizes chronic pain management through a multifaceted whole-person pain care approach, which can serve as a valuable resource for CCBHCs in developing effective pain management strategies. This model integrates conventional medical care with complementary and integrative health (CIH) therapies, such as acupuncture, yoga, and meditation, while also emphasizing mind–body approaches like Cognitive Behavioral Therapy for Chronic Pain (CBT-CP) and mindfulness. Veterans collaborate with providers to create personal health plans based on their individual goals and values and receive support through health coaching, peer connections, and group services. Additional focus is placed on movement, nutrition, social support, and environmental factors, ensuring a comprehensive approach to pain care that addresses both physical symptoms and emotional well-being. *—Ashley Delehanty, LSCSW, Community Engagement and Partnership Coordinator, VA Eastern Kansas Health Care System–Topeka*

The presentation of emotional dysregulation symptoms—specifically anger—can vary significantly. These may include intolerance, frustration, rage, road rage, aggressiveness, and a willingness to engage in confrontation. Military service, especially within the combat arms specialties of the Marine Corps and Army, encourages the development of these attributes into focused aggression needed to close with and engage the enemy directly. Although this warrior mentality may serve well in the military, its ingrained nature can prove problematic in the workplace, social settings, and personal relationships. Screening for the associated behaviors should be included in treatment planning, especially when close family members—who are often best positioned to recognize related personality changes—can provide relevant information. *—Tim Keesling, Director, Office of Veteran Services Coordination, Texas Health and Human Services*

Understanding that behavioral health concerns are not limited to service members or Veterans who experienced deployments or combat is essential for providers. Although some organizations focus solely on combat exposure, it is critical to recognize that all who have served may face unique behavioral health challenges shaped by military experiences beyond the battlefield. Best practice recommends asking the question, "Have you or a loved one ever served in the armed forces?" during intake assessments to allow individuals to self-identify as SMVF. This approach ensures that all who served—regardless of combat status—are recognized and that follow-up questions about branch and service history can guide more informed and personalized care. *—Sarah Melecki, Director of System Integration, Texas Health and Human Services*

VOAMASS staff support incarcerated SMVF clients by identifying service needs and developing release plans prior to release. Eligible clients may be referred to the GPD or other residential programs as well as therapy, medication management, and community support services. Engaging clients while they are still incarcerated helps reduce pre-release stress and improves post-release engagement by ensuring services are coordinated and in place. *—Angela Eberle, MBA, Vice President of Integration & Program Development, Volunteers of America, Massachusetts*

Consider novel approaches to supporting SMVF in meeting their needs, such as establishing Veteran-only food pantry days. Veterans often prioritize others' needs before their own, making them less likely to access general food pantries. SMVF-specific pantries reduce stigma, foster community, and create opportunities to connect individuals with additional resources. CCBHCs can enhance outreach by partnering with SMVF-focused organizations to deliver services in trusted, familiar environments. *—Sarah Strang, LPC, Mobile Crisis Outreach Team and Resiliency Team Director, The Harris Center for Mental Health and IDD*

High-risk behaviors such as substance misuse, gambling, and compulsive sexual behavior can significantly increase the likelihood of self-harm and suicidal ideation, particularly when co-occurring with trauma or mental health disorders. Comprehensive screening and early intervention are essential to reduce suicide risk and improve long-term outcomes.*—Kristin Sauerbier, LCSW, Senior Project Associate, Policy Research Associates, Inc.*

Reintegration into civilian life is a monumental milestone in military service—for both the service member and their family. Veterans may experience difficulties navigating roles, hopelessness, isolation, a lack of belonging, and a loss of purpose. Families may face challenges related to role navigation, disrupted routines, potential differences in parenting styles (as a spouse may have been primarily responsible in the service member's absence), sleep disruption, and ongoing hypervigilance (outside of PTSD). *—Sarah Baker, LSCSW, Community Engagement and Partnership Coordinator, VA Eastern Kansas Health Care System–Leavenworth*

