



# Final Report of the Veterans Behavioral Health Advisory Board

*Maryland Veterans  
Behavioral Health  
Needs, Gaps and  
Recommendations*

---

Report to the Governor and General Assembly as required by Section 13-2703 of Health – General Article of the Annotated Code of Maryland (Chapters 555 and 556)

January 31, 2011

**STATE OF MARYLAND**

OFFICE OF THE LT. GOVERNOR

---



**ANTHONY G. BROWN**  
LT. GOVERNOR

STATE HOUSE  
100 STATE CIRCLE  
ANNAPOLIS, MARYLAND 21401-1925  
(410) 974-2804  
(TOLL FREE) 1-800-811-8336

TTY USERS CALL VIA MD RELAY

January 31, 2011

The Honorable Martin J. O'Malley  
Governor of Maryland  
State House  
100 State Circle  
Annapolis, Maryland 21401-1925

The Honorable Thomas V. Mike Miller, Jr.  
President of the Senate  
State House  
100 State Circle, Room H-101  
Annapolis, Maryland 21401-1991

The Honorable Michael E. Busch  
Speaker of the House  
State House  
100 State Circle, Room H-107  
Annapolis, Maryland 21401-1991

Re: Health – General Article, Annotated Code of Maryland, Section 13-2703  
Final Report of the Veterans Behavioral Health Advisory Board

Dear Governor O'Malley, President Miller and Speaker Busch:

Pursuant to the requirements of Health – General Article, Annotated Code of Maryland, Section 13-2703, I respectfully submit on behalf of the Veterans Behavioral Health Advisory Board its Final Report, unanimously adopted, which addresses as required by the legislation the behavioral health needs and gaps in these services for Maryland's Veterans and their families.



Governor O'Malley, President Miller and Speaker Busch  
January 31, 2011  
Page 2 of 2

The Advisory Board has developed, as requested, significant recommendations that if adopted will address the concerns of the legislation with respect to improving outreach to Veterans and their families, promoting Federal and State collaboration, building provider capacity and increasing provider training, and improving the coordination of behavioral health services for Veterans and their families.

The Advisory Board has examined the myriad of activities across the State undertaken in support of Maryland Veterans, and has identified the gaps that exist in service availability and quality and effectiveness, between need and use of services, in health care coverage and access, coordination and communication, and availability of data. Importantly, with this knowledge base we are recommending that the State align, streamline and empower its overall Veteran agenda with the full authority of the Governor by creating a responsible and responsive sub-cabinet. We believe that a significant cultural shift across Maryland government to increasingly "Think Veteran" is critical to our being able to successfully address the needs of our Veterans.

I commend this report to you for your consideration. Let us work together to ensure that these recommendations receive the active response they deserve so that Maryland addresses its gaps in services and fully meets the needs of our Veterans and their families.

Sincerely,

A handwritten signature in black ink, appearing to read 'AG Brown', written in a cursive style.

Anthony G. Brown

## ***Acknowledgements***

The preparation of this report involved the efforts of many individuals who generously contributed their expertise and time. Staff members of many Maryland offices offered advice and assistance. Additionally, federal partners in many offices of the U.S. Department of Veterans Affairs, the U.S. Department of Defense, and the U.S. Department of Labor provided helpful explanations and data.

We would like to thank in particular: Adam Ortiz, Deputy Chief of Staff to the Lieutenant Governor; Valerie Roddy, Chief of Staff to the Deputy Secretariat for Behavioral Health & Disabilities, Maryland Department of Health and Mental Hygiene; Archie Wallace, Interim Director of Maryland's Commitment to Veterans; and, Jerry Boden, Chief of Staff to the Secretary, Maryland Department of Veterans Affairs.

We would also like to acknowledge the work of the members of the three workgroups. Their thinking, research, and valuable insights are evident in this report. These individuals provided direction and content through their service on the workgroups

### **Access and Transportation Workgroup**

Scott Rose, Chair, Advisory Board Member – President/CEO, Way Station, Inc.

Bill Forbes, Former Deputy Secretary, Maryland Department of Veterans Affairs (MDVA)

Michael Gafney, Lieutenant Colonel, Maryland National Guard (MDNG)

Brian Hepburn, MD, Executive Director, Mental Hygiene Administration, Maryland Department of Health and Mental Hygiene (DHMH)

Joseph Liberto, MD, Director, Mental Health Clinical Center, VA Maryland Health Care System, Advisory Board Member

Karen Montgomery, Senator, Maryland General Assembly

Patricia Sanders, Prince George's County Americans with Disabilities Coordinator

Connie Walker, Captain, U.S. Navy (ret.), Advisory Board Member (past)

### **Outreach and Education Workgroup**

Doug Peters, Chair, Advisory Board Member – Senator, Maryland General Assembly

Jerry Boden, Chief of Staff, MDVA

Chuck Bond, Prince George's County Director of Crisis Response System

Edward Chow, Advisory Board Member – Secretary, Maryland Department of Veterans Affairs

Cate Conroy, Deputy Director, Outreach and Advocacy, MDVA

Margaret Hornberger, Community Resources Dev. Specialist, VA Maryland Health Care System

John O'Brien, LCSW-C, Director of Social Work, Baltimore VA Medical Center (VAMC)

Bob Sharps, Former Director, Outreach & Advocacy, MDVA

Connie Walker, Captain, U.S. Navy (ret.), Advisory Board Member (past)

Charles Williams, Colonel, U.S. Army (ret.), Executive Director, Maryland Center for Veterans Education and Training (MCVET)

## **Children, Families and Special Populations Workgroup**

Note: This was originally two workgroups that were later consolidated into one.

Jim Martin, PhD, Colonel, U.S. Army (ret.), Chair – Advisory Board Member  
Major General Jim Adkins, Adjutant General, Advisory Board Member  
Marcia Andersen, DHMH, Mental Hygiene Administration  
Paulette Baldwin, Clinical Director, Mental Health & Disabilities Admin., Prince George’s County  
Marian Bland, DHMH, Mental Hygiene Administration  
John Colmers, MPH, Advisory Board Member – Former Secretary Maryland Department of Health and Mental Hygiene (DHMH)  
Laura Copland, Former Director, Behavioral Health Disaster Services, DHMH  
Susan Deal, Kennedy Krieger Institute  
Victoria Eyler, Psy.D., Mental Health Program Manager, VA Capitol Health Care Network , Veterans Integrated Service Network (VISN) 5  
Eugenia “Gena” Greenhood, Prince George’s County Core Service Agency (CSA) Child & Adolescent Coordinator  
Kathy Lockhart, Psychiatric Nurse, Past Director of Nursing, VA Medical Center, Baltimore, MD  
Jane McCarthy, Veteran, Member of Montgomery County Veterans Commission  
William Prescott, Rear Admiral, U.S. Public Health Service (ret.), Chairman, Major General Boyd Cook Veterans Memorial Foundation  
Eugene Siciliano, LCSW-C, Lead Social Worker for Mental Health, VA  
Veronica Thurmond, VISN 5, Operation Iraqi Freedom/Operation Enduring Freedom Women’s Program  
Raymond “Clive” Watson, Prince George’s County CSA Adult & Elderly Coordinator  
Charles Williams, Colonel, U.S. Army (ret.), Exec. Director, MCVETS, Advisory Board Member

We are grateful as well to these individuals who provided valuable time to meet and discuss their programs and initiatives and to provide insights into the behavioral needs of Veterans. We have endeavored to ensure that the following list is complete, but we apologize for any omissions.

Melissa Barber, Western Regional Resource Coordinator, Maryland’s Commitment to Veterans (MCV)  
Michael Bargiband, Eastern Regional Resource Coordinator, MCV  
Linda Bartnyska, Chief, Cost & Quality Analysis, Maryland Health Care Commission  
Allen Berkowitz, VA Capitol Health Care Network – VISN 5  
Eric Brenner, Director, Governor’s Grants Office  
Arianna Day, Southern Regional Resource Coordinator, MCV  
David Edwards, Chief of Public and Community Relations, VA Maryland Health Care System  
Larry Fitch, DHMH, Mental Hygiene Administration  
Sharon Gant, VISN 5 Rural Health Outreach Coordinator  
Mark Goldstein, Maryland Department of Planning  
George Hardinger, Carroll County Detention Center, Warden  
Chaplain (Colonel) Sean Lee, MDNG

Patricia Lane, Maryland Veterans Justice Outreach Coordinator, VA  
Sarah Leming, Office of the Lieutenant Governor  
Daryl Plevy, DHMH, Maryland's Mental Health Transformation Office  
Joe Rollo, Director, Psychological Services Division, Prince George's County Police  
Robin Sabatini, Chief of Staff, Department of Budget & Management  
Mary Beth Skupien, Director, Office of Rural Health, VA Central Office  
George Thorpe, DHMH, Family Health Administration  
Jesse Vazzano, Network Homeless Coordinator, VA Capitol Health Care Network – VISN 5  
Sheila Warren, Deputy Director, Office of Rural Health, VA Central Office  
Edgar Wiggins, CEO, Baltimore Crisis Response, Inc.

This report was prepared, under contract, by Patricia J. O'Neil, a consultant on Veterans Affairs.  
She was assisted by Lynne Smith, Research Associate.

## *Acronyms*

ADAA:	Alcohol and Drug Abuse Administration
ASP:	Anti-Stigma Project
BCRI:	Baltimore Crisis Response, Inc.
BH:	behavioral health
BHS:	behavioral health services
BHSP:	behavioral health service providers
BRAC:	Defense Base Closure and Realignment Commission
C2C:	<i>Combat2College</i> program
CBOCs:	Community Based Outpatient Clinics
CEVSS:	Centers of Excellence for Veteran Student Success program
CHALENG:	Community Homelessness Assessment, Local Education and Networking Groups
CHCBP:	Continued Health Care Benefit Program
CHVH:	Charlotte Hall Veterans Home
CSAs:	Core Service Agencies
DCoE:	Defense Centers of Excellence
DHCD:	Maryland's Department of Housing and Community Development
DHMH:	Maryland Department of Health and Mental Hygiene
DHR:	Maryland Department of Human Resources
DLLR:	Maryland Department of Labor, Licensing and Regulation
DOC:	Department of Corrections
DoD:	U.S. Department of Defense
DOL:	U.S. Department of Labor

E-RANGE:	Enhanced Rural Access Network for Growth Enhancement program
HCV:	Housing Choice Voucher
HRSA:	U.S. Health Resource and Service Administration
HUD:	U.S. Department of Housing and Urban Development
MCCJTP:	Maryland Community Criminal Justice Treatment Program
MCV:	Maryland's Commitment to Veterans
MCVET:	Maryland Center for Veterans Education and Training
MDARNG:	Maryland Army National Guard
MDNG:	Maryland National Guard
MDVA:	Maryland Department of Veterans Affairs
MHA:	Mental Hygiene Administration
MOS:	Military Occupation Specialties
MOU:	Memo of Understanding
MPT:	Maryland Public Television
MST:	military sexual trauma
MVTF:	Maryland Veterans Trust Fund
NCO:	Non-Commissioned Officer
OIF/OEF:	Operation Iraqi Freedom/Operation Enduring Freedom
PARIS:	Public Assistance Reporting Information System
PATH:	Projects for Assistance in Transition from Homelessness
PST:	Peer Support Technician
PTSD:	Post-Traumatic Stress Disorder
RAND:	The RAND Corporation, a research and analysis non-profit institution
RRCs:	Regional Resource Coordinators
RRS:	Veterans' Reentry and Reintegration Specialist



RUCA:	Rural-Urban Commuting Area Codes
RVHIC:	Rural Veterans Health Information Center
SAMHSA:	Substance Abuse Mental Health Services Administration
SSFVF:	Supportive Services for Veterans Families Program
TAMAR:	Trauma, Addiction, Mental Health and Recovery Program
TBI:	Traumatic Brain Injury or Injuries
VA:	U.S. Department of Veterans Affairs
VASH:	HUD-VA Supportive Housing Program
VHA:	Veterans Health Administration
VISN:	Veterans Integrated Services Network
VJO:	Veterans' Justice Outreach

## Table of Contents

List of Figures .....	10
1. EXECUTIVE SUMMARY.....	11
2. INTRODUCTION .....	15
A. Behavioral Health Services for Maryland Veterans .....	15
B. Veterans Behavioral Health Advisory Board.....	16
C. Statutory Charges to the Advisory Board .....	17
D. Maryland’s Commitment to Veterans .....	18
3. BACKGROUND INFORMATION .....	21
A. Behavioral Health Defined .....	21
A. Pathways to Behavioral Health Services.....	22
B. Maryland’s Veteran Population.....	23
4. Workgroup Analyses & Accomplishments .....	28
A. Access and Transportation .....	28
B. Children, Family and Special Populations.....	33
C. Outreach and Education .....	45
5. GAP ANALYSES.....	53
A. Gaps in Available Behavioral Health Services .....	53
B. Gap Between Need for Services & Use of Services .....	55
C. Gaps in Quality & Effectiveness of Services.....	58
D. Gaps in Health Care Coverage & Access .....	59
E. Gaps in Coordination & Communication .....	62
F. Gap in Availability of Data.....	64
6. CONCLUSION .....	65
7. RECOMMENDATIONS .....	68
8. APPENDICES.....	78
9. References and Resources .....	109

## LIST OF FIGURES

1. Veterans Behavioral Health Program - Appropriations.....	Page 16
2. Maryland’s Commitment to Veterans’ logo.....	Page 19
3. Maryland’s Commitment to Veterans Data Table.....	Page 20
4. Pathways to Behavioral Health Services.....	Page 23
5. Maryland Veteran Population by County.....	Page 24
6. Age Distribution of VISN 5 Veterans Utilizing VA Services.....	Page 25
7. Map of 30-minute Driving Distances.....	Page 29
8. E-RANGE .....	Page 40
9. VA/HUD Veterans Supportive Housing Project (VASH).....	Page 41
10. Veterans of Afghanistan and Iraq Conflicts Scholarship Program.....	Page 48
11. Map of Maryland Behavior Health Service Providers.....	Page 54
12. Maryland Public Mental Health System -- Medicaid & Uninsured Veterans Served.....	Page 61
13. Uninsured Veterans by County.....	Page 61

## 1. EXECUTIVE SUMMARY

This Final Report of the Maryland Veterans Behavioral Health Advisory Board represents more than two years of research and analyses performed by numerous people who are invested in the long-term health and welfare of the nearly half a million Veterans and their families who live in Maryland. The genesis of this important effort dates back to May 2008, when Governor Martin O'Malley signed the Maryland Veterans Behavioral Health Act into law addressing the behavioral health needs of an increasing number of Maryland Veterans suffering from trauma-related brain injuries and stress disorders.

This law required that an Advisory Board, comprising eleven members, conduct an analysis of the behavioral health needs of Maryland Veterans and their families, identify the barriers to accessing services, identify gaps in services, and facilitate collaboration among a broad spectrum of organizations and government entities that encounter and serve Veterans and their families. The statute also established and provided for funding of the Veterans Behavioral Health Initiative, which has been branded as Maryland's Commitment to Veterans. In turn, the program's funding has served to support: Regional Resource Coordinators, transportation contracts for Veterans to access behavioral health services, and the Veterans' services component of the Maryland Network of Care website.

The Advisory Board, chaired by Lieutenant Governor Anthony Brown, and co-chaired by the Secretaries of the Maryland Department of Health and Mental Hygiene and the Department of Veterans Affairs, addressed its legislative mission by first holding meetings around the State with behavioral health service providers, educators, Veterans, Veteran's family members, and healthcare representatives, among others. The information gleaned from these meetings led to the formation of three workgroups, each of which addressed a specific focal area relating to the current status of Veteran-related services in Maryland. Over the course of almost two years, each workgroup met separately and engaged in activities that helped it to formulate its topic-specific suggestions, goals, and recommendations for improving the behavioral service delivery system for Veterans and their families.

The workgroup that addressed access and transportation issues looked at the relative distance and drive time to access behavioral health services for Veterans living in each county, as well as the transportation options for actually getting to existing behavioral health services. They suggested that efforts that effectively address these two issues will, over time, help to diminish the fear and stigma Veterans reportedly experience in seeking such services. This workgroup assisted in the establishment of a U.S. Department of Veterans Affairs (VA) mobile treatment service on the Eastern Shore of Maryland and brokered a collaboration between the VA and a private agency in Western Maryland resulting in a VA satellite location in Grantsville, MD.

The workgroup that examined the unique needs of children, families and “special populations” (women, incarcerated, and homeless Veterans) examined public education programs in order to identify the ways in which the needs of children impacted by military service are being addressed. At the higher education level, the workgroup looked at programs which promote and support Veterans’ successful adaptation to the academic and social challenges of college. The workgroup considered avenues for adapting these programs for all Maryland community and higher education institutions. This workgroup also documented the ways in which incarcerated, homeless and female Veterans have unique behavioral health needs that require not only specialized services, but new pathways to help them access services. In its deliberations, the workgroup considered recent federal legislation that impacts benefits and services for one or more of these groups and assessed the special initiatives underway that promote awareness of the needs of these groups and serve to increase communication and coordinated efforts to meet these needs. Issues related to provider capacity and whether service providers in Maryland have the skill requirements and specialized training to effectively serve the needs of Veterans were also examined and within the context of behavioral health services, the workgroup also investigated the specific impact that “Other Than Honorable Discharges” have on a Veteran’s eligibility for VA health care benefits.

The workgroup that addressed outreach and education efforts looked at the degree to which current programs in Maryland are helping to ensure that Veterans have every opportunity to make the transition from military service to re-uniting with their families, rejoining their home communities, and re-entering the local economy. The workgroup also assessed the continuum of care for Veterans for evidence that Veterans and their families are being educated about the signs and symptoms of post- traumatic stress disorder and depression. The workgroup looked at ways to increase awareness among Veterans about their VA benefits and entitlements, and where available community health care services and Veteran-friendly programs are located. It was observed by this workgroup that increasing community awareness about the issues and challenges faced by Veterans returning to civilian life would, in turn, contribute to Veterans’ successful community reintegration.

The collective findings of these workgroups enabled the Advisory Board to subsequently identify gaps that are significant to the behavioral health needs of Maryland’s Veterans. The first gap analysis pertained to the availability of behavioral health services based on an extensive review of providers in each county of Maryland. There is no question that there is a wealth of service providers available in the State. However, a significant gap exists between the need for behavioral health services – particularly for treatment of dually-diagnosed mental illness and substance abuse conditions – and the use of such services. According to a RAND study, only between 23% and 40% of Veterans who met criteria for a mental health problem actually received mental health care. In recent years, suicides among active duty military have been on the rise. In examining violent death data among Veterans in Maryland, the Advisory

Board found that over the five-year period of 2004-2008, Veterans represented 22% of suicides in the State. Notably, the Advisory Board found that more than half of those Veteran suicides occurred among Veterans 65 years of age or older.

The Advisory Board also identified a gap in the quality and effectiveness of behavioral health services. There is evidence that many medical professionals and other behavioral health providers are not sufficiently trained in Veterans' issues and evidence-based practices. This problem extends beyond the direct provision of healthcare services. Many social support activities like housing, employment counseling, job qualification, benefits delivery assistance, and student services would benefit from specialized education and understanding of Veteran-specific issues and concerns.

Another gaps analysis conducted by the Advisory Board was supported by the work done by the Access and Transportation workgroup, which determined that in rural areas of the State there is often considerable distance to be traveled by a Veteran to access services, and in non-rural areas the difficulties of an urban commute often presented reasonable access difficulties. Further, the lack of availability of personal or public transportation is often an access barrier. Time and distance contribute also to consideration by the Veteran as to whether to use federally-provided VA services or seek community services that are closer or quicker to get to. And, the Advisory Board considered the extent to which the possible absence of health insurance for Veterans or for their families might be a barrier to obtaining needed behavioral health services.

Gaps in coordination and communication exist in spite of there being numerous efforts around the State that are actively supporting or have the potential to be supportive of Veterans. Many of those activities are within State government; yet they are not centrally coordinated under the umbrella of Veterans' services. For example, an area that is strongly related to the success of Veterans gaining employment, particularly recent Veterans, is the recognition of military occupational proficiency and training in occupational licensure and certification processes in the State and counties. The Board also found that little focus has been placed on grant opportunities in support of services to Veterans. Expanding the State's efforts to pursue such grants or to assist community service providers in seeking such grants, will improve service to Maryland Veterans and help to offset State costs. Furthermore, this gaps analysis identified the potential to save State dollars by transferring Veterans from Medicaid to VA or Department of Defense care. Veterans actually receive better benefits from the VA than from Medicaid and enrollment numbers in Maryland suggest that many Veterans may not even be aware that they qualify for such care.

And finally, as might be expected given other gaps discussed, there is only limited and disjointed availability of data on how Maryland's programs are serving its Veterans. True data

analyses of gaps and needs were made most challenging by the lack of a centralized or linked Veteran database.

In total, the workgroup findings and the outcome of these gaps analyses helped the Advisory Board to shape what became the recommendations detailed in Chapter 7 of this report and which taken together provide a systems approach to enhancing behavioral health services for Veterans in Maryland. The Advisory Board's recommendations speak to a multi-faceted community of organizations that work together on shared-mission objectives, with collaborative approaches, and with the ability to push information and services to the community level where veterans' needs are usually best addressed. The Board paid particular attention to the relationship that the State has forged and continues to nurture with the federal government, particularly the U.S. Department of Veterans Affairs, and advised that this important relationship be maintained and expanded upon to the benefit of Maryland's Veterans.

Most important among its recommendations, the Board strongly recommends the extension of the enabling statute for the Veterans Behavioral Health Initiative so that this program and the activities it supports may continue to benefit Maryland's Veterans. The Board concluded that there is increasing evidence that Veterans' needs, including behavioral health needs will continue to grow and will require enhanced coordination at the State level.

The Veterans Behavior Health Advisory Board, in this its final act, concludes that the State must align, streamline, and empower its overall Veteran agenda with the full authority of the Governor, which requires a responsible and responsive subcabinet and a cultural shift across government to increasingly "Think Veteran."

## 2. INTRODUCTION

### A. BEHAVIORAL HEALTH SERVICES FOR MARYLAND VETERANS

On May 22, 2008, Governor Martin O'Malley signed House Bill 372 and Senate Bill 210, thus establishing Sections 13-2701 through 13-2703 of Health – General Article of the Annotated Code of Maryland (Chapters 555 and 556). These Chapters established a new program for behavioral health services for Maryland Veterans of the Iraq (Operation Iraqi Freedom) and Afghanistan (Operation Enduring Freedom) wars.