A thorough biopsychosocial assessment of lifespan development is crucial for clinicians aiming to avoid cognitive bias. This approach ensures that biological, psychological, and social factors influencing a client's mental health are fully considered. Clinicians must avoid assuming a positive correlation between current mental health and prior military experience because this can stigmatize mental health conditions and perpetuate harmful stereotypes. By conducting detailed assessments, clinicians can provide accurate diagnoses and effective treatment plans, dismantling stereotypes and ensuring respectful, individualized care for SMVF clients. *— Kerry Bond, LSCSW, DBT-C, Community Engagement & Partnerships Coordinator, Robert J. Dole VA Medical Center*

At our CCBHC, we utilize the nationally standardized and stakeholder-driven Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE®) tool to identify and address other factors that influence health. Paired with the Implementation and Action Toolkit, PRAPARE enables our team and community partners to better understand patient needs and take meaningful action to advance health at individual, community, and systemic levels. This approach has been instrumental in uncovering needs that might otherwise go unrecognized. *—Mindy Miller, LMHC, LADC1, Chief Operating Officer, Volunteers of America of Massachusetts*

Notes From the Field

VOAMASS | Jamaica Plain, MA

Volunteers of America—Massachusetts (VOAMASS) ensures its clinical staff are trained in evidence-based treatments and interventions specific to the SMVF community. Staff have received training in PCL-5, Zero Suicide prevention, and serving military populations. This specialized training equips them to address the unique needs of Veterans and their families.

All clinical staff at VOAMASS are trained to address suicidal risk in the SMVF population. This includes comprehensive assessments covering risk assessment, suicide prevention, military history, safety, and demographic history diagnoses. The staff's training in Zero Suicide further enhances their ability to manage and mitigate suicidal risks among Veterans.

VOAMASS is well equipped to address SMVF's community-based needs through its integrated care model, which provides wraparound services for every client. This model includes access to recovery coaches, navigators, housing specialists, behavioral health therapists, and medication management. They also offer a program focused on assisting current and recently released Veterans from incarceration with training, education, employment, and navigating post-release barriers. VOAMASS is developing a centralized intake system for all Veteran programs, modeled after their integrated behavioral health care.

Community Counseling Center | Ashtabula, OH

Community Counseling Center of Ashtabula, Ohio, has trained its clinical staff in evidence-based treatments and interventions specific to the SMVF community, with one staff member completing the three tiers of STAR training. This specialized training ensures the staff are equipped to meet the unique needs of Veterans and their families. Staff have also completed Zero Suicide training to address suicidal risk in the SMVF population. However, the organization recognizes that additional training specific to SMVF is an opportunity for further development.

The organization has the capacity to address the community-based needs of SMVF, including housing, employment, and criminal legal system involvement. They employ adult and youth case managers and offer supported employment services. Although one Veteran serves as a case manager, the role is not specifically dedicated to Veteran clients. The organization also participates in the Veterans Court specialized docket to further support Veterans in the criminal legal system.

Berks Counseling Center | Reading, PA

Berks Counseling Center has trained some clinical staff in evidence-based treatments and interventions specific to the SMVF community. This specialized training helps ensure Veterans and their families receive appropriate and effective care.

Although the staff have received generalized suicide prevention training, they have not yet received training specifically focused on addressing suicidal risk in the SMVF population—an area for future growth and development.

The organization addresses the community-based needs of SMVF—including housing, employment, and criminal legal system involvement—either directly or through strong community relationships and partnerships. This comprehensive approach ensures Veterans receive the support across different areas of life.

Family Service of Rhode Island | Providence, RI

Family Service of Rhode Island (FSRI) has trained its clinical staff in evidence-based treatments and interventions specific to the SMVF community. Staff are trained in military experience and therapeutic approaches, including CBT, Dialectical Behavior Therapy (DBT), Motivational Interviewing (MI), and Trauma Focused-CBT, enabling them to provide effective and specialized care for Veterans and their families.

To address suicidal risk in the SMVF population, FSRI staff use the Columbia-Suicide Severity Rating Scale (C-SSRS) and have completed Assessing and Managing Suicide Risk–Zero Suicide training. This comprehensive training equips them with the necessary skills to manage and mitigate suicidal risk among Veterans.

FSRI addresses community-based needs—such as housing, employment, and criminal legal system involvement—through military case managers who coordinate with specialized community providers. Staff use multiple assessments to screen for behavioral health, medical, and community needs, including the bio-psycho-social assessment, PHQ, C-SSRS, Interpersonal Support Evaluation List (ISEL-12), Generalized Self-Efficacy Scale, Socio-Economic Status (SES), and Warwick Edinburgh Mental Wellbeing Scale (WEMWS). This thorough approach ensures SMVF needs are continuously monitored and addressed.

High Plains Mental Health Center | Hays, KS

High Plains Mental Health Center clinical staff are trained in evidence-based practices (EBPs) to serve the SMVF community effectively. These EBPs include CBT, Trauma-Informed CBT, DBT, EMDR, ACT, and MI. After conducting a needs assessment, they also added CPT to better address Veteran-specific needs.

Staff receive comprehensive training to address suicidal risk in the SMVF population, including suicide screening and assessment, suicide-specific interventions and best practices, and the Columbia Suicide Risk Assessment (C-SSRS). These trainings ensure staff are equipped to manage and mitigate suicidal risks among Veterans.

To address the community-based needs of SMVF, High Plains Mental Health Center and the DLA-20 assessment. They offer case management and community-based supports through their CSS and ACT programs. Additionally, they provide employment support through their Individual Placement and Support (IPS) program, ensuring comprehensive support for Veterans in various aspects of their lives.

Valley HealthCare System | Morgantown, WV

Valley HealthCare System equips its clinical staff with the necessary tools to treat and support SMVF through education and on-site training. Staff are trained in VA evidence-based treatment models such as EMDR, CBT, DBT, CBT for Insomnia, and MI, ensuring they can provide effective and specialized care.

To address suicidal risk, the Veterans Administration provides annual S.A.V.E. training during the Veteran Coalition Meeting in July. This training covers the signs of suicide, asking about suicide, validating feelings, and encouraging help. Additionally, Valley HealthCare System operates a 24-hour crisis line with trained staff available.

The organization addresses the community-based needs of SMVF through programs and partnerships. Their Law Enforcement Assisted Diversion (LEAD) Program improves public safety and reduces unnecessary criminal legal system involvement. Partnerships with WorkForce WV, the VA, SSVF, and other community providers support housing, utilities, education, and other essential needs. Valley HealthCare System also collaborates with a Veterans' sober living facility (Aspire Services Center) with the CEO serving on its board to ensure coordination.

Community Fairbanks Behavioral Health | Indianapolis, IN

Community Fairbanks Behavioral Health ensures its clinical staff are trained in evidence-based treatments and interventions specific to the SMVF community. The CCBHC provides Evidence-Based Training (EBT) for all populations, including SMVF. Specific to SMVF, the Veterans Care Coordinator (VCC) coordinates with the local VA's Prevention Department to present SAVE training. Additionally, the CCBHC offers training titled "An Understanding of Military Culture for Behavioral Health Paraprofessionals," which focuses on military structure, correct military terms, and the stigma associated with behavioral health in the military.

The organization provides training to assess suicide risk in all populations, including SMVF. The VCC coordinates with the local VA's Prevention Department to present SAVE training, ensuring staff are equipped to address suicidal risk in the SMVF population.

As part of CCBHC requirements, Community Fairbanks Behavioral Health focuses on identifying social drivers of health, especially for vulnerable populations like SMVF. The VCC coordinates with community partners, including the VA, to stay updated on Veteran-specific resources. These partnerships enable the VCC to assist referred Veterans, their families, and their multidisciplinary treatment team in accessing needed resources, addressing community-based needs such as housing, employment, and involvement in the criminal legal system.