In collaboration with the U.S. Department of Veterans Affairs (VA), the Maryland Department of Veterans Affairs (MDVA), the Maryland National Guard (MDNG), and the Maryland Defense Force, the Maryland Department of Health and Mental Hygiene (DHMH) is charged with assisting Veterans of the Iraq and Afghanistan conflicts (henceforth, OIF/OEF Veterans) in obtaining behavioral health services available at the federal level. Further, when federal services are not available or accessible, DHMH is to connect eligible Veterans to behavioral health services that may be available through the Mental Hygiene Administration (MHA) or the Alcohol and Drug Abuse Administration (ADAA) until federal services can be obtained. DHMH is also charged with providing information about behavioral health services and resources for Veterans through a web-based program.

Behavioral health services provided may include crisis services and short-term mental health or alcohol and substance abuse services (the short-term services were initially constrained to rural areas of the State). Short-term services are only provided until the Veteran is able to access adequate service through the VA. These services may include: screening assessments; individual, family and group therapy; substance abuse early intervention and detoxification; and substance abuse medication-assisted treatment.

DHMH is directed by the statute to seek reimbursement from the VA or other public or private payers for the short-term or crisis services provided by DHMH. DHMH is required to separately account for funds to provide these services.

An evolving program, the Maryland Veterans Behavioral Health Initiative was expanded with the enactment of House Bill 1475 and signed by the Governor on May 19, 2009. This Act eliminated the restriction to OIF/OEF Veterans and provided that all Maryland resident Veterans of the uniformed services who served on active duty and were discharged or released under other than dishonorable conditions were covered by the program. Other changes in the program brought about by this bill included the elimination of the rural restriction for provision of short-term mental health or alcohol and substance abuse services.



The program is set to terminate effective May 31, 2011. The following table reflects the appropriations for the Veterans Behavioral Health program since its inception.

<b>Veterans Behavioral Health Program – Appropriations</b>	
<b>Fiscal Year 2009</b>	\$2,279,376
<b>Fiscal Year 2010</b>	\$ 850,885
<b>Fiscal Year 2011</b>	\$1,297,542
<b>Fiscal Year 2012 (request)</b>	\$ 563,410*
<b>Total</b>	\$4,427,803
<b>*Gov's. request at time of printing; subj. to Gen.Assembly approval</b>	

Source: Maryland Department of Budget & Management

Figure 1.

Funding for the Veterans Behavioral Health Program has supported Maryland's Commitment to Veterans (MCV) (described below), transportation contracts for Veterans to access behavioral health services, and the Veterans' services component of the Maryland Network of Care website.

## **B. VETERANS BEHAVIORAL HEALTH ADVISORY BOARD**

The 2008 legislation also established the Veterans Behavioral Health Advisory Board chaired by Lieutenant Governor, Anthony Brown. The main function of the Advisory Board is to identify and address gaps in behavioral health services for Veterans in Maryland. There are 12 additional members defined in the statute, including:

- One member of the Senate of Maryland appointed by the President of the Senate
- One member of the House of Delegates, appointed by the Speaker of the House
- The Secretary of the Maryland Department of Veterans Affairs (or designee)
- The Secretary of the Health and Mental Hygiene (or designee)
- The Adjutant General (or designee)
- A representative of the U.S. Department of Veterans Affairs
- A representative of a Veterans service organization appointed by the Governor
- A representative of a local health department appointed by the Governor
- A representative of a private provider of behavioral health services appointed by the Governor

- A representative of a private provider of behavioral health services appointed by the Governor
- A Veteran appointed by the Governor
- A family member of a Veteran appointed by the Governor.

A list of actual Board members can be found at Appendix A.

Beginning in the third quarter of 2008, the Advisory Board held administrative and regional meetings around the State in order to hear from Veterans and their families about their experiences in accessing Veterans behavioral health services (BHS) and to learn about the challenges encountered by providers who delivered services to Veterans and their families. Information that emerged from these meetings led to the decision to divide the Advisory Board into four workgroups, each to perform an in-depth analysis of behavioral health needs of Veterans and their families in the context of the workgroup’s focal area. Each workgroup assessed gaps and access impediments or barriers relative to behavioral health services for Veterans and their families in Maryland. During the course of workgroup and Advisory Board deliberations, efforts were ongoing by the Board, the workgroups, MCV, DHMH, and MDVA to foster collaboration among relevant organizations. Throughout the last two years, the Advisory Board, and by its extension, MCV, worked to promote federal and state collaborations and to identify funding opportunities and resources to further the delivery of behavioral health services to Maryland Veterans and their families.

The four workgroups comprised Access and Transportation; Outreach and Education; Children and Family; and Special Populations. Subsequently, the Special Populations workgroup merged with the Children and Family workgroup as a means of defining children and family members of Veterans as a special population along with women Veterans, homeless Veterans and incarcerated Veterans.

### **C. STATUTORY CHARGES TO THE ADVISORY BOARD**

As defined in Section 13-2703 of Health – General Article of the Annotated Code of Maryland (Chapters 555 and 556), the Veterans Behavioral Health Advisory Board was assigned the following 9 charges:

1. Conduct an immediate analysis of the behavioral health needs of Veterans and their families;
2. Identify the gaps in behavioral health services available to Veterans and their families;
3. Identify impediments to the ability of Veterans and their families to access the behavioral health services that are available, particularly in the State’s rural areas;

4. Facilitate collaboration among organizations and entities, including hospitals, that provide behavioral health services to Veterans and their families;
5. Make recommendations with respect to improving outreach to Veterans and their families in need of behavioral health services;
6. Promote federal and State collaboration to maximize funding and access to resources for the behavioral health needs of Veterans and their families;
7. Make recommendations with respect to building provider capacity and increasing provider training to meet the behavioral health needs of Veterans and their families;
8. Make recommendations with respect to improving the coordination of behavioral health services for Veterans and their families; and,
9. Make recommendations on methods to provide behavioral health services to individuals who are not eligible for benefits from the United States Department of Veterans Affairs due to a dishonorable discharge or release for a reason relating to substance abuse or mental illness.

The discussions in this report of the findings and accomplishments of the workgroups (Chapter 4), as reviewed and accepted by the full Advisory Board, speak to all of the requirements of the enabling legislation that established and assigned responsibilities to the Advisory Board. In addition, this report discusses gaps (Charge 2) that cut across all the areas of workgroup review, applying broadly to most aspects of behavioral health services for Veterans and their families in Maryland (Chapter 5). And, as there are gaps that cut across all the workgroup focal areas, there are recommendations that extend beyond those areas as well. The Advisory Board presents all of its recommendations in Chapter 7 of this report (Charges 5, 7, 8, 9 and more).

It should also be noted that as the Advisory Board and its workgroups gathered information and insights into issues associated with behavioral health services for the Veteran population, the Board found it appropriate to expand our considerations beyond the specific charges given us by the statute. For example, the Advisory Board agreed with workgroup findings that suggested that training of law enforcement personnel while somewhat tangential was important to the successful management of behavioral health needs of Maryland's Veteran population.

#### **D. MARYLAND'S COMMITMENT TO VETERANS**

The Veterans Behavioral Health Initiative created by Senate Bill 210 and House Bill 372 in the 2008 Legislative Session has been branded as Maryland's Commitment to Veterans (MCV). This program is an outreach and referral initiative designed to assist Maryland's Veterans by connecting them with behavioral health services as they need them. The program also serves families, friends, and neighbors of Maryland's Veterans by helping them to learn more about and understand the challenges that many Veterans face in their transition into civilian life. The

program is a collaborative effort led by the Maryland Department of Health and Mental Hygiene working with the Maryland Department of Veterans Affairs, the Maryland National Guard, Maryland Defense Force, and the U.S. Department of Veterans Affairs.



Figure 2.

MCV provides access to a confidential toll-free telephone line that is staffed and available anytime, day or night (1-877-770-4801) through which Veterans and their families can connect with Regional Resource Coordinators (RRCs) serving every county in Maryland. Calls are routed to the RRCs for follow-up based on the location of the Veteran. The coordinators work one-on-one with each caller to provide referrals for counseling, housing and job resources, as well as assistance with paperwork and expedited care through the U.S. Department of Veterans Affairs. Call center operations were initially staffed only during normal business hours. In July 2009, operations were expanded to a 24/7 availability via a multi-service call center. Crisis intervention is available around the State through the Maryland Crisis Network. Crisis hotlines are able to provide crisis counseling to those in need of counseling, trace calls, and provide linkages to mobile crisis teams. Transportation contracts to help Veterans get to behavioral health services they need, including to appointments at VA facilities, have been established as follows: in one in Southern Maryland, three in Western Maryland, two in Central Maryland, and three on the Eastern Shore.

MCV's RRCs encourage all Veterans to enroll with the VA and attempt to schedule Veterans with the VA for needed behavioral health services. If the VA services are not readily available (within two weeks), Veterans are scheduled into Maryland's Public Mental Health System until VA services become available. RRCs follow-up with Veterans to ensure their needs are being met. Among the services that are accessible through this program are:

- Screening Assessments;
- Individual, Family and Group Therapy;
- Substance abuse early intervention and detoxification services; and,
- Substance abuse medication-assisted treatment.

Additionally, the coordinators make referrals to community services and the VA for job resources, education assistance, housing, VA benefit information, financial assistance and other community supports.

In November 2008, a Memorandum of Understanding (MOU) between Veterans Integrated Services Network - VISN 5, the VA Medical Centers in Washington, DC, and Martinsburg, WV, the VA Maryland Health Care System, and the State of Maryland Department of Health and Mental Hygiene and Mental Hygiene Administration was signed. [Note: The VA’s Veterans Health Administration is organized into 21 regions nationally called Veterans Integrated Services Networks. Each VISN is responsible for coordination and oversight of all administrative and clinical activities within its specified region of the country.] The MOU documents and describes the collaborative arrangement between the signatories particularly with respect to outreach, increased enrollment of Maryland Veterans, and training of health care providers. (See Appendix B.)

Through a media campaign initiated in November 2009, MCV has been significantly marketed throughout the State. A logo was designed and a wide variety of marketing tools have been utilized including brochures, advertisements on buses, and radio advertising. Information in Appendix C delineates how callers reported learning of the program.

Since the program’s inception in October 2008, there has been a steady growth in its utilization and in the number of Veterans who have received needed services. For example, in the first six months of Maryland’s 2011 fiscal year, MCV has already provided transportation services to 174 Veterans as compared to a total of 69 Veterans served in all of fiscal year 2010. (See Figure 3.) Additional background data can be found in tables at Appendix D.

<b>Maryland’s Commitment to Veterans</b>			
	10/1/08–6/30/09	7/1/09 – 6/30/10	7/1/10 – 12/31/10
Callers to Toll-Free Line	462	806	399
Veterans Receiving BH Services via MCV	17	97	61
Veterans Provided Transportation	7	69	174
MCV Website Visits	40,321 (4/1/09 – 6/30/09)	102,256	30,406
Veteran-Network of Care sessions	NA	51,841 (6/1/09-6/30/10)	42,372

Figure 3.

### 3. BACKGROUND INFORMATION

#### A. BEHAVIORAL HEALTH DEFINED

According to Webster’s dictionary, behavioral health, as a general concept, refers to the “reciprocal relationship between human behavior, individually or socially, and the well-being of the body, mind, and spirit, whether the latter are considered individually or as an integrated whole.” There is widespread recognition of how different behavioral health care is from the rest of health care. Different professionals are deployed for these services which are accessed through different facilities, and, at least in this country we have even devised different benefit designs to administer behavioral health services. It is these differences within medical care that complicate the coordination and improvement of care. But it is precisely that coordination or integration of services that is presently viewed as critical to successful behavioral health care.

In practice today, behavioral health care refers to an integrated continuum of services for individuals at risk of or suffering from mental, behavioral or addictive disorders. As a discipline, behavioral health refers to mental health, psychiatric, marriage and family counseling, and addictions treatment, and it includes services provided by social workers, counselors, psychiatrists, psychologists, neurologists, and family practice physicians and general practitioners. In the behavioral health research arena, researchers identify risk factors which predispose individuals to mental illness and protective factors which protect them from developing mental disorders. <sup>1</sup>

The term “behavioral medicine” was formally introduced in the late 1970s and was described as “the interdisciplinary field concerned with the development and integration of behavioral and biomedical science, knowledge and techniques relevant to health and illness and the application of this knowledge and these techniques to prevention, diagnosis, treatment and rehabilitation.” <sup>2</sup> Shortly thereafter, in 1979, behavioral health emerged as an aspect of behavioral medicine which promotes a philosophy of health that stresses the individual responsibility of the patient relative to the application of behavioral and biomedical science, health maintenance and illness or dysfunction prevention.

---

<sup>1</sup>National Institutes of Health; Department of Health & Human Service, Healthypeople.org

<sup>2</sup>Schwartz, G.E., Weiss, S.M. Behavioral medicine revisited: An amended definition. *Journal of Behavioral Medicine*, 1978. 1: 249-251.

As chronic diseases emerged as the leading causes of death--combined with the aging of the population, escalating health care costs, and research results that linked individual behaviors to increased risk of morbidity and mortality--we became more interested in preventing disability and death by changes in health-related behaviors, particularly changes in lifestyles and participation in screening programs. Much research continues into health-related behaviors to better understand their nature and causes. Health behavior encompasses many fields of study, from psychology and epidemiology to education, sociology and anthropology. For the purposes of this report, this working definition of health behavior is helpful to understand the potential expanse of resources and services applicable to providing behavioral healthcare: "those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics, including affective and emotional states and traits; and overt behavior patterns, actions, and habits that relate to health maintenance, to health restoration, and to health improvement."<sup>3</sup>

#### **A. PATHWAYS TO BEHAVIORAL HEALTH SERVICES**

Primary responsibility for behavioral health services for Veterans rests with the U.S. Department of Veterans Affairs. The VA provides comprehensive health care coverage and a full array of health care services to eligible Veterans. State agencies and community-based organizations that provide behavioral health services to Maryland residents serve as a backup to help connect Veterans and their families to needed services and to help fill service gaps that Veterans and their families may encounter. As illustrated in Figure 4, there are multiple pathways by which Veterans and their families may access behavioral health services: from when a service member is demobilized, to peer suggestions, information and referral services, encounters with the criminal justices system, or any number of other pathways.

---

<sup>3</sup> Gochman, D. S. "Labels, Systems, and Motives: Some Perspectives on Future Research." Health Education Quarterly.1982. 9:167-174.

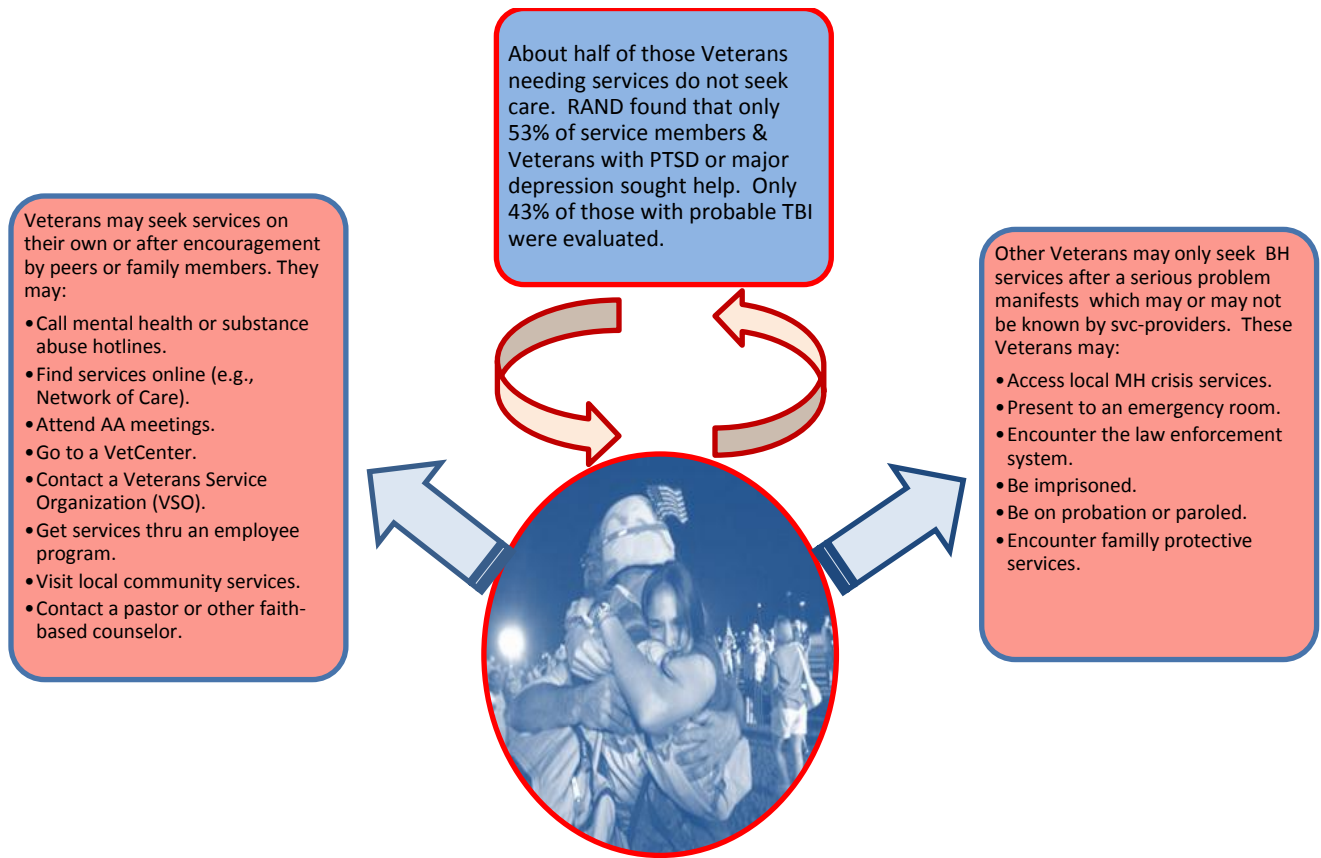


Figure 4 – Pathways to Behavioral Health Services

## B. MARYLAND’S VETERAN POPULATION

The U.S. Department of Veterans Affairs maintains the national database and projections of Veteran population. According to the latest published data, Maryland is estimated to have 471,238 Veterans residing in the State as of September 30, 2010. The projections for the State reflect a steady decrease in the number of Veterans over time largely due to the older Veteran population dying. The following table displays the estimates and projections of the number of Veterans by Maryland County in five-year increments through September 30, 2025. Veterans represent about 8% of the total population of the State and approximately 10% of the population over the age of 16.<sup>4</sup>

<sup>4</sup> Maryland estimates that approximately 79% or 4,502,587 of its total population is over the age of 16.



Additional data tables can be found in Appendix E providing information about the number of Veterans by gender, period of service, and age.

<b>MARYLAND VETERANS BY COUNTY</b>					
2010 - 2025					
	9/30/2010	9/30/2015	9/30/2020	9/30/2025	County Pop (2010)*
Allegany, MD	7,724	6,698	5,824	5,182	72,750
Anne Arundel, MD	59,218	55,325	51,974	48,798	525,700
Baltimore, MD	63,541	57,201	51,271	45,989	801,700
Calvert, MD	10,433	10,693	10,786	10,530	90,750
Caroline, MD	3,091	2,781	2,523	2,305	33,500
Carroll, MD	14,380	14,551	14,244	13,615	175,100
Cecil, MD	9,858	9,413	8,838	8,376	102,600
Charles, MD	16,530	16,120	15,523	14,783	143,900
Dorchester, MD	2,818	2,417	2,071	1,812	32,250
Frederick, MD	21,262	20,678	19,805	18,621	231,350
Garrett, MD	2,861	2,776	2,563	2,426	29,700
Harford, MD	26,056	25,613	24,345	23,151	245,900
Howard, MD	22,646	23,600	24,062	23,808	285,600
Kent, MD	2,167	1,998	1,824	1,628	20,300
Montgomery, MD	50,208	48,651	46,769	44,958	980,000
Prince George's, MD	68,075	62,020	56,872	52,255	850,200
Queen Anne's, MD	4,754	4,535	4,221	3,984	48,650
St. Mary's, MD	12,564	11,693	11,110	10,672	105,400
Somerset, MD	2,467	2,243	2,052	1,945	26,200
Talbot, MD	3,954	3,646	3,245	2,948	36,700
Washington, MD	12,471	11,420	10,427	9,567	147,800
Wicomico, MD	8,092	7,363	6,658	6,058	95,300
Worcester, MD	6,069	5,678	5,310	4,966	49,800
Baltimore city, MD	39,996	34,607	29,958	26,220	673,000
<b>Grand Total</b>	<b>471,238</b>	<b>441,721</b>	<b>412,275</b>	<b>384,597</b>	<b>5,774,000</b>

\* Estimates as of Nov 2010, MD Dept of Planning  
Source: US Dept of Veterans Affairs - VetPop2007 Estimates & Projections

Figure 5.

## Activations

As of December 28, 2010, the U.S. Department of Defense (DoD) reported that 92,082 National Guard and Reservists are currently activated and on duty in support of Operations Nobel Eagle (active duty other than Iraq or Afghanistan on or after September 11, 2001), Enduring Freedom (active duty in Afghanistan at some point after September 11, 2001) and New Dawn (active duty in Iraq at some point on or after September 1, 2010). Of these 92,082 Guard and Reserve, 1190 are from Maryland which represents approximately 1.3% of the total. DoD further reports that a total of 793,567 Guard and Reserve personnel have been activate for these Operations (as of

12/28/10).<sup>5</sup> It can be estimated that approximately 1.3% of that total or 10,316 individuals were Maryland Guard and Reservists. It is anecdotally reported that almost 25,000 individuals residing in Maryland have deployed in support of these operations and that an estimated 40% of them are Guard and Reservists.<sup>6</sup> It is notable that VA reports that of the total number of OIF/OEF separations, 46% have obtained VA health care; 3.2% of these individuals received their treatment at VISN 5 facilities.<sup>7</sup>

### Maryland Veterans Treated by VA Health Care System

- The U.S. Department of Veterans Affairs Maryland Health Care system reported that it had 7102 inpatient admissions in Fiscal Year 2008. There were 594,000 outpatient visits to 9 VA outpatient clinics (FY 08).<sup>8</sup>
- In federal Fiscal Year 2009 (10/1/08 – 9/30/09), the VA reported that 73,886 unique patients from the State of Maryland were treated at a VA facility.<sup>9</sup>
- The Veterans Integrated Services Network 5 (VISN 5) reports that approximately 25% of Maryland Veterans are enrolled in the health care system and approximately 13% actually use the VA for health care services (FY 08).<sup>10</sup>
- VISN 5 has approximately 788,000 Veterans in its area of coverage, more than 60% of whom reside in the State of Maryland.<sup>11</sup>

Age Distribution of VISN 5 Veterans Utilizing VA Services	
Age	Percent
17-44 years	9%
45-64 years	34%
65-84 years	45%
85+ years	8%

Source: VISN 5 Rural Health Communications/MyHealthVet Outreach Project Presentation- Nov. 2010

Figure 6.

<sup>5</sup> U.S. Department of Defense; DRS# 21800, Contingency Tracking System (CTS) Daily Processing Files; produced by the Defense Manpower Data Center.

<sup>6</sup> Tri-County Council for Southern Maryland, Veterans Integrated Healthcare Recommendations for Southern Maryland; June 22, 2009.

<sup>7</sup> U.S. Department of Veterans Affairs, Office of Public Health and Environmental Hazards, February 2010.

<sup>8</sup> VA Office of Public Affairs. State Summary: Maryland and the Department of Veterans Affairs. August 2009.

<sup>9</sup> U.S. Department of Veterans Affairs, Office of Policy and Planning. VA FY 09 Summary of Expenditures by State.

<sup>10</sup> U.S. Department of Veterans Affairs, VISN 5 Rural Health Communications/MyHealthVet Outreach Project Presentation - Nov. 2010

<sup>11</sup> VISN 5 Rural Health Comm.

## Employment

According to the Bureau of Labor Statistics, the unemployment rate for Veterans in December 2010 was 8.3%; 957,000 Veterans were reported as unemployed. Of these unemployed Veterans, 210,000 are Veterans of the post-September 11, 2001 Gulf War-era.<sup>12</sup>

Generally, combat Veterans have had a higher than overall rate of unemployment since at least 2005. Recognizing the difficulties encountered by Veterans in re-entering the job market, Governor O'Malley issued an Executive Order [see Appendix F] establishing the *Warrior to Worker* initiative – a coordinated statewide effort to expand Veterans' employment opportunities within State government and to promote employment, education and training opportunities for Veterans throughout Maryland. Further, the MDNG conducted a *Summit for Employers and Business Leaders* in January 2010. In partnership with the U.S. Department of Labor and Towson University, the meeting brought the maximum participation of over 200. The Summit presented the participants with information on the skills of OIF/OEF Veterans, governmental programs to assist in hiring Veterans, training opportunities, and assistance with any difficulties after a Veteran is employed.

Types of skills that troops hone during war – teamwork, mission focus, the ability to operate under extreme pressure – are often misunderstood or undervalued by employers. Further, these troops have a complicated legacy in which the public admires their service but also sees them as prone to mental illness, substance abuse, and violence.

## Income

The VA estimates that on an individual level, nearly 43% of Veterans in VISN 5 earn less than \$36,000 per year.<sup>13</sup>

## Family Status

Fifty-five percent (55%) of troops are married and 40% have children.<sup>14</sup> Sixty-three percent (63%) of military families live in over 4000 communities nationwide.<sup>15</sup>

---

<sup>12</sup>U.S. Department of Justice, Bureau of Labor Statistics. Employment Status of the Civilian Population 18 Years and Over by Veteran Status, Period of Service and Sex. December 2010. <http://www.bls.gov/news.release/empsit.t05.htm>

<sup>13</sup> VISN 5 Rural Health Comm.

<sup>14</sup> Flake, EM, Davis, BE, Johnson, PL, Middleton, LS. The psychosocial effects of deployment on military children. J Dev Behav Pediatrics 2009; 30:271-278.

<sup>15</sup> U.S. Government, White House Interagency Policy Cte. Strengthening Our Military Families: Meeting American's Commitment, Jan. 2011. p. 1.

## **Rurality**

Eleven of Maryland's 23 counties are defined as rural by VISN 5. Only 39% of enrolled Veterans in those counties are estimated by VA to actually utilize VA health care services. Rural Veterans in Maryland –according to VISN 5 – are predominantly male between the ages of 45 and 84.<sup>16</sup>

## **U.S. Department of Veterans Affairs Expenditures in Maryland (See Appendix G)**

The VA reports that in Fiscal Year 2009, it expended a total of \$1.6 billion in Maryland on benefits and services for Maryland Veterans. These expenditures break down as follows:

- Compensation and Pension payments: \$716 million
- Medical Care: \$708 million
- Education & Vocational Rehabilitation/Employment: \$82 million
- Insurance: \$39 million
- Operating Expenses & Construction: \$38.6 million.<sup>17</sup>

---

<sup>16</sup> VISN 5 Rural Health Comm.

<sup>17</sup> U.S. Department of Veterans Affairs, Office of Policy and Planning. [VA FY 09 Summary of Expenditures by State.](#)

## 4. WORKGROUP ANALYSES & ACCOMPLISHMENTS

### A. ACCESS AND TRANSPORTATION

---

*Workgroup Chair: Scott Rose, President/CEO, Way Station, Inc.*

The Access and Transportation workgroup focused on methods to improve access by Veterans to behavioral health services in the State. In the course of its deliberations, the workgroup identified three principal impediments to the ability of Veterans and their families to access behavioral health services, particularly in Maryland's rural areas: geographical distance, lack of transportation and fear or stigma of treatment.

Regarding geographical distance, the workgroup examined the availability of behavioral health resources throughout the State and considered the proximity of those services to population by county. The workgroup worked extensively with the U.S. Department of Veteran Affairs to examine the possibility of expanding the availability of VA Community Based Outpatient Clinics (CBOCs) in Maryland communities and the potential for developing collaborative relationships with the VA for the location of VA satellite sites and for expanding the availability of telepsychiatry for Maryland Veterans. [Figure 7 on the next page depicts 30-mile drive distance in Maryland. See Appendix H for a set of maps depicting driving distances for three regions of Maryland.]

The VA has acknowledged the need for additional CBOCs and some are in the works. They are moving forward with the temporary expansion of the Charlotte Hall CBOC in its current location, adding an additional 1600 square feet. The services offered there will be expanded to include teledermatology, telepodiatry, telerehabilitation, Traumatic Brain Injury (TBI), dietary education, exercise physiology, and homeless Veterans assistance. In addition, plans for a Charlotte Hall replacement clinic have been submitted to VA headquarters for review through the federal fiscal year 2012 Strategic Capital Investment Process.

Additionally, space has been leased at a location near Andrews Air Force Base and renovations of that space are underway for a new CBOC. It is hoped that it will be completed and opened around July 2011. A CBOC at Fort Dietrick is estimated to be opening in March 2011. The CBOC slated for Fort Meade is not expected to open for another year.

In its discussions with the VA, the workgroup was able to readily secure clarification that Maryland Veterans residing close to the southeast border of Delaware may receive mental health services from the Wilmington, Delaware, VA Medical Center, and the Georgetown, Delaware, VA Outpatient Clinic, even though they are Maryland residents. Further, it was clarified by DHMH that Maryland Veterans in receipt of Maryland Medical Assistance, who are

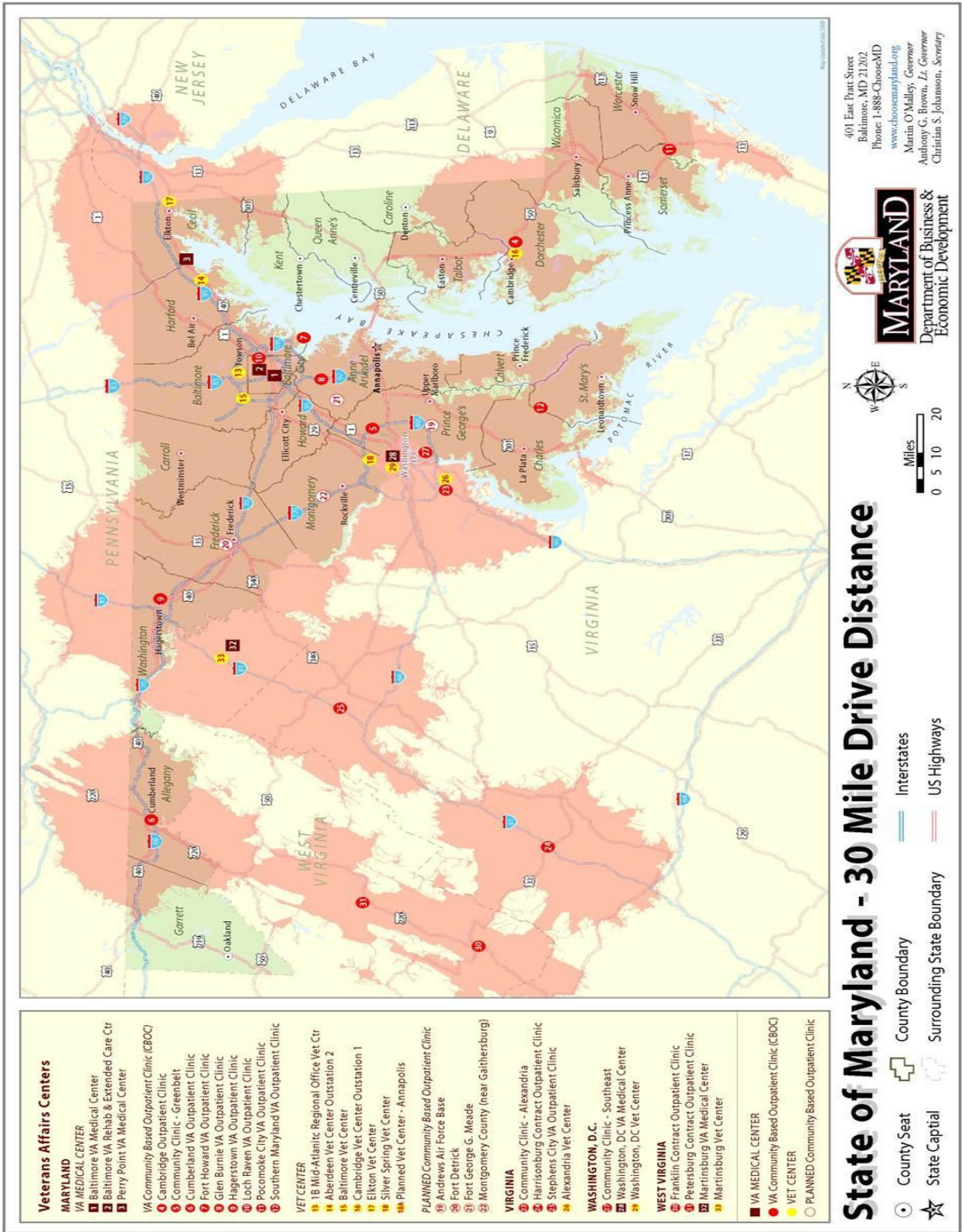


Figure 7



also eligible for VA mental health services, remain eligible for all public mental health system services.

The Advisory Board acknowledges that the VA has a national access standard that provides that 70% of enrolled Veterans will have access to VA primary care services (including mental health services) within a 30-minute driving distance of their home. It is recognized that there may be instances when the 30% of enrolled Maryland Veterans who are outside of that access standard are in significant need of services from the VA. In those cases, VA and Maryland should work toward a reasonable solution so as ensure the ready access to needed services by Maryland Veterans. Further, VA and the State should actively seek to identify collaborative initiatives to provide services sought by enrolled Veterans within a 30-minute driving distance. These initiatives may include low cost leases for VA satellite services, shared service agreements between VA and Maryland, cooperative agreements with DoD facilities, contract mental health care and fee-basis mental health care, telemental health or similar technology, etc.

The VA's national Office of Rural Health is responsible for rurality definitions with respect to Veterans' services in the United States. There are multiple definitions government-wide. The VA Office of Rural Health is presently working to apply RUCA codes to better define rurality for VA purposes. RUCA, Rural-Urban Commuting Area Codes, are a new census tract-based classification scheme that utilizes the standard Bureau of Census Urbanized Area and Urban Cluster definitions in combination with work commuting information to characterize the rural and urban status of all of the nation's census tracts. It is not yet known how this may impact Maryland's rural Veterans.

Public Law 110-387, Section 403 requires VA to conduct a pilot program to provide health care services to eligible Veterans through contractual arrangements with non-VA providers. The statute directs that the pilot program be conducted in at least five VISNs. VA has determined that VISNs 1, 6, 15, 18 and 19 meet the statute's requirements. This program will explore opportunities for collaboration with non-VA providers to examine innovative ways to provide health care for Veterans in remote areas. Maryland should closely monitor the outcomes of these pilots particularly those in neighboring VISN 6 (Virginia).

Further, Public Law 110-387, Section 107 requires VA to conduct a 3-year pilot program to assess the feasibility and advisability of providing OIF/OEF Veterans (particularly Guardsmen and Reservists) with peer outreach and support services, readjustment counseling services, and other mental health services. For purposes of providing readjustment counseling and other mental health services, the VA is directed to provide these pilot services through community mental health centers, the Indian Health Service, or other appropriate entities. The statute directs that the pilots be carried out in at least 3 VISNs and in rural locations within those VISNs that are lacking in comprehensive mental health services. VA indicated in its Fiscal Year 2011

Budget Submission to the Congress that it intends to use this pilot authority to work with community based non-profit and co-op agencies to provide supportive services specifically designed to prevent homelessness. VA requested \$26 million in fiscal year 2011 and \$27 million in fiscal year 2012 to fund this initiative. VA announced the availability of funding for the Supportive Services for Veterans Families Program (SSFVF) on December 17, 2010. Applications for these grants will be accepted until March 11, 2011.

The workgroup acknowledged the advances made by VA in addressing transportation issues throughout the Veterans Integrated Service Network (VISN 5). A performance standard was put in place that requires that 70% of VA enrollees in the Network would be able to access primary care within 30 miles of their homes. Additionally, VA expended \$1 million in expanding the availability of transport vehicles, purchasing additional vans and providing a shuttle from Charlotte Hall. VA also contracted with private sector transportation providers.

Through the efforts of the workgroup, a VA mobile treatment service on the Eastern Shore of Maryland (near Salisbury) was developed. This service effectively leverages the collaborative relationship between VA and DHMH, e.g., DHMH provides the space to the VA at a nominal cost. Additionally, the workgroup brokered collaboration between the VA and a private agency in Western Maryland resulting in the VA establishing a satellite to the Cumberland CBOC located in Grantsville in order to make services more readily available to Veterans in Allegany and Garrett Counties.

Within the strategy developed by this workgroup for improving Veterans' accessibility of behavioral health services, the workgroup focused on concerns that those programs that seek to primarily address serious mental illness conditions of Veterans may not be able to provide sufficient resources for the less serious mental health needs of Veterans. These concerns led to the initiation of discussions with VA and a private mental health provider, Crossroads Community, Inc., on Maryland's Eastern Shore about a potential collaborative relationship. Crossroads has offered to give free space to VA in Chestertown and Centerville for satellite sites. VA has taken the offer under advisement.

The workgroup observed the importance of the Regional Resource Coordinators (RRCs) to Veterans' ability to access behavioral health services. The effectiveness of these individuals has also been recognized by the VA. In reviewing the efforts of the RRCs over the last two years, it has become apparent that their effectiveness in ensuring that needed services are obtained has grown substantially over time. The RRCs coordinate with VA and various other public and private providers of behavioral health services, including faith-based organizations, temporary housing services, etc., to meet the needs of Maryland's Veterans. Given the success of the RRCs and their effectiveness in assisting Veterans in obtaining VA services, the workgroup recommended that exploratory discussions be held with the VA relative to financial sharing of



this resource. The workgroup believes that it is vital that the services of these coordinators continue to be funded.

Significant among the accessibility activities of the workgroup is the collaboration among the VA, DHMH, and Maryland's Department of Housing and Community Development (DHCD) to fund the capital costs of a 27-bed transitional housing and employment facility in Hagerstown. VA has provided a grant for all of the on-going operations of this facility under its Homeless Grant and Per Diem Program. Renovations will begin this summer, and occupancy is slated to occur by late 2011. Additionally, the State has secured a grant from the U.S. Department of Labor that will fund employment support services for incarcerated Veterans. The Access and Transportation workgroup was instrumental in securing this funding and in providing technical assistance to justice system stakeholders to develop a statewide template of protocols for jail diversion programs.

Related to viewing transportation as one of the top impediments to BHS, the workgroup supported VA efforts to increase transportation resources for Veterans to BHS. The plan involves engaging private transportation providers in the three major rural areas of the State: Eastern Shore, Southern Maryland, and Western Maryland. Initial work has focused on the Eastern Shore; all counties have agreements in place with transport entities.

Increasingly, there is recognition of the value of technology in enhancing the availability and accessibility of services for Veterans. Both the VA and the Department of Defense (DoD) have acknowledged that the use of technology like telepsychiatry can help to address the problems presented by a national shortage of mental health care workers. Further, such technologies offer a means for local access to care versus having to take a 50 mile drive. The VA currently operates telepsychiatry services through many of its CBOCs.

The Maryland Telepsychiatry Program began in November 2008 as a partnership between the Mental Hygiene Administration, The University of Maryland School of Medicine – Department of Psychiatry, and three Core Service Agencies to offer psychiatric care in seven of Maryland's rural counties. The program is funded by a 3-year grant from the Health Resource and Service Administration (HRSA) and DHMH. Currently, this program serves these priority populations: Children/Adolescents, Geriatrics, Co-Occurring Substance Abuse and the Deaf/Hard of Hearing. Staff of Maryland's Commitment to Veterans are in discussions with this program as to how it might serve Veterans as a focal population group. This program may offer potential for expanded federal and state collaboration with the VA.

The pilot study being conducted by the U.S. Army testing a telehealth mobile phone outreach program is of interest. This program provides mobile case management support and is designed to track progress, improve quality of care and increase optimal outcomes in treatment of TBI and other behavioral health conditions. If the pilot test demonstrates the program is

successful, it should be considered for expanded collaboration between DoD, VA, and potential State applications.

Lastly, the workgroup also recommended that the State continue discussions with the VA relative to the effective utilization of VA's fee-basis program to enhance behavioral health services to Veterans. Veterans are presently able to use private providers who are paid by VA when they are individually authorized by VA on a case-by-case basis. More objective and predictable criteria for fee-basis eligibility would increase Maryland's ability to coordinate resources with the VA for individual Veterans and address systemic service gaps.

## **B. CHILDREN, FAMILY AND SPECIAL POPULATIONS**

*Workgroup Chair, James A. Martin, Ph.D., BCD, Colonel, U.S. Army (retired)*

In analyzing the behavioral health needs of "special populations" of Veterans and the family members of Veterans, this workgroup opted to first look at societal systems with which children and family members of Veterans interact on a routine basis, starting with the educational system, which the workgroup segmented by type. During the course of its work, the Children, Family and Special Populations workgroup also honed in on behavioral health service (BHS) needs as they pertain to women Veterans, incarcerated Veterans and homeless Veterans. These analyses required asking "content experts" to provide the workgroup with their assessments of what is working and what isn't, in terms of the extent to which the Maryland BHS delivery system is addressing the needs of these special populations

### **K-12 Public Education**

Although this workgroup was able to identify a variety of supportive public education activities related to children impacted by military service (defined as a child or teen with a parent or sibling serving on active duty or serving in the Guard or Reserve, or having returned home as a combat Veteran), it is not aware of the existence of an overarching plan to focus on the needs of these children throughout their public education.

Further, there was no obvious military child or family, or Veteran child or family resource information on any State or county education sponsored website. However, the workgroup facilitated a phone conference with the Maryland State Department of Education representatives in June 2009 that revealed that, in fact, many such supportive efforts were underway. Significant findings included:

- School counselors and pupil personnel professionals are being educated about the needs of military children. Maryland’s Department of Education has worked with the “Military Child Education Coalition” to provide train-the-trainer workshops for local school systems on meeting the needs of the military child;
- Relationships between State and County school leaders and Active Duty and National Guard representatives that provide services to military children and families are being cultivated. The MDNG began training Maryland educators with presentations such as those made to the Maryland Department of Education's Military Child Meeting on October 27, 2009;
- A public service video series (produced locally in collaboration with Montgomery College) was aired on local public TV that highlighted issues and challenges encountered by military members and families while deployed and during and after reintegration into their community (June 2010). Five panel discussion “shows” have been planned, to cover topics including behavioral health issues (PTSD, TBI), female Veterans, strengths, resources and benefits for Veterans, and a Veterans Day Panel Tribute (all era Veterans).

Consideration of the findings and additional research led the workgroup to create this list of areas that the workgroup believes warrant further examination, based on gaps that remain within the public education system in Maryland.

1. School efforts to address needs of children impacted by military service should partner with other community-based youth programs, e.g., Boys & Girls Clubs, Scouting, etc.;
2. Maryland needs to leverage the connections that the National Guard has with military education groups (National Military Family Association, National Military Education Coalition, Zero to Three) and foster the building of bridges between the military installations in Maryland and schools and parents around the State;
3. There is a need for a variety of written and video materials (e.g., those produced by DoD and VA) to be available in public schools and libraries.

## Higher Education

Within the *higher education* category of public education, the workgroup had the following insights.

- The *Combat2College* program (C2C) at Montgomery College provides an important program model that could be adapted by other Maryland community colleges and higher education institutions and expanded to focus on families of returning Veterans.

Initiated in late 2008, the C2C educational initiative is intended to promote and support Veterans' successful adaptation to the academic and social challenges of college;

- Because there appears to be very little engagement on the part of Maryland's higher education graduate programs to support K-12 education efforts to outreach to youth impacted by military service, graduate students studying sociology, psychology, social work, marriage and family therapy, and other forms of counseling services governed by state licensure could be trained as subject-matter experts to support the emotional needs of military children and families via internships;
- MDVA undertook an effort to foster a community of practice to promote and support best practices at community colleges to sustain returning Veterans using their educational benefits as well as family members. The formation of a Maryland Community College Affinity Group has now been endorsed by the college presidents. This group, with MDVA's support, will work to provide services and support to student Veterans and their families.

In further recognition of the importance of higher education's response to Veteran students, the O'Malley/Brown Administration has sponsored the *Campus Compact for Student Veterans* which seeks to ensure the educational success of Veterans who choose to return to a Maryland school by promoting opportunities for colleges and universities to enhance their awareness and understanding of both the academic and reintegration needs of these Veterans. Recognizing that a number of Maryland colleges and universities have developed inclusive campuses where student Veterans feel welcomed and quickly become an integral part of campus life, one of the goals of this compact is to facilitate the sharing of these best practices among all of Maryland's public and private institutions with a hope that higher education in Maryland will become truly "Veteran Friendly" in both spirit and practice.

Additionally, the MDNG has begun to teach Maryland educators about the challenges faced by Veteran students. In January 2010, in partnership with Towson University, MDNG hosted an Educator's Summit. This event met its capacity with over 200 educators, administrators, and counselors in attendance. The Summit promoted various schools' best practices for Veteran students and highlighted programs available to schools from federal, state and local governments, as well as private organizations. Panels of Veteran students addressed the difficulties of returning to a school environment after combat, what's involved in a Veteran's choice of an institution of higher learning, and what it takes for a Veteran to be successful and remain in school.