Ideas for Action

EMBED SCREENING QUESTIONS:

Incorporate the question, “Have you or a family member ever served in the military?” into all intake forms, electronic health records (EHRs), and assessment tools to systematically identify SMVF clients.

IMPLEMENT COMPREHENSIVE SCREENING PROTOCOLS:

Develop and utilize detailed screening, assessment, and diagnostic tools tailored to the full range of clinical needs and life circumstances of SMVF clients.

CREATE INCLUSIVE TREATMENT AND SAFETY PLANS:

Design person- and family-centered treatment plans that integrate military identity and address the full spectrum of behavioral health, substance use, and life circumstances.

COORDINATE CASE MANAGEMENT:

Establish focused case management services that coordinate care across providers, reducing the burden on clients to manage their care independently.

DEVELOP TRAINING TO ADDRESS BIOPSYCHOSOCIAL CONCERNS:

Provide ongoing training for staff on the clinical concerns specific to SMVF, including the effects of trauma, substance use, and transition stress.

BUILD A REFERRAL NETWORK TO SUPPORT LIFE CIRCUMSTANCES:

Develop a robust referral network with local organizations and agencies to address life circumstances such as housing instability, financial insecurity, and legal issues, ensuring comprehensive support for SMVF clients.

Resources

RAND Resources for Service Members, Veterans, Families and Caregivers

The RAND Corporation's Military Veterans topic page explores research and analysis focused on the health, well-being, and reintegration of U.S. military Veterans. It covers issues such as mental health, suicide prevention, employment, education, and access to care.

STAR Behavioral Health Providers Training Program

Star Behavioral Health Providers (SBHP) connects military SMVF with trained mental health providers. SBHP offers training on military experiences and effective treatments to ensure providers understand and address the unique needs of military-connected clients.

Strong Star Training Initiative

The STRONG STAR Training Initiative provides comprehensive training for mental health clinicians with a focus on evidence-based treatments for PTSD and suicide prevention. It aims to enhance mental health care for Veterans and military members through education, resources, and support.

Justice for Vets: Veteran Court Resources

Justice for Vets transforms how the justice system responds to Veterans by providing training, technical assistance, and advocacy for Veterans Treatment Courts. It supports efforts to address mental health and substance use disorders, ensuring no Veteran is left behind.

Veteran Housing Programs: Supportive Services for Veteran Families

The SSVF program helps low-income Veterans and their families by providing case management and supportive services. It aims to prevent homelessness and rapidly rehouse Veterans experiencing housing instability.

National Veterans Financial Resource Center

The VA's Financial Integration for Well-Being (FinVET) program, hosted by VISN 19 MIRECC, supports Veterans by integrating financial well-being into mental health care. It offers tools, training, and research to address financial stress as a factor in suicide prevention and recovery.

Department of Labor Veterans Employment and Training Service (VETS)

The Veterans' Employment and Training Service (VETS) helps Veterans, service members, and military spouses achieve their career goals. It offers employment resources, training, and grants, and protects employment rights to ensure meaningful careers and successful transitions to civilian life.

VA Health Care Provider Resources

The VA provides resources and training for health care providers to support Veterans' mental health. It covers topics such as PTSD, depression, and substance use, offering tools to enhance care and improve Veterans' well-being.

Uniformed Services University Center for Deployment Psychology

The Center for Deployment Psychology (CDP) provides training for behavioral health professionals on evidence-based treatments for military-related psychological concerns. It offers workshops, online courses, and resources to enhance care for service members, Veterans, and their families.

Supporting People with Brain Injury through CCBHCs

This resource, developed by NASHIA, guides CCBHCs in supporting clients with brain injury. It emphasizes integrated treatment, crisis services, and support for SMVF, aiming to improve access, quality, and outcomes in behavioral health care.

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SAMHSA
Substance Abuse and Mental Health Services Administration

SAMHSA leads public health and service delivery efforts that treat mental illness, especially serious mental illness, prevent substance abuse and addiction, and provide treatments and supports to foster recovery while ensuring access and better outcomes for all.

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