## Women Veterans

According to the U.S. Department of Veterans Affairs, there were 49,129 female Veterans as of September 2010 resident in the State of Maryland. (See Appendix E.) This is approximately 1.7 percent of the entire population of women in the State.<sup>18</sup>

Women represent approximately 8% of the nation's Veteran population, but are more than 11% of the OIF/OEF Veteran population, and on average are 48 years old (versus their male counterparts who on average are 63 years old). Women are the fastest growing segment of the Veteran population carrying significant implications for the types of services offered and how they are offered. The VA has found that among those women Veterans they have treated (51.3% of women OIF/OEF Veterans), the most prevalent diagnoses are PTSD, hypertension and depression. About 20% of the women Veterans seen by the VA indicate that they have experienced military sexual trauma (MST).<sup>19</sup>

In reviewing services available to Maryland's women Veterans, the workgroup observed that the U.S. Department of Veterans Affairs' Center for Women Veterans ensures that mental health and MST counseling, and readjustment counseling are available to this population of Veterans.

A Women Veterans Program Manager is located at each VA medical center to advise and advocate for women Veterans. That Program Manager helps coordinate all services needed by women Veterans cared for at VA health care facilities, from primary care to specialized care. Mental health services provided by the VA for women Veterans include evaluation and assistance for issues such as depression, mood, and anxiety disorders; intimate partner and domestic violence; sexual trauma; elder abuse or neglect; parenting and anger management; marital, caregiver, or family-related stress; and, post-deployment adjustment or PTSD. Additionally, VA provides special services for MST – providing free, confidential counseling and treatment for mental and physical health conditions related to MST.

Additionally, in terms of federal programs, recent legislation has extended the availability of certain federal benefits to women Veterans:

- “The Veterans Health Improvement Act of 2004” (Public Law 108-422) permanently extended VA's authority to provide MST counseling to active duty service members.
- PL 110-186, the “Military Reservist and Veterans Small Business Reauthorization and Opportunity Act,” established a Women Veterans Business Training Resource Program.

---

<sup>18</sup> Maryland Vital Statistics Annual Report, 2009

<sup>19</sup> U.S. Department of Veterans Affairs. Office of Public and Environmental Hazards. Women Veterans Health Care: Facts and Statistics. <http://www.publichealth.va.gov/womenshealth/facts.asp>

- “The Caregivers and Veterans Omnibus Health Services Act of 2010” (PL 111-163) provides for a comprehensive study on barriers to health care for women Veterans, a pilot program to provide group readjustment counseling in retreat settings for newly separated women combat Veterans, and requires the Veterans Health Administration to carry out a 2-year pilot program to assess the feasibility and advisability of offering child care to Veterans.

While the workgroup was aware that there are many other services in Maryland for women (mother and child programs, post-partum depression programs, sexual trauma programs, etc.), it was unable to readily identify information about non-VA female Veteran-specific behavioral health services. It did learn that the Maryland Center for Veterans Education and Training (MCVET) a non-profit organization established to provide homeless Veterans, and other Veterans in need, with comprehensive services that will enable them to rejoin their communities as productive citizens, collaborates with the Weinberg Foundation, the Abel Foundation, the Women’s Auxiliary, Johns Hopkins Hospital, and Mercy Hospital for women’s training programs.

The workgroup discussed the merits of the Maryland Department of Veterans Affairs (MDVA) establishing special initiatives to promote awareness of the needs of women Veterans. This would include mobilizing women’s advocacy groups to develop counseling and other supportive services, as well as hosting a Women’s Veterans Conference that would include offering training modules for BHS providers. The Advisory Board, in turn, advised MDVA and DHMH to work together in assessing the current status of women Veterans in Maryland (e.g., collecting data on homeless female Veterans). MDVA and DHMH are also to establish a women Veterans’ workgroup group that is tasked to host a leadership conference that would serve to motivate women’s groups to address female Veterans’ issues. The Advisory Board observed that such conferences have been successfully hosted by the States of Wisconsin, Oregon, Ohio, California, Delaware and Massachusetts.

### **Domestic Violence**

According to VA research, domestic violence is a growing problem creating victims of spouses, partners, family and the children of the Veteran who returns home suffering with PTSD. Research indicates that Veterans with PTSD are two to three times more likely to batter their partners, family and children than Veterans without PTSD. Community responses to domestic violence must be adapted to respond to the increasing number of Veterans with PTSD. This also includes older Veterans who may be suffering from chronic mental illness, PTSD, or dementia.

## **Incarcerated Veterans**

Incarcerated Veterans are an identified at-risk population for pre- and post-incarceration behavioral health and relationship problems. According to the Bureau of Justice Statistics, in 2004 there were an estimated 140,000 Veterans held in state and federal prisons. State prisons held 127,500 of these Veterans and federal prisons held 12,500.<sup>20</sup> Identification, proper assessment, and specialized treatments for Veterans' BH and relationship issues often represent an important pathway from the criminal justice system to their successful reintegration back into family and society.

In November 2010, the Department of Health and Mental Hygiene submitted a Veterans' survey, to all local detention centers in Maryland. Nine local detention centers reported that there were 194 Veterans incarcerated between November to December 2010. However, a new Department of Corrections' computer program developed in late 2009, contains a "Veteran Status" field which helps to standardize the screening process for identifying Veterans incarcerated in or entering MD DOC facilities, according to the VA's Veterans' Reentry and Reintegration Specialist (RRS) for Veterans Integrated Service Network 5 (VISN 5).

The TAMAR program (Trauma, Addiction, Mental Health and Recovery) currently serves male and female inmates who have serious mental illnesses, a co-occurring substance use disorders, and histories of trauma. In partnership with a variety of agencies including the Core Service Agencies and the Maryland Correctional Administrators Association, the TAMAR program continues to expand. MHA currently supports trauma programs in Anne Arundel, Baltimore, Caroline, Dorchester, Frederick, Garrett, Prince George's and Washington Counties, as well as Springfield State Hospital. Those jurisdictions reported that 14 Veterans (2.5% of total) were beneficiaries of this program in fiscal year 2010.

The Maryland Community Criminal Justice Treatment Program (MCCJTP) provides comprehensive and coordinated services to individuals who have serious mental illness or co-occurring conditions in detention centers in 22 of Maryland's 24 jurisdictions (excludes Baltimore City and Montgomery County). In the period of July 1, 2009 thru June 30, 2010, MCCJTP reported that of the 6670 individuals served, 250 were Veterans (3.7%).

While the VA provides outreach to incarcerated Veterans in an effort to facilitate transition to VA care on release, the workgroup observed that the VA does not provide medical treatment—including BHS—to Veterans when they are incarcerated. The Maryland Department of Corrections does, however, regularly contract with outside agencies to provide psychiatric

---

<sup>20</sup>U.S. Department of Justice, Bureau of Labor Statistics. Veterans in State and Federal Prison, 2004. April 2007. <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=808>

services to its inmates—the workgroup cited southern Maryland as having a regional contract for psychiatric services in detention centers in Charles, Calvert, and St. Mary’s Counties.

However, of concern to the members of the workgroup was not being able to discern whether providers executing contracts for BHS to incarcerated people have received specific training on combat trauma, military sexual trauma (MST) and mild to moderate traumatic brain injury (TBI). Similarly, the workgroup was unable to determine whether specialized training is given to those providing services to Veterans under the TAMAR, PATH, or MCCJTP programs. The workgroup concluded that the absence of these specialized services for incarcerated Veterans should be seen as a significant impediment to successful community reintegration for this population of Veterans.

The workgroup noted that the Department of Labor has prison-based programs in support of post-incarceration employment for Veterans evaluated by MCVETS, but federal regulations prevent those with felony convictions from getting federal jobs. The workgroup concluded that “these regulations need to be changed.”

Taking into account all these findings, the workgroup formulated a final recommendation to promote opportunities for incarcerated Veterans (at Maryland state and county correctional facilities) to have access to evidence-based BH services focused on Veteran populations and BH conditions related to military service and combat exposures. Training for the correctional and forensic workforce will also be necessary.

### **Homeless Veterans**

According to the Fiscal Year 2009 “Community Homelessness Assessment, Local Education and Networking Groups for Veterans (CHALENG)” report, there were an estimated 2,062 homeless Veterans in VISN 5. Based on this point-in-time survey, it is estimated that there are 107,000 Veterans who are homeless in the country. Nationwide, about 23% of homeless adults are Veterans and about 33% of homeless *men* are Veterans.<sup>21</sup>

Significant among services provided to homeless Veterans in Maryland is the Mental Health Intensive Case Management Enhanced Rural Access Network for Growth Enhancement program (E-RANGE) being demonstrated by the VA’s Veterans Integrated Service Network 5 (VISN 5). This demonstration project seeks to address the housing needs for seriously mentally ill Veterans – in some cases homeless Veterans – and their continuing mental health treatment needs. Mobile outreach teams working on the Eastern Shore of Maryland are providing intensive case management for seriously mentally ill Veterans in their homes. In the first six

---

<sup>21</sup> Kuhn, JH, Nakashima, J., [The Sixteenth Annual Progress Report. Community Homelessness Assessment, Local Education and Networking Group \(CHALENG\) for Veterans \(FY 2009\): Service Homeless Veterans Assessment and Coordination.](#) March 17, 2010.



months of the program 20 patients were enrolled, of these 7 had been homeless. The current census for the program is depicted in Figure 8.

<b>E-RANGE Eastern Shore Demonstration Project US Department of Veterans Affairs</b>	
<b>County</b>	<b>Enrolled Veterans</b>
Caroline	2
Dorchester	1
Queen Anne	1
Somerset	1
Talbot	2
Wicomico	10
Worcester	6
<b>TOTAL</b>	<b>23*</b>
*Includes 21 men, 2 women; ages 21-68; Dx (includes dual) - PTSD: 11, Schizophrenia: 7, Mood disorder:13	
Source: US Dept of VA, VISN 5, Mental Health Program Manager	

Figure 8.

Additional enrollees will be accepted up to a maximum of 30. The Lieutenant Governor of Maryland was influential in assisting the VA in receiving the necessary funding for this program from VA headquarters. Depending on future funding availability, the VISN would like to see the E-RANGE program extended to the Western and Southern regions of Maryland. VISN 5 is working with Maryland’s Regional Resource Coordinators to identify potential population that might be served through additional E-RANGE programs. [A full description of the E-RANGE program is located in Appendix I.]

The HUD-VA Supportive Housing Program (VASH) combines Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the VA. VA provides these services for participating Veterans at VA medical centers and CBOCs. The 2008 Appropriation for this program required HUD to make funding available for the program to entities designated by the VA based on geographic need for such assistance, public housing agency administrative performance and other factors. Further, the Appropriations Committee made it very clear that this program was to be open to all homeless Veterans, including recently returning Veterans. Hence the only significant program restriction on eligibility for these Veterans is that known sex offenders are precluded. [See Appendix J for the HUD-VASH Regulations: *Implementation of the HUD-VA Supportive Housing Program.*]

VA / HUD Veterans Supported Housing Program (VASH) Veterans Integrated Service Network 5			
Public Housing Authority	Vouchers Allocated (Fiscal Yr)	Vouchers in Use (currently)	Total Vets Under Lease
Baltimore City	75 (2010)	45	19
Baltimore County	70 (2009)	69	65
Baltimore County	105 (2008)	100	93
Cecil County	70 (2008)	69	67
Montgomery County	25 (2010)	25	16
Prince George's County	40 (2010)	25	14
Prince George's County	35 (2009)	35	34

Source: VISN 5 Homeless Veterans Coordinator, January 2011.

Figure 9.

The VA (VISN 5 Network) has also recently begun a new homeless initiative to increase communication and coordinated efforts to meet the needs of homeless Veterans. In February 2011, they will have the first Interagency meeting with invitees from several federal offices, including the US Interagency Council on Homelessness, and the Veterans Benefits Administration; different state (MD, DC, VA, and WV) offices including Housing, Labor, Child Support Enforcement, Veteran Affairs; and, different non-profit leaders, including Common Ground and Homeless Persons Representation Project.

Other activities that have occurred over the past several years on behalf of homeless Veterans in Maryland include the launch of a Veteran's Housing Assistance program in Prince George's County under the auspices of their Department of Social Services.

The workgroup sought out Col. Charles Williams (USA ret.), the Director of the Maryland Center for Veterans Education and Training (MCVET), to help it identify gaps in services for homeless Veterans. MCVET is a model program designed to assist homeless Veterans and other Veterans in need of a wide range of services that will enable them to return to a life that is functional and productive. Conversations with Col. Williams raised concerns about the homeless and employment difficulties faced by Veterans with punitive dishonorable discharges that may have related to substance abuse and mental health problems experienced by the Veteran when on active duty.

Maryland's Projects for Assistance in Transition from Homelessness (PATH) program was developed in 1991. PATH is a federal formula grant from the Substance Abuse Mental Health Services Administration (SAMHSA) Center for Mental Health Services. PATH provides flexible community and detention center based services to individuals who are homeless and have a mental illness. Services include screening and assessments, rehabilitation and habilitation services, case management linkage to housing, referrals to primary health and mental health, employment and education services, housing assistance, security deposits, one-time only funds to prevent eviction in Baltimore City and 22 counties in Maryland, and other services. In Fiscal Year 2009, the PATH program engaged with 285 Veterans through outreach (5% of a total of 5691 PATH participants) and enrolled 118 Veterans (5% of 2369 total enrollees).

Health Care for the Homeless was identified by the workgroup as an organization that provides comprehensive BHS and addiction treatment to residents of Maryland. Confirming that Veterans are eligible and ensuring that this service is widely promoted is an activity that the workgroup referred to MCV.

MHA's Shelter Plus Care Housing Program provides tenant or sponsor-based rental assistance to individuals and families with an adult member who has a serious mental illness, who are homeless and are being released from the local detention centers, as well as individuals and families with an adult member who is homeless and at risk for incarceration due to behavior manifestations resulting from a serious mental illness. In Fiscal year 2010, the Shelter Plus Care program served 12 Veterans out of the total 365 adults served.

### **Provider Capacity and Training**

In addition to identifying specific areas of concern related to children and family members impacted by military service and the barriers special populations encounter while obtaining BH services, the Children, Family and Special Populations workgroup also addressed issues related to provider capacity and training needs to meet the BH needs of Veterans and their families.

The workgroup analyzed professional continuing education options for behavioral health practitioners as it relates to providing Veterans and their families with behavioral health services (BHS).

Since the workgroup was not aware of any existing data regarding to what degree Maryland BHS providers were already equipped to respond to the specialized needs of Veterans and their family members, it contacted the University of Maryland School of Social Work and other institutions and governmental programs for more information. Among its findings, the workgroup determined that the MDNG was hosting forums on Veterans' reintegration issues. The workgroup became involved with the third forum, *Summit for Healthcare Providers*, conducted in partnership with Maryland DHMH, MDVA, Johns Hopkins University and the VA.

The event was fully subscribed with over 450 healthcare professionals who received continuing education credit for participation. The workgroup arranged for the keynote speaker, Harold Kudler, MD, a PTSD expert from VA's VISN 6 and Duke University Medical Center. By February 2010, another four sessions had taken place in Maryland that specifically addressed Veteran issues and were delivered to various mental health professional groups.

Primary health care providers, as well as members of the clergy, are important community "points of entry" for Veterans experiencing behavioral health or serious relationship problems. Veterans, and their immediate family members (spouse, child, parent), may present these community providers with a variety of symptoms, or expressions of personal or family distress, in the context of seeking help. Veterans and their family members may choose these points of entry because they are immediately accessible and free from the perceived stigma associated with seeking care from the VA or the community behavioral health system. It is critical that these community gate keepers are aware of and knowledgeable about this population and their behavioral health needs.

The workgroup also reviewed best practices in other states. For example, the North Carolina "Governor's Focus on Servicemembers, Veterans and Their Families" provides on-line training programs for health professionals. These programs are: Military Cultural Competence, Working with Service members and Veterans with PTSD, Prolonged Exposure Therapy for the Treatment of PTSD, Cognitive Processing Therapy for PTSD in Veterans and Military Personnel, The Impact of Stress and Trauma Related to Military Deployment, Addressing the Psychological Health Needs of Service members and Their Families (includes 4 modules – TBI, Military Culture & Deployment, PTSD & Treatment, Suicide & Depression), Topics in Deployment Psychology, and Advanced Therapeutic Techniques for Treating Our Military and Their Families.<sup>22</sup> Consideration of its findings and deliberations relative to provider capacity and training needs, prompted the workgroup to discuss the following important goals with the Advisory Board:

1. Funding of a proposed University of Maryland survey of licensed social workers. The workgroup felt that with the successful collection of relevant data, the survey could be expanded to reach all BHS providers in order to inform continuing education training requirements and also to help inform the content that needs to be integrated into courses in graduate school.
2. Cultivation of relationships between the leadership of Maryland behavioral health associations and non-profit organizations serving Veterans, their families or special populations.

---

<sup>22</sup> North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "The Governor's Focus on Servicemembers, Veterans and Their Families." [www.veteransfocus.org](http://www.veteransfocus.org)

3. Catalogue and widely distribute the current continuing education and special interest workgroup efforts that focus on addressing the BH needs of returning Veterans and their families.
4. Identify the mental health practice skill requirements related to serving Veterans and their family members and initiate public/private collaborations to address them.
5. Consider establishing a specialized certification that would identify Maryland behavioral health providers who have the requisite credentials to serve the needs of returning Veterans and their family members. A program that already exists in North Carolina could serve as the model for a Maryland certification program.

### **Veterans Ineligible for VA Benefits & Services**

The workgroup investigated the specific impact that “Other Than Honorable Discharges” have on a Veteran’s eligibility for VA health care benefits. VA has extensive rules and guidance available relative to these determinations. A significant distinction is that to be considered a “Veteran” eligible for VA health care benefits, a former service member must have been discharged “under conditions other than dishonorable.” Under VA’s regulations, administrative discharges officially characterized as “Honorable” or “General under Honorable Conditions” are qualifying. Discharges that are punitive and issued by *general* court martial are disqualifying (these include Dishonorable or Bad Conduct discharges). However there are “in-between” categories that may or may not be disqualifying for purposes of VA health benefits eligibility and which require special determinations.

Further, an individual with an “Other than Honorable” discharge who is disqualified from most VA benefits, generally retains eligibility for VA health care benefits for service-incurred or service-aggravated disabilities. [See Appendix K for VA Fact Sheet 16-8 on Other than Honorable Discharges.]

The workgroup observed that those Veterans who received punitive discharges by general court martial represent a significant at-risk population for behavioral health and related life adjustment and relationship problems requiring BH intervention. DHMH is able to provide BHS to this population. Limited BHS are also available from the State-supported Pro Bono Counseling Project; however, the Children, Family and Special Populations workgroup found that the general population, human service organizations, and BH professionals are not aware of the BHS available to this population or how to help this population access these services.

The workgroup advised the Advisory Board that there needs to be appropriate outreach consideration for this group of Veterans. The workgroup also raised the question of whether or not the discharge quality should take on a *continuing* punitive quality, “...given that there are

subjective factors that may have entered into the final result of a less than honorable discharge.” Discharges other than honorable have a profound effect on benefit limitations.

## Caregivers

A 2009 study, “Caregiving in the U.S.” showed that 11% of all caregivers of adults have served in the armed forces and 17% of their care recipients are Veterans. A recent survey of caregivers indicated that an estimated 58% of the Veterans cared for are 55 years of age or older. But unique among caregivers in the U.S. are those who are caring for the newly injured Veteran, many in their twenties. These caregivers may be parents (61%) who are just entering their 50s or 60s and who now face decades in the caregiver role, 32% are spouses and 7% are friends, children, and others.<sup>23</sup> While as many as 44% of Veterans served by these caregivers are Vietnam era vets, another 40% are post-Vietnam, with some 30% estimated to be OIF/OEF Veterans. The vast majority of these Veterans receive their care at home.<sup>24</sup>

Caregiving impacts not just the recipient or the caregiver; it impacts the entire family, marital relationship, children, friends, etc. Caregivers say that “this isn’t just a full-time job, it’s a life.” In some instance this “life” has significantly impacted the economic condition of families because a caregiver may have had to give up a job. On May 5, 2010, the President signed into law the “Caregivers and Veterans Omnibus Health Services Act of 2010” (Public Law 111-163) which will ensure that families of severely wounded Veterans receive comprehensive coordinated financial and other support that will enable them to provide these Veterans with needed home care. VA is presently developing implementation regulations.

## C. OUTREACH AND EDUCATION

*Workgroup Chair, Senator Douglas J.J. Peters, Maryland General Assembly*

From its inception, the Outreach and Education workgroup identified five overarching goals for its efforts:

1. Ensure Veterans have every opportunity to make the transition from combat to re-uniting with their families, rejoining their home communities and re-entering the local economy;

---

<sup>23</sup> The Third Annual Trauma Spectrum Conference: Emerging Research on Polytrauma, Recovery and Reintegration of Servicemembers, Veterans and their Families, Bethesda, MD. Joan Griffin, PhD., U.S. Department of Veterans Affairs, Center for Chronic Disease Outcomes Research. [Family and Caregiver Experiences Survey](#). December 2010.

<sup>24</sup> National Alliance for Caregiving. [Caregivers of Veterans—Serving on the Homefront. Report of Study Findings](#), November 2010.

2. Educate and reinforce Veterans and their families, about the signs and symptoms of post- traumatic stress disorder, depression and behavioral issues that can arise in children and adolescents of deployed service members or when a family is under stress because of untreated symptoms;
3. Increase awareness about VA benefits and entitlements, and available community health care services and vet-friendly programs;
4. Increase community awareness about the issues and challenges faced by combat Veterans returning to civilian life; and,
5. Educate community stakeholders so they understand how they can contribute to Veterans' successful community reintegration.

The workgroup conducted extensive meetings and discussions with various content experts to assess what outreach and education activities are needed in the State.

In considering education and outreach issues, the workgroup looked at those programs and services that interact with the Veteran population. In considering the law enforcement area, the workgroup felt that local law enforcement personnel would benefit by knowing how to look for symptoms of Veterans' behavioral health issues so that they could more efficiently refer Veterans to the appropriate BHS resource. The workgroup found that DHMH already works with Baltimore Crisis Response, Inc. (BCRI) to provide a variety of mental health trainings. It seemed that developing and providing a module specific to Veteran reintegration issues which would be delivered to police officers, would be a reasonable and advisable activity. DHMH is looking into accomplishing this, at the direction of the Advisory Board.

Additionally, recently VISN 5 personnel have been working with Maryland law enforcement personnel in Calvert County to address law enforcement-related services, to include

1. Providing in-service training for Southern Maryland Tri-county Sheriff offices on PTSD, suicide prevention and awareness.
2. Providing information on Veteran eligibility for VA benefits and services.
3. Establishing a procedure for a single point-of-contact with the Washington, DC VA Medical Center mental health program to determine eligibility and connect Veterans with services (Note: a similar procedure has been established with District of Columbia Department of Mental Health Services and Montgomery County Department of Mental Health).
4. Providing contact information for the Veterans Justice Outreach (VJO) Specialist and the Re-entry Specialist and providing the re-entry Veteran handbook to the sheriff's offices representatives in the Tri-county area.

The workgroup examined the current "Muster" events conducted by MDVA. It learned that the events need to be more geared toward family members of Veterans, in addition to the

Veterans themselves. The workgroup suggested that MDVA bill these events as “Veterans Family Appreciation Day” events that could be held in each county, as were traditional musters. These events could be held at community colleges to minimize cost, along with soliciting donations from local businesses that could provide food, games, rides, child care, classes on behavioral health, etc. The National Guard could be asked to bring equipment for children to learn about reintegration issues, etc. The workgroup also suggested having information booths to educate family members on Veteran benefits. MDVA was advised by the Advisory Board to plan such events.

The workgroup met with VA officials to learn more about the Veterans’ Justice Outreach (VJO) initiative. VJO Specialists located at VA Medical Centers are developing working relationships with the court system and local law enforcement and must now provide outreach to those Veterans involved with the justice system in the communities they serve. The purpose of the VJO initiative is to find ways to avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible justice-involved Veterans have timely access to VA mental health and substance abuse services, and other VA services as appropriate. The workgroup also examined the various Veterans Courts in other states (including the model in Buffalo, NY) to assess best practices, and development and operational issues.

Courts across the country, including California, Pennsylvania, Oklahoma and Wisconsin have adopted Veterans Courts. Typically, Veterans charged with nonviolent crimes and suffering from substance abuse or mental health problems or both are placed in a special docket. After an initial screening and assessment by the court, they are offered a place in a treatment program geared to Veterans instead of standing trial. Compliance is monitored and volunteer mentors are assigned to support the participants. Both the VA and community organizations are available to provide treatment after assessments. Because the courts are reserved for Veterans, they serve as a form of recognition of past service and an effective way to re-awaken service members’ pride, discipline and courage — critical elements in helping many resolve their problems. It helps, too, that the Veterans are in the program with one another, fostering a sense of camaraderie. Generally, as many as 90% of participants complete the program, and recidivism is rarely reported.<sup>25</sup>

The Maryland National Guard is providing classes to the judges as part of the annual training conducted at the Judicial Training Institute. These include topics on the mental health preparation for combat, the return of the Reserve Component Veteran to the community, the behaviors learned in the combat zone for survival which do not work well in the community, and the programs available to National Guard and Reserve Veterans for Reintegration.

---

<sup>25</sup> “A Separate Peace: Specialized courts for war veterans work wonders. But why stop at veterans?” Slate. Dahlia Lithwick, Feb. 11, 2010.



As was noted by the Children, Family and Special Populations workgroup, the Outreach and Education workgroup found that substantive Veterans’ programs exist in certain higher education institutions in Maryland. Further, the workgroup examined various educational initiatives for Veterans throughout the country and found pilot programs in some states that are piloting training programs for faculty and staff of higher education institutions about the mental health needs of student Veterans. Generally, such programs are funded by grants. For example, the US Department of Education has provided grants to colleges to develop Centers of Excellence for Veteran Student Success (CEVSS) program. These grants are intended to foster and support the success of student Veterans by developing flagship programs that coordinate and collaborate on all aspects of student services. In 2010, the University of Maryland received a three-year CEVSS grant of \$396,000 to establish a Center of Excellence for Veteran Student Success designed to increase awareness, communication, coordination, and information dissemination across all campus units (academic and administrative services, physical and mental health services, campus life, and student involvement, etc.) serving Veterans.

The University of Maryland was also a recipient of an American Council on Education/Wal-Mart Foundation “Success for Veterans Award Grant” of \$100,000 in 2009. The grant is being used to develop, implement, evaluate and disseminate a Veterans service model that integrates comprehensive services into a web-based platform. This platform may prove to be an effective model for State-wide application.

Maryland’s Higher Education Commission administers a scholarship program for Veterans of the Afghanistan and Iraq Conflicts. The following table displays funding and recipient information about the program.

Veterans of Afghanistan and Iraq Conflicts Scholarship Program Maryland Higher Education Commission				
Fiscal Year	Total # of Initial Awards	# of Vet Awards	# of Family Awards	Funding
2008	123	76	47	\$1,200,252
2009	86	69	17	\$1,437,133
2010	34	34	0	\$1,320,474
2011	64	18	46	\$1,320,474

Source: Maryland Higher Educ. Comm. and MD Department of Budget & Mgmt.

Figure 10.

The workgroup examined various outreach approaches and determined that a quarterly Maryland Veterans show on Maryland Public Television (MPT) would be extremely effective.

The Advisory Board advised MDVA to work with MPT to develop such a program which would include a segment for Veterans to call in with questions.

Considering the extensive use of social networking by Veterans, particularly OIF/OEF Veterans, the workgroup observed the need for enhanced electronic communication with the Veteran population in the State. More effective use of Facebook, for example, was considered an effective form of outreach. Further, all websites in the State were reviewed and many were found to lack links for Veterans programs, e.g., the MCV website. In its discussions, the Advisory Board advised MDVA to enhance its Facebook page so as to reach more Veterans and to work with other State agencies to ensure that their websites link to MCV.

Another area of focus for outreach and education activities are the friends and family members of Veterans. Often these individuals are the first to reach out for assistance on behalf of the Veterans in their lives. In some respects it may be that these individuals are easier to target because they may not have the stigma concerns and other culturalization obstacles that may prevent or deter Veterans from seeking help. Strategies for reaching these groups need to be developed.

VISN 5 is developing a Rural Veterans Health Information Center (RVHIC) -- a concept for an online community. The RVHIC is proposed to consist of an online library – with access to information and resources relating to Veterans health topics, VA benefits and enrollment, new VA programs and My HealtheVet (VA’s personal health record for Veteran enrollees). It will also offer an online classroom, with formal education and training modules tailored for self-instruction, and a social network, with resources for Veterans to connect with a community and network with caregivers, students, researchers, other Veterans, family members, etc. The primary goal of the RVHIC is to provide its target audiences with social media capabilities and tools to increase ‘connectedness,’ enable two-way communications, and facilitate collaboration across the traditional barriers of geography, organization domain or hierarchy, and professional affinity.

In addressing the ever-growing mental health needs of service members and Veterans, the VA and DoD are increasingly turning to virtual forms of intervention – using the Internet and digital technology. It has been observed that the newer generation of Veterans sometimes opens up more through the use of such technologies as Skype, rather than sitting in a room with a mental health care provider. The Army is using internet-based mental health screening to assess soldiers returning from deployments. The VA has started an Internet-based chat line for service members to discuss stress, recognizing that the younger generation of Veterans is much more used to “chatting” on the Internet and “texting” on phones. Using these sorts of technologies is also acknowledged to be more effective in reaching many Veterans and Guardsmen and Reservists who are not on active duty.

While recognizing the importance and value of initiatives such as the RVHIC, the Advisory Board observed that the demographics of Veterans located in Maryland's rural areas (older and lower income), coupled with Internet access challenges they face, suggest that successful outreach efforts must take a multi-faceted approach. The Advisory Board noted that Allegany, Caroline and Somerset counties face particular Internet access challenges because of the significant number of areas in those counties lacking service from broadband ISPs.

Because of the importance of having a means to directly communicate with Veterans in the State, the workgroup commended the MDVA effort to develop a database of Maryland Veterans, including their addresses and email addresses, if available. This effort, currently ongoing, will enable more direct contact with Veterans relative to programs, for surveys, etc. However, the Advisory Board observed that more needs to be done to ensure ongoing access to email addresses of Veterans. This is increasingly becoming a primary form of communication and the federal government can do much to assist the states in acquiring this important contact information. While Maryland will look at numerous avenues for acquiring email addresses such as license applications, the State encourages the Department of Defense to modify the data collected and provided on the DD-214 Certificate of Release or Discharge from Active Duty discharge form, to routinely report email addresses upon separation as part of the DD-214's "Report of Separation" of veterans at discharge.

Another effective interaction with Veterans to address behavioral health needs is Peer-to-Peer support groups. VA is developing a Peer Support Training Manual that will detail the 34 competencies based on 10 domains of knowledge that are needed to be competent in the provision of peer support. This manual is intended to assist in training VA employees and volunteers who work in peer-to-peer groups. VISN 5 has a Peer Support Technician (PST) in each of its Psychosocial Rehabilitation Recovery Centers. The success of the PSTs helped to demonstrate that peer support is a critical need in the mental health services delivery system. Consequently, Volunteer Peer Supports was developed. The VA Maryland Health Care System has trained 19 Veterans to become Certified Volunteer Peer Supports and they are providing such services through the Mental Health Clinical Center. In addition, from the state "best practices" perspective, The State of Vermont has a Peer-to-Peer program, "Vet-to-Vet" worthy of consideration.

It was also noted that the MDNG is actively involved in a number of studies that have been proposed or are in the process of award. These include:

1. *Effectiveness of Working Memory Training on Cognitive, Emotional and Functional Outcomes After Mild TBI*. Partnership with Johns Hopkins University. Award pending from the Congressionally Directed Medical Research Programs (CDMRP), Psychological Health/Traumatic Brain Injury (PH/TBI).

2. 5-HT6 Antagonist GL2119 for the Treatment of TBI and PTSD. Partnership with Johns Hopkins University, School of Medicine.
3. *Managing the Return of Young Veterans to the Workforce: Paradigm Shift for Managers.* Partnership with Johns Hopkins University, School of Education.
4. *Study of the Markers of Injury that Predict Risk for Development of Neuropsychiatric Problems After Exposure to Blast Injury.* Partnership with Johns Hopkins University.
5. *Psychological First Aid (PFA) Training for Mobilizing MDARNG NCOs and First Line Supervisors to Facilitate Early Recognition and Triage for those Suffering from Acute Traumatic Stress and Traumatic Depression.* Partnership with Johns Hopkins University, Bloomberg School of Public Health.

And, the MDNG is contributing a chapter entitled “Ensuring Equality after the War for National Guard and Reserve Forces: Revisiting the Yellow Ribbon Initiative” to a new text on Veterans: Young Veterans: A Resilient Community of Honor, Duty and Need.<sup>26</sup> It is also notable that MDNG is advancing knowledge internationally about the “Maryland Model” developed by MDNG on addressing the unique stresses faced by deployed National Guard and Reservists and their families, which will be presented at the 11<sup>th</sup> World Congress of the International Critical Incident Stress Foundation.

Based on its findings throughout its deliberations, the workgroup identified a number of areas that it suggested to the Advisory Board as areas warranting further action. These included the following suggested action items:

1. Train Local Law Enforcement on Veterans and PTSD and TBI. The workgroup also suggested that the Baltimore Crisis Response group be approached about the possibility of recording a Veterans’ behavioral health segment for “Mental Health Matters,” a cable television program that airs in Baltimore County and Baltimore City.
2. Encourage the Maryland Judicial Branch to undertake expanded efforts to insure awareness of the issues associated with mental health issues among Veterans, particularly PTSD and Traumatic Brain Injury. Quarterly training of judges on Veterans issues should be developed and made available.
3. Foster expanded collaboration among the Judicial Branch, MDVA and VA’s VJO initiative and expand research efforts to determine whether or not there is a need for a Veterans specialty court in Maryland. Encourage Judicial Branch to review other state’s Veterans Courts, e.g., Municipal Court in Philadelphia.
4. Develop a “bench card” for all judges in Maryland that will identify contact information for services available to Veterans. The bench card should also be distributed to National Guard and Reserve Family Support Groups.

---

<sup>26</sup> Young Veterans: A Resilient Community of Honor, Duty and Need. Diann Cameron Kelly, David Gitelson and Sydney Howe Barksdale, eds., Springer. Forthcoming.

5. Ensure that outreach efforts use effective terminology and age-appropriate communication strategies.
6. Emphasize peer-to-peer communications when possible.
7. Consider disseminating information about available services through 12-step groups to reach Veterans dealing with alcohol and substance abuse.
8. Examine the University of Maryland “Success for Veterans” grant program for possible broader application in the State.

## 5. GAP ANALYSES

### A. GAPS IN AVAILABLE BEHAVIORAL HEALTH SERVICES

In fulfilling the assignment to examine gaps in available behavioral health services, the Advisory Board accomplished an extensive review of behavioral health service providers by county. This review examined federal, state, county, and community providers of behavioral health services – public and private. There is no question that there is a wealth of service providers available in the State. [Figure 11 on the next page depicts behavioral health service organizations, public and private, by county location in the State of Maryland (also see Appendix L). A list of these providers represented on the map in Fig. 11 can be found in Appendix M. This list does not include individual practitioners.]

Some providers may be specialized to areas that not all Veterans in need of behavioral health assistance would require. Some providers (particularly among individual practitioners) may not be accepting new patients into their practices. Moreover, many providers may not be trained in or even familiar with the often specialized nature of the behavioral health needs, and mental health conditions associated with a Veteran’s military service. Still others may be focused on the treatment of the most serious of mental health conditions – often not the conditions for which Veterans require treatment. The Advisory Board was able to collect substantial anecdotal evidence that while services exist they are likely not sufficiently specialized to the needs of the Veteran population. The actual extent to which that is true could not be verified within the resources of the Advisory Board, nor was the need apparent. As noted elsewhere in this report, the Advisory Board is concerned about the access rural veterans in Maryland have to mental health services. The Board noted that similar concerns have been expressed in other states and, in fact, VA’s Inspector General has been asked in the case of at least one state to examine this issue.<sup>27</sup>

Further anecdotal evidence, augmented by data from the VA network, indicates that only about one half of returning Veterans have accessed VA services. The Advisory Board heard that time and distance to VA facilities and stigma associated with BH care reinforce the importance of promoting awareness and competence among Maryland’s BH providers, with particular

---

<sup>27</sup> U.S. Department of Veterans Affairs, Office of the Inspector General, Washington, DC. [Access to VA Mental Health Care for Montana Veterans](#). Report No. 08-00069-102, March 2009. p.ii

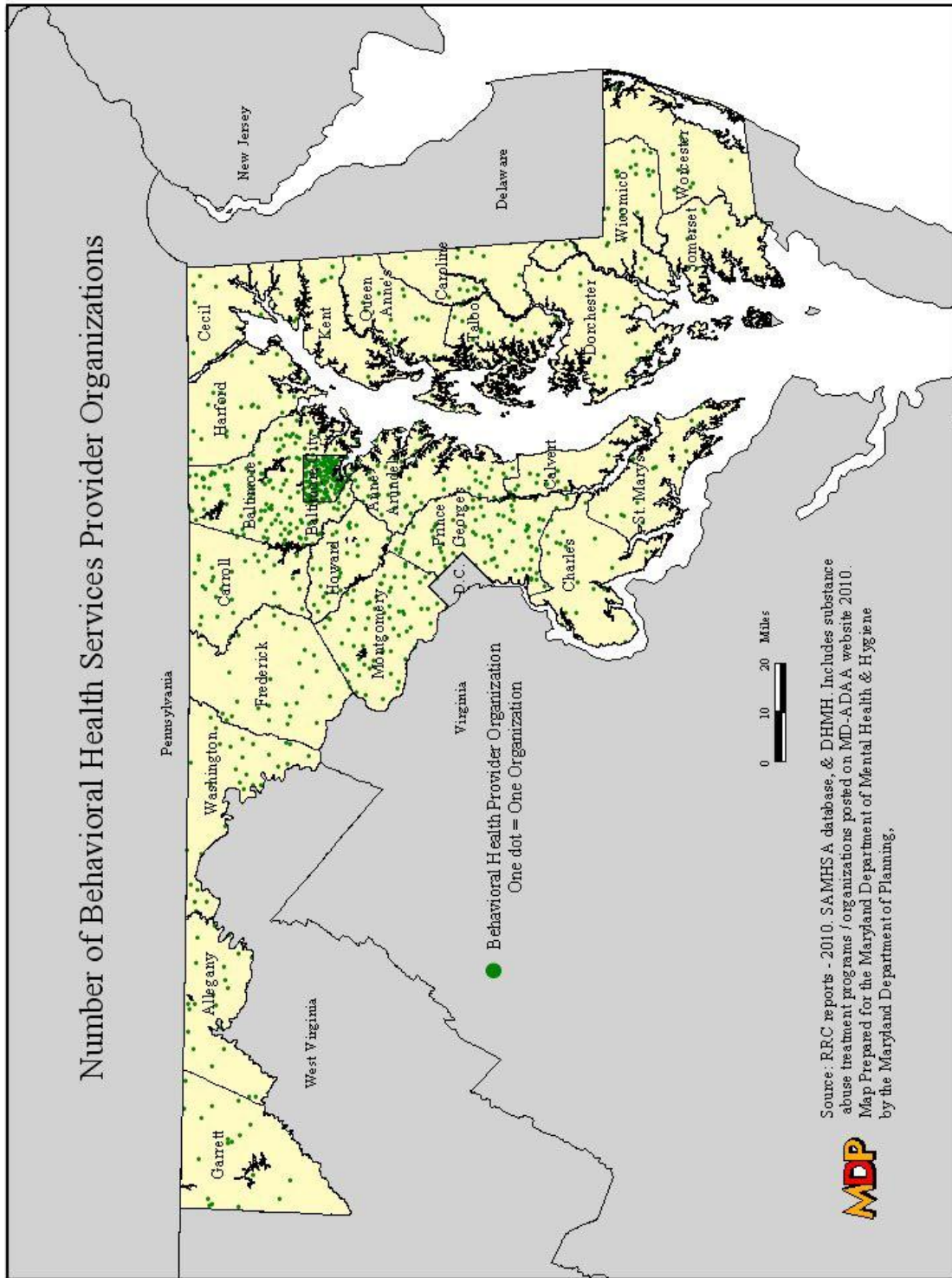


Figure 11



emphasis on those working in primary care settings, as well as educational counseling and employee assistance programs.

In assessing the needed behavioral health services in Maryland, the efforts to transform Maryland's mental health services under the federal Mental Health Transformation State Incentive grant were reviewed. Most of the needs originally identified under this program were applicable to the Veteran population. These included: need for peer support groups, need for transportation services, shortages of housing, lack of integration and collaboration between state agencies as well as between the public and private sectors, fragmentation of programs, funding silos, and lack of specially-trained clinical personnel. Much has been done to address these needs. Over the past four years, Maryland's Mental Health Transformation Office has undertaken a number of innovative projects to transform the mental health system. Maryland's transformation efforts are now being recognized nationwide. The state was one of only six to be awarded a grade of "B" – the highest rating given in the National Alliance on Mental Illness' (NAMI) *Grading the States 2009* report. NAMI notes that Maryland is a national leader in several areas, including support of consumer empowerment, collaboration with consumer and advocacy organizations, and in its wellness and recovery approach to mental health services. The advances made in transforming Maryland's mental health system should serve the Veterans in Maryland well.

## **B. GAP BETWEEN NEED FOR SERVICES & USE OF SERVICES**

There is a gap between the need for behavioral health services – particularly for treatment of often dually diagnosed mental illness and substance abuse conditions – and the use of such services. Much research has demonstrated that only a small proportion of returning Veterans who have symptoms seek mental health care services. In its research, RAND found that only between 23% and 40% of Veterans who met criteria for a mental health problem actually received mental health care.<sup>28</sup>

It has been widely reported that many service members are reluctant to seek mental health care because they fear negative repercussions on their military careers. A new study of recent Veterans suggests that some of the same resistance continues among men and women who have left the military. The study found that only about a third of the Veterans who appeared to need mental health care – typically for depression, post-traumatic stress disorder or substance abuse – had actually received it in the previous year. Asked why, many said they feared that seeking treatment would lead colleagues or bosses to lose respect for them and would hurt

---

<sup>28</sup> Taanielian, TL and RAND Corporation and Cte for Military Health Policy Research, 2008. [Invisible Wounds of War: Summary and recommendations for addressing psychological and cognitive injuries.](#) RAND, Santa Monica: 2008.



their careers. Others raised concerns about the side effects of medications or the cost and effectiveness of therapy.<sup>29</sup>

More alarmingly, in recent years, suicides among active duty military have been on the rise. The Army saw a record number in 2009. Last year, 160 active-duty soldiers killed themselves, up from 140 in 2008 and 77 in 2003.<sup>30</sup>

But the data are much more difficult to identify on Veterans who have left active duty. The VA calculated the suicide rates using Centers for Disease Control and Prevention data from 16 states. In 2005, the rate per 100,000 Veterans among men ages 18-29 was 44.99, compared with 56.77 in 2007, per the VA. The Secretary of Veterans Affairs has observed that of the 30,000 suicides that occur in the US each year, approximately 20% of them are Veterans.

"Theater of War" is a DoD project designed to remove stigma related to psychological injuries by illustrating that many of the bravest war heroes in history have lived with the psychological effects of battle. This theatrical performance includes a dramatic reading of selected scenes from the plays "Ajax" and "Philoctetes" by Greek General and playwright Sophocles, performed by a rotating cast of acclaimed film and stage actors. The reading is followed by a town-hall discussion with the audience and a panel of members from the local military community. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) recognized the project's potential for military audiences to confront and discuss the emotional and psychological effects of combat and war, and the challenges of homecoming. One hundred performances in 50 military venues are scheduled in the next year throughout the United States. The availability of performances for Maryland Veterans should be investigated.

In examining violent death data among Veterans in the State of Maryland, the Advisory Board found that over the five-year period of 2004-2008, Veterans represented 22% of suicides in the State. Notably, the Advisory Board found that more than half of those Veteran suicides occurred among Veterans 65 years of age or older. It is unknown whether the victims were suffering from PTSD, other military-related mental health conditions or disabilities, or possibly otherwise terminal illnesses. [Appendix 14 contains detailed Maryland Violent Death data.]

The Maryland Governor's Commission on Suicide Prevention, established in October of 2009, consists of 21 members that represent the State (including the Department of Veterans Affairs), mental health advisory councils, Core Service Agencies, organizations for older adults, and a number of advocacy and survivor groups. It is charged with developing a two-year, comprehensive and coordinated strategic plan to target suicide prevention, intervention, and

---

<sup>29</sup> Farmer, C. et al. *A Needs Assessment of New York State Veterans – Final Report to the New York State Health Foundation*, ed. Terry L. Schell and Terri Tanielian, RAND Corporation, Santa Monica. 2011.

<sup>30</sup> "Is the U.S. Army Losing Its War on Suicide? Time. Mark Thompson. April 2010  
<http://www.time.com/time/nation/article/0,8599,1981284,00.html>

post-intervention for individuals and families across the State. This Commission's study should include a focus on the sub-population of Veterans and their families.

In an effort to better understand these increasing rates of suicide and in the interest of informing and educating Army leaders on the importance of recognizing and reducing high risk behavior related to suicide and accidental death, and reducing the stigma associated with behavioral health and treatment, the Army undertook a 15-month effort culminating in the July 2010 "Health Promotion, Risk Reduction, and Suicide Prevention Report." Among the Army's key findings were the need for increased surveillance and detection of high risk behaviors and the need to reduce stress among a military force that has been under stress for almost a decade of war. In some case, it is this stress that leads to problems with alcohol and drug abuse, legal troubles, mental health issues, and, in the extreme, suicide. These stressors often manifest themselves when service members return home in between or at the end of deployments. State agencies, colleges and universities, and community organizations can play a role to ensure that military service members, Veterans, and their families are aware of services and supports within their communities that they can access in confidence and without risk to their military status.

The Maryland Mental Hygiene Administration's "Anti-Stigma Project (ASP)" offers workshops that challenge participants to examine the impact of stigma on both their professional and personal lives. In FY 2010, the Anti-Stigma Project reached more than 3,000 people through 61 workshops held across the State. It is not known the number of Veterans who may have been among those 3000 people.

It is anecdotally reported that Veterans – if aware that there are benefits and services available to them – are confused by the governmental instructions, the many different groups involved, and eligibility requirements in general. Further, many of these Veterans do not have sufficient resources to pay for basic needs and services. Sometimes the cost of a required certification exam to get an occupational license or the cost of a security deposit for an apartment is beyond a Veteran's resources. Many states, including Maryland, have Veterans Trust Funds. However, a number of these states, e.g., Massachusetts, Oregon, Iowa, Michigan, Wisconsin, Alabama, provide loans and grants to Veterans for various financial needs. State policies vary regarding paying back these loans. In some cases, it is reported that application of the "pay it forward" principle is most effective with the Veteran population, who realize that by paying back monies they have received—as they are able—they are helping future Veterans in need. This is a powerful sentiment in the Veteran community.

The Maryland Veterans Trust Fund (MVTF) took effect on October 1, 2009. It is within the authority of the MVTF to provide grants and loans to Veterans and their families, as well as to public and private programs that support Veterans and their families. However, such loans and

grants have not yet been made, pending development of implementing policies and procedures. Prior to the creation of MVTF, the Charlotte Hall Veterans Home (CHVH) fund existed; it has since been merged with the MVTF. However, contributions to CHVH will remain directed to CHVH to benefit the residents who live at the home. It is expected that MDVA will conduct an advertising campaign to solicit funds and applications from Veterans in need once the policies and procedures are finalized.

### **C. GAPS IN QUALITY & EFFECTIVENESS OF SERVICES**

It has been noted by the RAND Corporation that “treatments for PTSD and major depression vary substantially in their effectiveness,” and that there are gaps at the national level in how TRICARE and the VA address therapies. [Note: TRICARE is a DoD regionally managed health care program for Active Duty, Activated Guard and Reserves, retired members of the uniformed services, their families, and survivors.] It has been suggested that only the most effective, evidence-based therapies should be provided and covered by insurance. Further, and most significantly, there is evidence that many medical professionals and other behavioral health providers are not sufficiently trained in Veterans’ issues and evidence-based practices. Generally, licensure and certification requirements do not address Veteran-specific care; nor do continuing education requirements address it. Unless one is working within the field, it is likely that they may not fully understand the symptoms of PTSD, depression, and TBI and the fact that many symptoms can occur years or decades after one’s military service.<sup>31</sup>

It was noted by the Advisory Board that the VA has trained providers at all three VA facilities that serve Maryland Veterans in Cognitive Processing Therapy, Prolonged Exposure Therapy, Cognitive Behavioral Therapy, and Acceptance and Commitment Therapy, and continues to place significant emphasis on evidence-based care for PTSD and depression.

This problem of lack of training specific to Veteran issues extends beyond direct provision of healthcare services. Many social support activities like housing, employment counseling, job qualification, benefits delivery assistance, and student services would benefit from understanding of Veteran-specific issues and concerns. The Advisory Board found sporadic evidence of Veterans and family-specialized programs in various social support areas throughout State government:

- Montgomery College’s *Combat2College* program is a great example of a program specifically designed to assist Veterans – often transitioning from the battlefield to the classroom – to successfully adapt to the educational environment.

---

<sup>31</sup> Tanielian, pp. 38-39

- The *Warrior to Worker* initiative established by the O’Malley/Brown administration in October 2010 is another example of a specialized program designed to enhance employment opportunities for Veterans within the State government and to promote employment, education and training opportunities for Veterans throughout Maryland.
- The *Helmets to Hardhats* program, a national program that connects National Guard, Reserve, and transitioning active duty military members with quality career opportunities in the construction industry, is led in Maryland by the Department of Labor, Licensing and Regulation in partnership with the Department of Veterans Affairs.
- The Department of Business and Economic Development’s *Military Reservist and Service-Disabled Veteran No-Interest Loan Program* was approved in fiscal year 2010 for \$300,000 for 6 loans expected to support an estimated 7 jobs.
- On October 1, 2010, a statute establishing a veteran-owned small business procurement participation goal went into effect in Maryland.

But programs such as these while growing in number are not common enough in the State.

The effectiveness of behavioral services for Veterans is further complicated by the extent to which they are gender-specific, insofar as it is understood that the needs of women Veterans are different from those of men. And these needs are growing with the newest population of Veterans because of the increased prevalence of women in the military and in combat-related roles. As of September 30, 2010, Maryland’s Veteran population was approximately 10% female. This percentage is expected to creep up to over 14% over the next fifteen years. [See Appendix E.]

As reported to the Advisory Board by the Children, Family, and Special Populations Workgroup, there is no readily available information for women Veterans about female Veteran-specific behavioral health services, other than those available through the U.S. Department of Veterans Affairs, and it is not clear the extent to which Maryland’s female Veterans are aware of VA’s specialized services for them.

#### **D. GAPS IN HEALTH CARE COVERAGE & ACCESS**

DoD and VA provide health care coverage and services for service members and Veterans. While most Veterans and their families may technically be “covered” by at least one of these federal programs, many still face barriers to accessing the services they need. The RAND

Corporation asserts that “improving access to mental health services ... will require reaching beyond the DoD and VA health care systems. Given the diversity and the geographic dispersal of these Veterans, other options for providing health services must be considered, including Vet Centers, non-medical centers that offer supportive counseling and other services to Veterans, and other community-based providers.”<sup>32</sup> This is particularly true for OIF/OEF Veterans.

As noted earlier, the Advisory Board examined the offerings of behavioral health services throughout the State. In looking at the general location of these services, the Access and Transportation workgroup found that in rural areas of the State there is often considerable distance to be traveled by a Veteran to access services, and in non-rural areas the difficulties of an urban commute often presented reasonable access difficulties. Further, the lack of availability of transportation –personal or public – is often an access barrier. Time and distance contribute also to consideration by the Veteran as to whether to use federally-provided VA services or seek community services that are closer or quicker to get to.

While health care coverage for Veterans is provided by VA (at least for some time frame after discharge or for some conditions), it does not generally extend to coverage for treatment by non-VA providers. Further, for treatment of non-service related conditions, VA will seek reimbursement from any personal insurance coverage that a Veteran may carry. That insurance coverage, if any, would also be a Veteran’s best option for coverage of the costs of seeking care from non-VA providers (except when VA has authorized such care on a case-by-case basis). And, because VA’s coverage of the families of Veterans is quite limited (generally education and support and some counseling), family members must seek care from non-VA providers. Again, the possible absence of health insurance may be a barrier.

Families of recently discharged Veterans may buy coverage from DoD’s Continued Health Care Benefit Program (CHCBP) for up to 18 months after a service member is discharged, but premiums for family coverage cost approximately \$2000 per quarter. This cost may be a significant barrier.

Unemployed or low-income Veterans may be eligible for medical assistance (Medicaid) from the State, as well as their families. However, Veterans in receipt of disability compensation from the VA may not qualify for medical assistance. While these Veterans would be eligible to receive health care from the VA, their families may be caught in a situation where the family income from the disability payment is too high to qualify for medical assistance but insufficient to cover the cost of insurance. Figure 12 displays data on recipients of services from the Maryland Public Mental Health System.

---

<sup>32</sup> Tanielian, p. 34

Maryland Public Mental Health System							
Medicaid Services				Uninsured			
FY	All Vets	OIF/OEF	Expenditures	All Vets	OIF/OEF	Expenditures	
2009	775	54	\$4,286,131	424	48	\$1,662,031	
2010	867	61	\$6,517,854	464	46	\$1,719,734	
2011*	620	48	\$2,505,753	223	23	4 438,613	

\*6 Months of data for 7/1 – 12/31/2010 Source: MD MHA PMHS

Figure 12.

The Advisory Board developed an estimate of uninsured Veterans in Maryland based on the application of the Veteran to Total County Population ratio to Total County Uninsured Population. Figure 13 depicts the estimate by County.

UNINSURED MARYLAND VETERANS - ESTIMATE			
County	Vet % of Total Pop	Total Uninsured Pop	Est. # of Uninsured Vets
Allegany, MD	10.6%	7,786	825
Anne Arundel, MD	11.3%	59,276	6698
Baltimore, MD	7.9%	86,891	6864
Calvert, MD	11.5%	9,253	1064
Caroline, MD	9.2%	5,029	463
Carroll, MD	8.2%	16,716	1371
Cecil, MD	9.6%	10,514	1009
Charles, MD	11.5%	16,061	1847
Dorchester, MD	8.7%	3,739	325
Frederick, MD	9.2%	23,666	2177
Garrett, MD	9.6%	4,605	442
Harford, MD	10.6%	24,002	2544
Howard, MD	7.9%	30,516	2411
Kent, MD	10.7%	2,830	303
Montgomery, MD	5.1%	123,741	6311
Prince George's, MD	8.0%	149,038	11923
Queen Anne's, MD	9.8%	5,684	557
St. Mary's, MD	11.9%	11,935	1420
Somerset, MD	9.4%	2,693	253
Talbot, MD	10.8%	4,646	502
Washington, MD	8.4%	17,569	1476
Wicomico, MD	8.5%	14,253	1212
Worcester, MD	12.2%	6,968	850
Baltimore city, MD	5.9%	77,570	4577
	<b>TOTAL</b>	<b>714,981</b>	<b>57424</b>

Source: Census, 2007; US Dept of Veterans Affairs, VetPop2007, *Estimates & Projections*

Figure 13.

## **E. GAPS IN COORDINATION & COMMUNICATION**

As assessed by the Advisory Board there are numerous efforts actively supporting or having the potential to be supportive of Veterans – many beyond the data gathering of the Advisory Board to date – ongoing in the State. Many of those activities are within State government; yet they are not centrally coordinated under the umbrella of Veterans’ services. For example, there appears to be a tendency to view Veterans’ services only in the context of the benefits assistance work of the MDVA or, to some extent because of the Advisory Board and the MCV initiative, in the context of health care delivery. Yet, coordination of initiatives and programs like those with which the Maryland Department of Labor, Licensing and Regulation (DLLR) works is consistent with meeting the behavioral health needs of Veterans. As an example, DLLR coordinates State participation in the federal REAL Lifelines program which works with OIF/OEF wounded and injured service members transitioning to civilian life and their family members and provides resources needed to successfully transition to a rewarding career. To date, DLLR reports that 25 Veterans have participated in the REAL Lifelines program since March 2008.

Although there have been promising efforts on the part of the Executive Branch, there is only sporadic evidence that all State departments, programs, Commissions, etc., have effectively incorporated a focus on Veterans’ needs and interests into their day-to-day operations. For example, all programs should be collecting data on Veteran-status among their participants, targeted audience, and beneficiaries. There should be “no wrong door” with regard to the ability of any State agency to assist a Veteran in locating and or making a connection to appropriate Veteran’s resources. Every State agency should have a staff member (or access to someone) who is knowledgeable about accessing Veterans’ services.

As another example, an area that is strongly related to the success of Veterans gaining employment—particularly recent Veterans—is the recognition of military occupational proficiency and training in occupational licensure and certification processes in the State and counties. The DLLR Office of Occupational and Professional Licensing’s website does not indicate that any particular consideration is given to military experience and training with respect to licensing requirements. The Department of Defense (DoD) provides some of the best vocational training in the nation for its military personnel and establishes, measures and evaluates performance standards for every occupation with the armed forces. There are many occupational career fields in the armed forces that can easily translate to a civilian counterpart; additionally, there are many occupations in the civilian workforce that require a license or certification. In the armed forces, these unique occupations are performed to approved military standards that may meet or exceed the civilian license or certification criteria. Upon separation, however, many service members, certified as proficient in their military occupational career, are not licensed or certified to perform the comparable job in the civilian workforce, thus hindering chances for immediate civilian employment and delaying career advancement. This situation creates an artificial barrier to employment upon separation from



military service. Veterans with Military Occupation Specialties (MOS) or ratings such as electrician or motor transport often have to undergo additional training, once out of the service, to work in their career path. This process slows down the Veteran in obtaining gainful employment. A study by the Presidential Commission on Servicemembers' and Veterans' Transition Assistance identified a total of 105 military professions where civilian credentialing is required. Despite a very specific interest expressed in statute to seek federal funding to offset costs associated with state-provided behavioral health services for Veterans, little focus has been placed on grant opportunities that could assist in this arena.

Further, there is much potential to substantially save State dollars by transferring Veterans and their dependents from Medicaid to VA or DoD care. Veterans actually receive better benefits from the VA than from Medicaid—and enrollment numbers in Maryland suggest that many Veterans may not even be aware that they qualify for such care. The State of Washington undertook a focused project starting in 2003 cross matching data through the PARIS database that saved the State more than \$16 million. The Public Assistance Reporting Information System (PARIS) is an information exchange system designed to provide State Public Assistance Agencies with appropriate data as a result of federal computer matches. PARIS data matches include VA and DoD beneficiary data.<sup>33</sup> Discussion with Maryland's Department of Human Resources (DHR), PARIS database coordinator revealed that indeed VA matched data are reported to appropriate program officials. However, effective dispositions of these matches should be reviewed for effectiveness. The DHR PARIS data coordinator is well aware of the successful Washington State program and advises that the Washington coordinator has indicated willingness to assist other states in setting up a similar program.

Clearly, many issues associated with Base Closure and Realignment Commission (BRAC) transition considerations are similar to transition issues for Veterans and families. Further, State BRAC activities have served to attract many Veterans who had transitioned to civilian military employment. The BRAC transition efforts should be mirrored and expanded in the context of continuing service to Veterans, e.g., one-stop career centers.

Early responses to Veterans' needs have included websites that provide a laundry list of services but do little to assist the Veteran in selection or evaluation of those services. Generally, such websites are not terribly informative. Some simply put a "for Veterans" heading on information that is precisely the same as information provided for "adults." There are many models to review or adopt, including the National Resource Directory, a website for connecting wounded warriors, service members, Veterans and their families with those who support them at the state and national levels (a DoD, DoL, VA project), or the "TexVet: Partners

---

<sup>33</sup> U.S. Department of Health and Human Services, Administration for Children & Families. Public Assistance Reporting and Information System: Success Stories and Examples of Savings Using PARIS. [http://www.acf.hhs.gov/programs/paris/state\\_info/succ\\_par.html#wa](http://www.acf.hhs.gov/programs/paris/state_info/succ_par.html#wa). [See also: <http://www.governing.com/topics/economic-dev/moving-vets-off-medicaid-VA.html> ]



Across Texas” approach. A notable model is the “Citizen Soldier Support Program” which grew out of a national demonstration program established by the Congress in 2005 to help build bridges between community resources and Reserve component families. The program is hosted by the University of North Carolina and is working with numerous partners throughout the country and with DoD to develop effective and sustainable military and community partnerships, to build and reinforce the military and civilian capacity of behavioral health professionals, agencies, systems and resources, and to penetrate into geographically isolated, rural and underserved regions to more effectively serve reserve component members and their families.<sup>34</sup>

## **F. GAP IN AVAILABILITY OF DATA**

As might be expected given other gaps discussed, there is only limited, and disjointed availability of data on how Maryland’s programs are serving its Veterans. Most recently, there has been an increasing effort on the part of programs to include Veteran identifiers among the data collected. However, these data are all maintained separately by programs or Departments. True data analyses of gaps and needs are made most challenging by the lack of a centralized or linked Veteran database.

---

<sup>34</sup> Citizen Soldier Support Program: <http://www.citizensoldiersupport.org/>

## 6. CONCLUSION

Maryland, like the rest of the nation, faces fresh challenges both in the short and long term with respect to its Veteran population. Each conflict in our nation's history is unique from the one before, and so, today's generation of men and women returning from a theatre of war have experiences that are new, both on the battlefield and upon return, at home.

This is a population facing significantly disabling conditions at much earlier ages than previous generations. The signature conditions of the Iraq and Afghanistan conflicts, TBI and PTSD, stand to present notable shifts in services and increased costs in terms of the long-term care needs of the younger Veterans now suffering from these conditions. More than 19% of service members returning from combat reported potentially experiencing TBI during deployment.<sup>35</sup> Though commonly assumed to be a mental or emotional matter, PTSD is a condition that we now know is directly associated with physical ailments. It is an independent risk factor for heart disease and more than doubles a Veteran's risk of death from any cause. It is associated with a near doubling of the risk of dementia in older Veterans. Further, the effects of trauma have been documented to extend beyond the person who is directly involved, to family members, friends and co-workers. This is a damaging, insidious condition, but it is treatable.

Maryland not only has a moral obligation to help Veteran residents afflicted with PTSD and other ailments, it has a practical, economic obligation to all of its residents to do so. The costs associated with these conditions are not just the dollars and cents in treatment costs for an often unseen group of people, they are *commitments* for brothers and sisters who are part of everyday life for all of us, everywhere. These disabled Veterans are the among the few who have made tremendous sacrifices so the many need not; for that alone, they have earned our deepest support.

Furthermore, the public health, policy and biological implications are substantial. Appropriate and early intervention can help to stem costs that are inevitable when mental and behavioral health needs go unaddressed. A 2008 RAND Corporation study has suggested that early intervention could save billions of dollars nationally throughout the lifetime of Veterans from current wars.

---

<sup>35</sup> U.S. Government, White House Interagency Policy Cte. Strengthening Our Military Families: Meeting America's Commitment, Jan. 2011. p. 7.

There is increasing evidence that Veterans' needs, including behavioral health needs, will continue to grow and will require enhanced coordination at the state level. The recent White House report on Strengthening Military Families, encourages Governors to develop strategic plans to strengthen behavioral health care systems for returning service members, Veterans, and their families. Eighteen of the 59 states and territories have developed such strategic plans and have identified innovative programs.<sup>36</sup>

In most cases, it has been acknowledged that there needs to be a central coordination and oversight effort to ensure that the focus on Veterans is present and ongoing. With such a focus, a systems approach to enhancing behavioral health services for Veterans is much more readily achieved. In effect, the whole becomes greater than the sum of its parts because of the relationships and coordination ensured by such an approach. A national study of state Veteran programs conducted by Booz Allen Hamilton and Gallup and reported in February 2010, indicated that successful programs "...typically involved a multi-faceted community of organizations that worked together on shared mission objectives," with collaborative approaches, and the ability to push information and services to the community level where veterans' needs are usually best addressed.<sup>37</sup> As noted most aptly by Advisory Board Member, J.A. Martin: "It Takes A Community."<sup>38</sup>

Maryland is rising to fulfill these responsibilities. Programs like the Veterans Behavioral Health Initiative (Maryland's Commitment to Veterans), Warrior to Worker, Helmets to Hardhats, and the Campus Compact for Student Veterans are steps in the right direction. However, much more can be done without great financial cost.

Notably, the State must align, streamline and empower its overall Veteran agenda with the full authority of the Governor. This requires a responsible and responsive subcabinet of some kind. It also requires a cultural shift across government to increasingly "Think Veteran." Most agencies, beyond the Maryland Department of Veterans Affairs, have a role to play, be it training, hiring, services or education. Helping a homeless Veteran is not just the responsibility of housing authorities. Helping a child whose parent is deployed or having difficulties readjusting to familial roles is not just a school's responsibility. These are examples of issues that warrant broader consideration and coordinated response.

---

<sup>36</sup> U.S. Government, White House Interagency Policy Cte. Strengthening Our Military Families: Meeting America's Commitment, Jan. 2011. p. 8.

<sup>37</sup> Booz Allen Hamilton, Gallup on behalf of Business Executives for National Security Warrior Gateway Program. Veterans Reintegration: A View from the States. February 2010.

<sup>38</sup> J.A. Martin workgroup report, Veterans Behavioral Health Advisory Board, Maryland. 9/27/2010.

There are specific actions that we can take, for certain. These are acknowledged to some extent in the recommendations that follow and in the discussions throughout this report. But the most important action is adopting that “Think Veteran” attitude and having it permeate throughout government. When we create a new database, “Think Veteran.” When we issue an application, “Think Veteran.” When we create or update a website, “Think Veteran.”

This is when Maryland should most exemplify its State motto, as countless Veterans have themselves done: “Strong Deeds, Gentle Words.”

## 7. RECOMMENDATIONS

Based on the input from the workgroups, the Advisory Board considered all findings and discussed the ramifications in terms of the successful delivery of BHS to Maryland Veterans and their families. Among its principal concerns was the relationship that the State has forged and continues to nurture with the federal government as it pertains to Veterans services. This relationship is particularly exemplified by the collaborative activities that the State has fostered with the VA's Veterans Integrated Service Network 5 (VISN 5). Maryland should maintain and expand these relationships to the benefit of its Veterans. Discussion should continue relative to the enhancement of access to VA services by Maryland's Veterans, particularly those located in more rural areas of the State.

The deliberations of the Advisory Board led to recommendations inclusive of the matters considered by the workgroups and to areas beyond the scope of the workgroup considerations. These recommendations, developed in large part from the findings of the workgroups augmented by staff input, are represented below. The recommendations have been listed by topical areas.

### Organization and Accountability

1. Submit Bill to General Assembly to extend the Maryland Veterans Behavioral Health initiative. The current program, per statute, is scheduled to sunset on May 31, 2011. During this pilot period compelling and ample evidence has accumulated to demonstrate the need for the State to continue to proactively fill gaps in and address the increasing need for behavioral health services for Maryland's veterans.
2. Establish a Veterans Subcabinet with the mission to enable the State to better fulfill its responsibilities to care for its Veterans and their families who reside in the State, while maximizing the State's relationships with federal programs benefitting Veterans. It should be the goal of the Subcabinet to ensure that support and service to Veterans are a paramount consideration in all applicable State programs. Further, representation from the Veterans Subcabinet should be included in all State programs that may impact this sub-population, e.g., education, housing, etc. Require representation from the Veterans Subcabinet on the BRAC Subcabinet and study groups to ensure that impact of BRAC activities are considered in the context of the needs of Maryland Veterans and their families.

3. A Veterans Subcabinet should develop an Interagency Strategic Action Plan for Veterans with specific charges and responsibilities. Many of the recommendations of this report should be operationalized in the plan.
4. Clear goals and performance measures of the Veterans Subcabinet should be established with oversight by the StateStat Office, so Subcabinet members are held accountable for progress through regular “VetStat” sessions.

## Funding and Revenue

5. Require Maryland Department of Veterans Affairs to identify grant programs applicable to Veterans’ services, work with appropriate organizations in Maryland government, as well as not-for-profits and community organizations, to submit effective grant applications, and monitor application status and ultimate utilization of grants awarded.
6. Increase revenues in the Maryland Veterans Trust Fund so as to provide for the special short-term needs of Veterans. Possible sources for such revenue include: a check-off on tax returns; direction of some portion of fees collected for military motor vehicle license plates to the MVTF; and, direction of some portion of revenue generated by State-authorized slot machines in Veterans Service Organization facilities to the MVTF.
7. Accomplish a thorough review of the actions taken to effectively use the cross-matched data from the PARIS database to substantially save State dollars by transferring Veterans and their dependents from Medicaid to VA or DoD care. Report on findings and potential dollar savings to the Subcabinet. This effort is to be coordinated among DHR, DHMH and MDVA with the State of Washington’s successful program used as a model in designing such a program for Maryland. MDVA will ensure that the effort is undertaken in a manner that ensures that Veterans are made aware of the better benefits available to them from the VA (as opposed to Medicaid).

## Outreach

8. Require all State organizational components to ensure that any Veteran-related information that is disseminated or contained on websites is current and accurate, recognizing that Veterans’ programs are rapidly evolving.

9. Provide for collection of Veterans' email addresses as a primary form of communication. Include fields for Veterans' status and email addresses on State application forms (e.g., license applications; military license plate applications) and actively work with the DoD to encourage modification of DD-214 forms to include email addresses as part of separation information on discharged Veterans.
10. Require Maryland's Motor Vehicle Administration to request "Veteran" status (voluntary) on drivers' license renewal; provide that information to MDVA as well as mailing address and email address of those identifying themselves as Veterans. (Florida "Vets Connect" concept). Also, provide information from applications for military motor vehicle licenses to MDVA. MVA is to ensure that Veteran applicants are provided information on why this information is requested. This outreach program is to be developed in concert with MDVA.
11. MDVA should develop a program that will utilize the email and mailing addresses for Veterans to send timely alerts regarding programs available to them through federal and state entities. A complementary outreach effort to identify and communicate with friends and family members of Veterans should also be established.

## Access

12. The Veterans Subcabinet will work with the VA to address the access needs of those 30% of Maryland Veterans who are outside the VA's primary care/mental health access standards (70% treated within a 30 minute driving distance) and are in significant need of services from the VA. In those cases, the Sub-cabinet will work with the VA to identify reasonable solutions so as ensure the ready access to needed services by Maryland Veterans and in so doing will actively seek to identify collaborative initiatives, including local providers, to provide services sought by enrolled Veterans within a 30 minute driving distance.

## Services for Veterans

13. Increase by 20% by 2015 the number of Veterans who receive occupational licenses and certifications in Maryland. This increase may be achieved in part by ensuring that licensing and credentialing requirements in the State provide reciprocal recognition of military training and work experience. (The Veterans Skills and Education Strategic Plan

being developed under the Warrior to Worker program may provide an effective avenue for accomplishing this review.)

14. Require MDVA to focus on all services provided by Maryland to ensure that these services address the particular needs of Veterans and their families to the greatest extent possible. Aggressive efforts should be made so as to increase Veterans' and their families' awareness of these programs and how they may be of assistance to them. These services should include: Medical Assistance (Medicaid), the Maryland State Health Plan, ValueOptions contract services, the Network of Care contract, Educational programs and scholarships, etc.

### **Provider Education and Training**

15. The Maryland Higher Education Commission, in concert with DHMH, MDVA, and the State's professional licensing boards is to explore ways to enhance the awareness, knowledge, and clinical skills of Maryland's behavioral health workforce to ensure their understanding of the needs of Veterans and their families in order to provide the most effective services. By 2015, there should be related course content in all behavioral health graduate programs that provides a basic understanding of this population and the unique behavioral health challenges associated with military service. Also by 2015, continuing education requirements for licensed Maryland behavioral health providers should include a similar requirement for training in Veterans' issues and evidence-based treatment practices.
16. By the end of calendar year 2011, MDVA in collaboration with DHMH, should have established a targeted outreach effort to the leaders of the faith communities in Maryland that will serve to ensure that clergy and other faith-community leaders have the awareness, knowledge and skills to positively engage with Veterans and their families—particularly since these providers are often serving as the Veterans' gatekeeper to larger behavioral health services.

### **Support Services**

17. MDVA and DHMH are to partner with the National Alliance for Caregivers and VeteranCaregiver.com to effectively disseminate information to caregivers of Veterans



and to provide assistance in meeting VA requirements to be announced with respect to obtaining caregiver benefits from VA.

18. DHMH and MDVA are to develop a pilot peer-to-peer assistance program under the auspices of Maryland's Commitment to Veterans. Peer-to-peer groups are generally led by veterans who are not medical professionals; often they are volunteers. Self-sustainment is a basic tenet for the success of these groups. Once one group is established it can be effectively used to provide training, with the assistance of MCV, DHMH and MDVA, in the techniques needed for other such groups to establish themselves.

## WORKGROUP RECOMMENDATIONS

### Access and Transportation Workgroup

1. Establish a 30-minute drive distance protocol for all Veterans in MD
2. Actively seek to identify collaborative VA and State initiatives to provide services sought by enrolled Veterans within a 30-minute driving distance.
3. Additional funding should be sought to support expansion plans for CBOCs.
4. The feasibility for financial sharing to fund RRC positions should be researched.
5. Increase the availability of transitional housing and employment programs by following the example of the Hagerstown facility which was supported by a VA grant for all of the on-going operations under its Homeless Grant and Per Diem Program.
6. Jail diversion programs should be replicated throughout the State.
7. The State should continue discussions with the VA relative to the effective utilization of VA's fee-basis program to enhance behavioral health services to Veterans and in so doing, should try to establish objective criteria for fee-basis eligibility.
8. As has been done in Eastern Maryland, transportation resources for Veterans to access behavioral health services should be expanded by contracting with private transportation providers in Southern and Western Maryland. *(accomplished)*

## WORKGROUP RECOMMENDATIONS

### Children, Families and Special Populations Workgroup

1. School efforts to address needs of children impacted by military service should partner with other community-based youth programs, e.g., Boys & Girls Clubs, Scouting, etc.;
2. Maryland needs to leverage the connections that the National Guard has with military education groups (National Military Family Association, National Military Education Coalition, Zero to Three) and foster the building of bridges between the military installations in Maryland and schools and parents around the State;
3. There is a need for a variety of written and video materials (e.g., those produced by DoD and VA) to be available in public schools and libraries.
4. The Combat2College program (C2C) at Montgomery College provides an important program model that could be adapted by other Maryland community colleges and higher education institutions and expanded to focus on families of returning Veterans.
5. Because there appears to be very little engagement on the part of Maryland's higher education graduate programs to support K-12 education efforts to outreach to youth impacted by military service, graduate students studying sociology, psychology, social work, marriage and family therapy, and other forms of counseling services governed by state licensure could be trained as subject-matter experts to support the emotional needs of military children and families via internships;
6. Maryland Department of Veterans Affairs (MDVA) should establish special initiatives to promote awareness of the needs of women Veterans, including: mobilizing women's advocacy groups to develop counseling and other supportive services; and, hosting a Women's Veterans Conference that would include offering training modules for BHS providers.
7. Community responses to domestic violence must be adapted to respond to the increasing number of Veterans with PTSD. This also includes older Veterans who may be suffering from chronic mental illness, PTSD, or dementia.
8. Promote opportunities for incarcerated Veterans (at Maryland state and county correctional facilities) to have access to evidence-based BH services focused on Veteran populations and BH conditions related to military service and combat exposures. Training for the correctional and forensic workforce will also be necessary.
9. A proposed University of Maryland survey of licensed social workers should be funded. The survey could be expanded to reach all BHS providers in order to inform continuing education training requirements and also to help inform the content that needs to be integrated into courses in graduate school.

## WORKGROUP RECOMMENDATIONS

### Children, Families and Special Populations Workgroup (continued)

10. Cultivate relationships between the leadership of Maryland behavioral health associations and non-profit organizations serving Veterans, their families or special populations.
11. Catalogue and widely distribute the current continuing education and special interest workgroup efforts that focus on addressing the BH needs of returning Veterans and their families.
12. Identify the mental health practice skill requirements related to serving Veterans and their family members and initiate public/private collaborations to address them.
13. Consider establishing a specialized certification that would identify Maryland behavioral health providers who have the requisite credentials to serve the needs of returning Veterans and their family members. A program that already exists in North Carolina could serve as the model for a Maryland certification program.
14. Institute appropriate outreach to Veterans with Other Than Honorable Discharges and investigate whether dishonorable discharge status should have continuing punitive quality relative to obtaining behavioral health services.

## WORKGROUP RECOMMENDATIONS

### Outreach and Education Workgroup:

1. Develop "Veterans Family Appreciation Day" events that could be held in each county, as were traditional musters.
2. Having information booths at musters to educate family members on Veteran benefits.
3. Develop a quarterly Maryland Veterans show on Maryland Public Television (MPT) including a segment for Veterans to call in with questions.
4. Enhance electronic communication with the Veteran population in the State; use Facebook more effectively.
5. Encourage all State agencies to link websites to the MCV website.
6. Develop strategies for reaching the friends and families of Veterans.
7. Train Local Law Enforcement on Veterans and PTSD and TBI.
8. Collaborate with the Baltimore Crisis Response group to record a Veterans' behavioral health segment for "Mental Health Matters," a cable television program that airs in Baltimore County and Baltimore City.
9. Encourage the Maryland Judicial Branch to undertake expanded efforts to insure awareness of the issues associated with mental health issues among Veterans, particularly PTSD and Traumatic Brain Injury. Quarterly training of judges on Veterans issues should be developed and made available.
10. Foster expanded collaboration among the Judicial Branch, MDVA and VA's VJO initiative and expand research efforts to determine whether or not there is a need for a Veterans specialty court in Maryland. Encourage Judicial Branch to review other state's Veterans Courts, e.g., Municipal Court in Philadelphia.
11. Develop a "bench card" for all judges in Maryland that will identify contact information for services available to Veterans. The bench card should also be distributed to National Guard and Reserve Family Support Groups.
12. Ensure that outreach efforts use effective terminology and age-appropriate communication strategies.
13. Emphasize peer-to-peer communications when possible.
14. Consider disseminating information about available services through 12-step groups to reach Veterans dealing with alcohol and substance abuse.
15. Examine the University of Maryland "Success for Veterans" grant program for possible broader application in the State.

## WORKGROUP RECOMMENDATIONS

### **Special Populations Workgroup (eventually merged into Children, Families & Spec. Pops. Workgroup)**

1. Awareness of women Veteran issues should be raised within the public sector.
2. An MDVA-DHMH Women Veterans Workgroup should be established which could, as its premier activity, host a Leadership Conference for women's groups and non-profit organizations on female Veteran issues.
3. Specialized training about Veteran-specific issues should be delivered to BHS providers with the TAMAR, PATH, & MCCJTP programs.
4. Opportunities for incarcerated Vets to have access to evidence-based BHS which focuses on conditions relating to military service and combat exposures should be increased.
5. Training about Veteran-specific BH issues should be delivered to correctional and forensic workers.
6. The E-RANGE program should be expanded.
7. There should be an effort to identify any non-VA female-specific BHS programs within Maryland and raise awareness about the existence of these services among women Veterans, VA service providers, et al.
8. An effort to collect and analyze data on women Veterans should be initiated, with an emphasis on homeless women Veterans.
9. The absence of specialized services for incarcerated Veterans is a significant impediment to their successful community reintegration and thus should be addressed.
10. The employment difficulties faced by Veterans with punitive dishonorable discharges should be addressed.

## 8. APPENDICES

- A. Veterans Behavioral Health Advisory Board Members
- B. Memorandum of Understanding Between Maryland DHMH and VA VISN 5
- C. Maryland's Commitment to Veterans Marketing Data
- D. Maryland's Commitment to Veterans Data Tables
- E. Veteran Population Data – U.S. Department of Veterans Affairs
- F. Executive Order – *Warrior to Worker* Initiative
- G. U.S. Department of Veterans Affairs FY 2009 Expenditures – Maryland
- H. Maryland Regional Maps – 30 mile Drive Distance
- I. U.S. Department of Veterans Affairs VISN 5 - E-RANGE Brochure
- J. HUD-VASH Veterans Affairs Supportive Housing Program
- K. U.S. Department of Veterans Affairs Fact Sheet – Other Than Honorable Discharges
- L. Maryland Behavioral Health Services by County
- M. Maryland BHS Resources - including substance abuse treatment providers
- N. Data on Violent Deaths Among Veterans - Years 2004 - 2008 combined

Veterans Behavioral Health Advisory Board Members

---

**The Honorable Anthony G. Brown**, Chairman  
Lieutenant Governor, State of Maryland

**Major General James A. Adkins**  
Adjutant General, Maryland Military Department

**John M. Colmers, MPH**  
Former Secretary, Maryland Department of Health and Mental Hygiene

**Edward Chow, Jr.**  
Secretary, Maryland Department of Veterans Affairs

**Joseph G. Liberto, MD**  
Director, Mental Health Clinical Center  
US Department of Veterans Affairs, Maryland Health Care System

**James A. Martin, Ph.D., BCD**  
Colonel, US Army (Retired)

**Karen S. Montgomery**  
Senator, Maryland General Assembly

**Douglas J.J. Peters**  
Senator, Maryland General Assembly

**William G. Prescott, MD**  
Rear Admiral, U.S. Public Health Service (Retired)  
Chairman, Major General Boyd Cook Veterans Memorial Foundation

**Scott Rose**  
President/CEO, Way Station, Inc.

**Joshua M. Sharfstein, MD**  
Secretary, Maryland Department of Health and Mental Hygiene

**Raymond C. Watson** (deceased)  
Prince George's County  
Adult and Elderly Services Coordinator

**Charles Williams**  
Colonel, US Army (Retired)  
Executive Director, Maryland Center for Veterans Education and Training



Memorandum of Understanding Between Maryland DHMH and VA VISN 5

Memorandum of Understanding Between VISN 5 VA Medical Centers and the State of Maryland Department of Health and Mental Hygiene and Mental Hygiene Administration

MEMORANDUM OF UNDERSTANDING

I. PARTIES

THIS MEMORANDUM OF UNDERSTANDING (MOU) is made as of October 17, 2008, by and between the State of Maryland Department of Health and Mental Hygiene (DHMH) and the VISN 5 VA Medical Centers--VA Maryland Health Care System, Martinsburg VA Medical Center, and Washington DC VA Medical Center.

II. PURPOSE OF THE MOU

There is a need to provide outreach to veterans, particularly in the rural areas, to enroll them into VA services. There is also a continuing and growing need to provide behavioral health services and support to veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). The parties have agreed on a collaborative partnership. This agreement is not to exceed three (3) years.

The MOU documents and describes this collaborative arrangement between the VISN 5 VA Medical Centers and the DHMH.

III. RESPONSIBILITIES OF THE PARTIES

DHMH will

Provide outreach to the rural areas of Maryland to try to increase the enrollment of veterans into VA services. Collaborate with the VISN 5 VA Medical Centers to provide behavioral services to veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), in the rural areas of Maryland. For enrolled veterans, arrange for mental health and/or substance abuse services for OEF or OIF veterans in rural areas through

Memorandum of Understanding Between VISN 5 VA Medical Centers and the State of Maryland Department of Health and Mental Hygiene and Mental Hygiene Administration

VISN 5 VA Medical Centers. For non-enrolled veterans of OEF and OIF, DHMH will work with VISN 5 Medical Centers to get the individual enrolled and to provide needed behavioral health services. This will be accomplished through DHMH providers until the individual is enrolled and able to be served by VISN 5 VA Medical Centers.

DHMH will provide training, in collaboration with the Maryland Defense Force (MDF) and VISN 5 VA Medical Centers, to clinicians or programs who will provide services to OEF or OIF veterans under this MOU. Assure that only licensed mental health professionals or licensed mental health programs will provide services to OEF or OIF veterans. Ensure that liability insurance is maintained by its providers who will provide evidence of coverage to the VISN 5 VA Medical Centers as requested.

VISN 5 VA Medical Centers will

Collaborate with the State of Maryland to provide outreach to increase enrollment of veterans into VA services and provide behavioral services to veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), specifically, but not restricted to, the rural areas of Maryland. For enrolled veterans, VA behavioral health services will be provided by VISN 5 VA Medical Centers or fee basis contractors in accordance with applicable federal law. For non-enrolled veterans the VA will facilitate enrollment of the eligible veterans and the transfer of their care from DHMH providers once the individual is enrolled.

Work closely with DHMH/Mental Hygiene Administration (MHA) in the recruitment and training of personnel within the Initiative.

Memorandum of Understanding Between VISN 5 VA Medical Centers and the State of Maryland Department of Health and Mental Hygiene and Mental Hygiene Administration

IV. Points of Contact

Laura Copland, MA, LCMHC  
Director, Maryland's Commitment to Veterans Project  
Mental Hygiene Administration  
(410) 724- 3175  
[CoplandL@dhmh.state.md.us](mailto:CoplandL@dhmh.state.md.us)

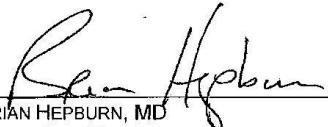
Joseph Liberto, MD,  
Director, Mental Health Clinical Center  
VA Maryland Health Care System (VAMHCS)  
(410) 605-7368  
[Joseph.liberto@va.gov](mailto:Joseph.liberto@va.gov)

THIS MOU CONTAINS THE DUTIES AND RESPONSIBILITIES OF THE PARTIES. THE TERM OF THE MOU IS FOR THREE YEARS FROM THE DATE THE PARTIES HAVE SIGNED. THE PARTIES MAY EXTEND THE MOU BY MUTUAL AGREEMENT. NOTHING IN THIS MOU SHALL BE CONSTRUED AS REQUIRING THE VISN 5 VA MEDICAL CENTERS TO REFER ANY MINIMUM NUMBER OF VETERANS TO DHMH/MHA FOR THE HEALTH SERVICES DESCRIBED HEREIN. IT IS FURTHER AGREED THAT THIS MOU MAY BE CANCELLED AND/OR RESCINDED AT THE OPTION OF THE VISN 5 VA MEDICAL CENTERS OR VA AT ANY TIME FOLLOWING THE EXECUTION HEREOF.


Memorandum of Understanding Between VISN 5 VA Medical Centers and the State of Maryland Department of Health and Mental Hygiene and Mental Hygiene Administration

  
\_\_\_\_\_  
JOHN M. COLMERS  
Secretary  
Department of Health and Mental Hygiene

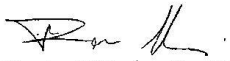
10/5/08  
Date

  
\_\_\_\_\_  
BRIAN HEPBURN, MD  
Executive Director  
Mental Hygiene Administration


10/28/08  
Date

  
\_\_\_\_\_  
DENNIS H. SMITH, DIRECTOR  
VA Maryland Health Care System

11/12/08  
Date

  
\_\_\_\_\_  
FERNANDO RIVERA, DIRECTOR  
Washington DC VAMC

11-12-08  
Date

  
\_\_\_\_\_  
ANN BROWN, DIRECTOR  
Martinsburg VAMC

11/12/08  
Date

  
\_\_\_\_\_  
SANFORD M. GARPUNKEL, FACHE  
VISN 5 Network Director

11/12/08  
Date

Maryland's Commitment to Veterans Marketing Data

<b>Maryland's Commitment to Veterans</b>		
<b>How Callers Reported Learning of Program</b>		
<b>Marketing Method</b>	<b>10/1/08 - 6/30/09</b>	<b>Fiscal Year 2010</b>
Bus Ad	1	54
Billboard (stadium / roadside)	0	102
Brochure	17	27
Cinema Ad	0	3
Coffee Sleeve	0	0
Focus Group	0	1
Gas Tank topper	0	11
Movie Ads	0	0
Newspapers	1	32
Not Identified	0	29
Other	470	220
Poster	0	15
PSA	0	13
Radio	7	31
RRC Outreach	285	16
Website	4	55
Word of Mouth	3	197
<b>Total</b>	<b>788</b>	<b>806</b>

**Maryland's Commitment to Veterans Data Tables**

---

<b>MARYLAND'S COMMITMENT TO VETERANS</b>			
<b>CALLS RECEIVED ABOUT MCV (TELEREP)</b>			
		<b>10/1/08 - 6/30/09</b>	<b>FY2010 Total</b>
<b>Western Region:</b>	Veterans:	28	78
	Family:	11	27
	Others	0	61
<b>Central Region:</b>	Veterans:	44	209
	Family:	6	12
	Others	0	62
<b>Southern Region:</b>	Veterans:	86	130
	Family:	21	19
	Others	0	50
<b>Eastern Region:</b>	Veterans:	26	101
	Family:	9	22
	Others	0	35
<b>Total:</b>	Veterans:	184	518
	Family:	47	80
	Others	0	208
<b>Grand Total:</b>		<b>462</b>	<b>806</b>

<b>Veterans Receiving VA or PMHS Services thru MCV Efforts</b>		
	<b>10/1/08 - 6/30/09</b>	<b>FY2010 Total</b>
<b>Western Region:</b>	3	
<b>VA</b>		14
<b>State (PMHS)</b>		4
<b>Central Region:</b>	0	
<b>VA</b>		20
<b>State (PMHS)</b>		9
<b>Southern Region:</b>	6	
<b>VA</b>		22
<b>State (PMHS)</b>		6
<b>Eastern Region:</b>	8	
<b>VA</b>		13
<b>State (PMHS)</b>		9
<b>Total:</b>	17	97
<b>VA</b>		69
<b>State (PMHS)</b>		28

**Veteran Population Data – U.S. Department of Veterans Affairs**

MARYLAND VETERANS OF ALL GULF WAR CONFLICTS BY AGE and GENDER - 2010,2015,2020,2025														
Age Group	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+	Grand Total
	9/30/2010													
Maryland	109	5,829	16,154	19,564	23,000	25,513	19,135	12,867	5,052	1,461	243	41	31	128,999
Males	91	4,768	12,923	15,397	18,541	20,869	15,237	10,308	3,786	969	142	25	12	103,067
Females	18	1,062	3,230	4,167	4,459	4,643	3,899	2,560	1,266	492	101	16	19	25,932
	9/30/2015													
Maryland	295	10,665	19,348	21,268	25,252	27,296	19,754	12,751	4,876	1,357	214	33	23	143,132
Males	244	8,746	15,583	16,857	20,473	22,398	15,772	10,229	3,661	902	123	20	9	115,017
Females	51	1,920	3,765	4,411	4,779	4,898	3,982	2,522	1,215	455	90	13	15	28,115
	9/30/2020													
Maryland	334	11,869	20,793	23,570	26,949	27,897	19,527	12,236	4,495	1,195	179	25	15	149,083
Males	276	9,758	16,811	18,763	21,899	22,910	15,613	9,818	3,367	789	101	15	5	120,127
Females	58	2,111	3,982	4,807	5,050	4,986	3,914	2,417	1,127	406	77	10	10	28,956
	9/30/2025													
Maryland	353	12,582	23,181	25,277	27,514	27,625	18,754	11,294	3,949	997	137	16	7	151,687
Males	292	10,369	18,759	20,160	22,376	22,698	14,999	9,043	2,942	651	76	9	2	122,377
Females	60	2,213	4,422	5,117	5,138	4,927	3,756	2,251	1,007	346	61	6	5	29,309

Source: US Dept of Veterans Affairs - VetPop2007 Estimates & Projections

MARYLAND VETERANS BY AGE GROUP and GENDER - 2010 - 2025																	
Age Groups	< 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+	Grand Total
	9/30/2010																
Maryland	185	5,965	16,167	19,567	23,678	35,678	46,347	46,723	42,112	66,503	49,314	36,394	33,213	26,225	16,473	6,693	471,238
Males	154	4,879	12,934	15,399	19,082	29,486	38,200	39,313	36,873	63,373	47,776	35,353	32,267	25,603	15,334	6,081	422,108
Females	31	1,086	3,233	4,167	4,597	6,192	8,147	7,410	5,239	3,130	1,539	1,041	946	621	1,139	612	49,129
	9/30/2015																
Maryland	154	5,492	14,182	19,896	21,377	25,938	37,593	46,994	46,433	41,149	61,984	43,192	29,565	23,722	15,167	8,883	441,721
Males	127	4,507	11,616	16,027	16,944	21,014	31,146	38,792	39,110	36,046	59,018	41,788	28,661	22,980	14,747	8,113	390,637
Females	27	985	2,566	3,869	4,433	4,924	6,447	8,201	7,323	5,103	2,966	1,404	904	742	420	770	51,084
	9/30/2020																
Maryland	155	5,320	13,645	17,842	21,805	23,770	27,648	38,200	46,459	45,087	38,480	54,180	35,310	21,450	13,992	8,933	412,275
Males	127	4,340	11,149	14,628	17,627	18,923	22,446	31,669	38,392	37,979	33,656	51,501	34,095	20,729	13,490	8,476	359,226
Females	27	980	2,496	3,215	4,177	4,847	5,202	6,531	8,068	7,108	4,824	2,679	1,215	720	502	457	53,049
	9/30/2025																
Maryland	154	5,391	13,511	17,338	19,685	24,397	25,512	28,213	37,803	44,879	42,049	33,889	44,281	25,955	12,949	8,591	384,597
Males	126	4,374	10,977	14,169	16,165	19,743	20,348	22,921	31,349	37,087	35,349	29,532	41,980	24,988	12,450	8,195	329,752
Females	28	1,016	2,534	3,168	3,521	4,654	5,164	5,292	6,454	7,792	6,700	4,357	2,301	968	498	397	54,845

Source: US Dept of Veterans Affairs - VetPop2007 Estimates & Projections

MARYLAND SEPARATIONS BY AGE GROUP and GENDER - 2010,2015,2020,2025											
Age Group	< 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Grand Total
	9/30/2010										
<b>Maryland</b>	371	2,039	1,124	425	406	543	314	112	28	14	<b>5,375</b>
<b>Males</b>	306	1,674	915	342	326	428	250	90	22	12	<b>4,365</b>
<b>Females</b>	64	365	208	83	80	115	64	23	6	2	<b>1,011</b>
	9/20/2015										
<b>Maryland</b>	315	1,897	905	337	267	388	223	109	27	12	<b>4,479</b>
<b>Males</b>	259	1,547	732	269	213	304	176	86	21	10	<b>3,618</b>
<b>Females</b>	56	349	172	67	54	85	47	22	6	2	<b>861</b>
	9/20/2020										
<b>Maryland</b>	318	1,870	928	333	337	393	206	99	31	13	<b>4,528</b>
<b>Maryland</b>	260	1,516	747	265	267	305	162	78	24	11	<b>3,634</b>
<b>Females</b>	58	353	181	68	70	88	44	21	7	2	<b>893</b>
	9/20/2025										
<b>Maryland</b>	318	1,897	932	341	286	392	183	85	27	13	<b>4,473</b>
<b>Males</b>	258	1,531	746	269	225	302	143	66	21	11	<b>3,573</b>
<b>Females</b>	60	366	186	72	61	90	40	18	6	2	<b>900</b>



Executive Order – Warrior to Worker Initiative



*The State of Maryland*  
Executive Department

EXECUTIVE ORDER  
01.01.2010.21

Maryland Warrior to Worker Initiative

WHEREAS, Veterans have served and sacrificed in defense of our Nation and State;

WHEREAS, The State has an obligation to do everything in its power to promote veterans' transition to civilian life through employment opportunities;

WHEREAS, Military experience is an under-recognized source of workforce training and credentialing;

WHEREAS, Our veterans, who possess a wide variety of skills and experiences, as well as the motivation for public service, will help fulfill State government staffing needs;

WHEREAS, Maryland's future prosperity depends upon the ability of all Marylanders to contribute to our economic life at their fullest potential;

WHEREAS, The public, private, and non-profit sectors are in need of highly skilled individuals to meet workforce needs;

WHEREAS, A wide variety of services are available across State Government to assist veterans in their transition to civilian life, and to meet our future workforce needs; and

WHEREAS, An interagency council will increase the coordination and accessibility of these State services for veterans.

NOW, THEREFORE, I, MARTIN O'MALLEY, GOVERNOR OF THE STATE OF MARYLAND, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND LAWS OF MARYLAND, HEREBY PROCLAIM THE FOLLOWING EXECUTIVE ORDER, EFFECTIVE IMMEDIATELY:



A. Establishment. There is a Governor's Warrior to Worker Council (Council).

B. Duties. The Council shall:

(1) Advise and assist the Governor and the Secretary of the Department of Budget and Management in establishing a coordinated statewide effort to expand veterans' employment opportunities;

(2) Oversee the implementation of the Warrior to Worker Initiative described in Paragraph E of this Executive Order;

(3) Oversee the development of the Strategic Plans described in Paragraph F of this Executive Order;

(4) Serve as a State forum for promoting veterans' training, education, and employment services in Maryland;

(5) Establish goals and performance measures to assess the effectiveness of the Initiative;

(6) Promote the delivery of the highest quality services to Maryland veterans in the most accessible and efficient manner possible; and

(7) Submit an annual report to the Governor on the activities of the Council and the results of the Initiative.

C. Membership. The Council is a subcabinet of the Governor and shall consist of the heads of the following State agencies or their designee and such other executive branch agencies as the Governor may designate:

(1) The Department of Veterans Affairs;

(2) The Department of Labor, Licensing and Regulation;

(3) The Department of Budget and Management;

(4) The Governor's Workforce Investment Board;

(5) The Department of the Military;

(6) The Department of Health and Mental Hygiene;

- (7) The Maryland Higher Education Commission;
- (8) The Department of Business and Economic Development; and
- (9) The Department of Disabilities.

D. Procedures.

(1) The Secretary of Veterans Affairs shall chair the Council. The Chair shall:

- (a) Oversee the implementation of this Executive Order and direct the work of the Council;
- (b) Determine the Council's agenda;
- (c) Except as provided in Paragraph F of this Executive Order, establish subcommittees, and appoint subcommittee chairs, as necessary, to carry out the work of the Council;
- (d) Assign a staff member to serve as an Executive Director to support the Council's activities; and
- (e) Identify additional support as needed.

(2) The Secretary of Budget and Management shall serve as the Vice Chair of the Council.

(3) The Council shall meet at the call of the Chair, at least four times annually.

(4) A majority of the Council members shall constitute a quorum for the transaction of any business.

(5) The Council may adopt other procedures or bylaws as necessary to ensure the orderly transaction of business.

E. The Maryland Warrior to Worker Initiative. There is a Maryland Warrior to Worker Initiative (Initiative). The Initiative will to enhance employment opportunities for veterans within State government and promote employment, education, and training opportunities for veterans throughout Maryland. All State agencies shall participate in the Initiative and shall, as appropriate and to the extent permitted by law:

(1) Develop an agency-specific operational plan for the implementation of the Strategic Plans described in Paragraph F of this Executive Order, consistent with applicable law, merit system principles, the agency's human resources plan, and other applicable workforce planning strategies and initiatives; and

(2) Within 120 days of the issuance of this Executive Order, designate an agency officer or employee to implement the Initiative within each agency.

F. Strategic Plans.

(1) The Veterans Recruitment for State Employment Strategic Plan. Within 90 days after the first meeting of the Council, a subcommittee of the Council, established and chaired by the Secretary of Budget and Management, shall develop a Veterans Recruitment for State Employment Strategic Plan. This Plan shall address ways to enhance the employment opportunities of veterans in State government and shall be updated every three years. The Plan shall focus on:

(a) Identifying actions that agency officials should take to improve employment opportunities for veterans;

(b) Marketing State Government as an employer of choice to service members and veterans;

(c) Making State agencies aware of the talent, experience, and dedication that service members and veterans offer as employees;

(d) Promoting the recruitment and employment of veterans in State government;

(e) Disseminating employment information to veterans and hiring officials;

(f) Identifying key occupations, focusing on positions in high-demand occupations where talent is needed, for which the State may provide job counseling to veterans and service personnel; and

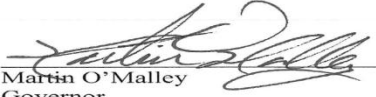
(g) Compiling government-wide statistics on the hiring of veterans.

(2) The Veterans Skills and Education Strategic Plan. Within 90 days after the first meeting of the Council, a subcommittee of the Council, established and chaired by the Secretary of Labor, Licensing and Regulation shall develop a Veterans Skills and Education Strategic Plan. This plan shall address ways to enhance the education, training, and employment opportunities for veterans in Maryland and shall be updated every three years. The plan shall focus on:


(a) Developing and implementing counseling, training, and outreach programs to create an improved pipeline from military service to Maryland's skilled workforce; and

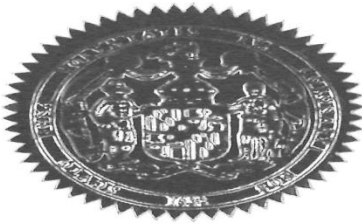
(b) Promoting opportunities for apprenticeships, scholarships, and higher education for veterans in Maryland.

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, this 4<sup>th</sup> Day of October 2010.

  
Martin O'Malley  
Governor

ATTEST:

  
John P. McDonough  
Secretary of State

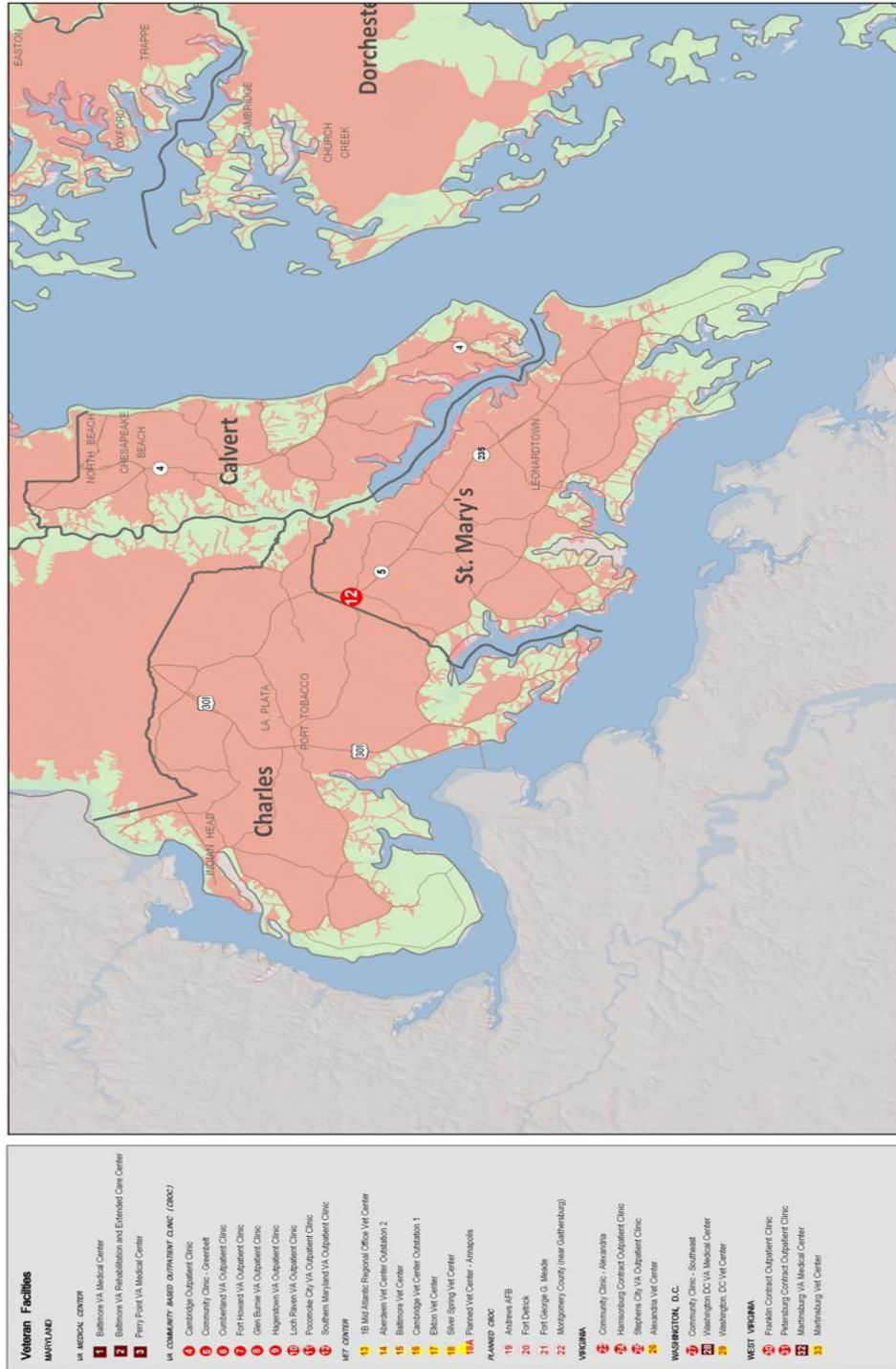


### U.S. Department of Veterans Affairs FY 2009 Expenditures – Maryland

<b>FY 2009 Summary of Expenditures by State (10/1/2008 -9/30/2009)</b>										
<b>Expenditures in \$000s</b>										
County/ Congressional District	Veteran Population*	Total Expenditure	Compensation & Pensions	Construction	Education & Vocational Rehabilitation/ Employment	Loan Guaranty#	General Operating Expenses	Insurance & Indemnities	Medical Care	Unique Patients **
Allegany	7,917	\$ 28,931	\$ 14,626	\$ -	\$ 554	\$ -	\$ -	\$ 500	\$ 13,252	2,286
Anne Arundel	59,565	\$ 152,649	\$ 87,465	\$ -	\$ 13,165	\$ -	\$ -	\$ 5,340	\$ 46,678	6,593
Baltimore	64,902	\$ 189,571	\$ 74,920	\$ -	\$ 19,545	\$ -	\$ -	\$ 6,361	\$ 97,745	11,184
Calvert	10,316	\$ 17,486	\$ 11,575	\$ -	\$ 1,564	\$ -	\$ -	\$ 522	\$ 3,825	763
Caroline	3,129	\$ 7,531	\$ 3,908	\$ -	\$ 286	\$ -	\$ -	\$ 59	\$ 3,278	499
Carroll	14,327	\$ 23,955	\$ 13,067	\$ -	\$ 1,617	\$ -	\$ -	\$ 1,041	\$ 8,231	1,207
Cecil	9,886	\$ 71,245	\$ 14,457	\$ 58	\$ 854	\$ -	\$ 3,698	\$ 431	\$ 51,746	2,206
Charles	16,427	\$ 49,983	\$ 33,846	\$ -	\$ 4,737	\$ -	\$ -	\$ 684	\$ 10,715	1,867
Dorchester	2,888	\$ 13,552	\$ 4,906	\$ -	\$ 184	\$ -	\$ -	\$ 76	\$ 8,387	934
Frederick	21,232	\$ 44,770	\$ 25,010	\$ -	\$ 3,135	\$ -	\$ -	\$ 1,452	\$ 15,174	2,154
Garrett	2,859	\$ 10,462	\$ 6,068	\$ -	\$ 197	\$ -	\$ -	\$ 173	\$ 4,023	676
Harford	25,968	\$ 82,593	\$ 39,657	\$ -	\$ 3,959	\$ -	\$ -	\$ 2,166	\$ 36,810	4,054
Howard	22,409	\$ 44,573	\$ 25,260	\$ -	\$ 4,581	\$ -	\$ -	\$ 1,666	\$ 13,067	1,868
Kent	2,190	\$ 6,092	\$ 2,629	\$ -	\$ 133	\$ -	\$ -	\$ 246	\$ 3,084	297
Montgomery	50,995	\$ 123,905	\$ 68,978	\$ -	\$ 9,469	\$ -	\$ -	\$ 8,751	\$ 36,707	4,802
Prince George's	69,212	\$ 275,114	\$ 146,785	\$ -	\$ 13,629	\$ -	\$ -	\$ 3,903	\$ 110,797	11,689
Queen Anne's	4,776	\$ 7,907	\$ 4,170	\$ -	\$ 375	\$ -	\$ -	\$ 162	\$ 3,200	537
St. Mary's	12,582	\$ 30,086	\$ 19,788	\$ -	\$ 3,221	\$ -	\$ -	\$ 819	\$ 6,257	1,285
Somerset	2,490	\$ 7,829	\$ 3,911	\$ -	\$ 227	\$ -	\$ -	\$ 115	\$ 3,576	473
Talbot	4,019	\$ 9,306	\$ 4,467	\$ -	\$ 131	\$ -	\$ -	\$ 442	\$ 4,267	734
Washington	12,686	\$ 48,486	\$ 19,820	\$ -	\$ 1,801	\$ -	\$ -	\$ 757	\$ 26,108	2,809
Wicomico	8,204	\$ 24,173	\$ 12,013	\$ -	\$ 1,229	\$ -	\$ -	\$ 720	\$ 10,210	1,641
Worcester	6,135	\$ 12,993	\$ 6,250	\$ -	\$ 333	\$ -	\$ -	\$ 435	\$ 5,974	940
Baltimore (city)	41,086	\$ 300,819	\$ 72,453	\$ 7,767	\$ 6,007	\$ -	\$ 27,058	\$ 2,493	\$ 185,041	12,387
<b>Maryland Totals</b>	<b>476,202</b>	<b>\$ 1,584,011</b>	<b>\$ 716,030</b>	<b>\$ 7,824</b>	<b>\$ 81,935</b>	<b>\$ -</b>	<b>\$ 30,756</b>	<b>\$ 39,314</b>	<b>\$ 708,152</b>	<b>73,886</b>
* Veteran population estimates, as of September 30, 2009 - VetPop2007.										
** Unique patients are patients who received treatment at a VA health care facility.										
1. Expenditures are rounded to the nearest thousand dollars. For example, \$500 to \$1,000 are rounded to \$1; \$0 to \$500 are rounded to \$0; and \$ - = 0 or no expenditures.										
2. The Compensation & Pension expenditures include dollars for the following programs: veterans' compensation for service-connected disability; dependency and indemnity compensation for service-connected deaths; veterans' pension for nonservice-connected disabilities; and burial and other benefits to veterans and their survivors.										
3. Medical Care expenditures include dollars for medical services, medical administration, facility maintenance, educational support, research support, and other overhead items.										
4. Medical Care expenditures are based on where patients live instead of where care is delivered. Medical Care expenditures do not include dollars for construction or other non-medical support.										
Source: US Department of Veterans Affairs (GDx-2009)										



Maryland Regional Maps – 30 mile Drive Distance



- Veteran Facilities**
- MARYLAND**
- 1 VA Medical Center
  - 2 Baltimore VA Medical Center
  - 3 Baltimore VA Rehabilitation and Extended Care Center
  - 4 Perry Point VA Medical Center
- VA COMMUNITY AND OUTPATIENT CLINIC (OCC)**
- 5 Cambridge Outpatient Clinic
  - 6 Community Clinic - Greenbelt
  - 7 Cumberland VA Outpatient Clinic
  - 8 Fort Howard VA Outpatient Clinic
  - 9 Glen Burnie VA Outpatient Clinic
  - 10 Hagerstown VA Outpatient Clinic
  - 11 Loch Raven VA Outpatient Clinic
  - 12 Poolesville City VA Outpatient Clinic
  - 13 Southern Maryland VA Outpatient Clinic
- VA CENTER**
- 14 1B Mid Atlantic Regional Office Vet Center
  - 15 Aberdeen Vet Center Outstation 2
  - 16 Baltimore Vet Center
  - 17 Cambridge Vet Center Outstation 1
  - 18 Elkon Vet Center
  - 19 Silver Spring Vet Center
  - 20 Pharmed Vet Center - Annapolis
- VA MEDICAL CENTER**
- 21 Andrews AFB
  - 22 Fort Detrick
  - 23 Fort George G. Meade
  - 24 Montgomery County (near Gaithersburg)
- VIRGINIA**
- 25 Community Clinic - Alexandria
  - 26 Hanscomburg Contract Outpatient Clinic
  - 27 Stephens City VA Outpatient Clinic
  - 28 Alexandria Vet Center
- WASHINGTON, D.C.**
- 29 Community Clinic - Southwest
  - 30 Washington D.C. VA Medical Center
  - 31 Washington, DC Vet Center
- WEST VIRGINIA**
- 32 Franklin Contract Outpatient Clinic
  - 33 Petersburg Contract Outpatient Clinic
  - 34 Martinsburg VA Medical Center
  - 35 Martinsburg Vet Center

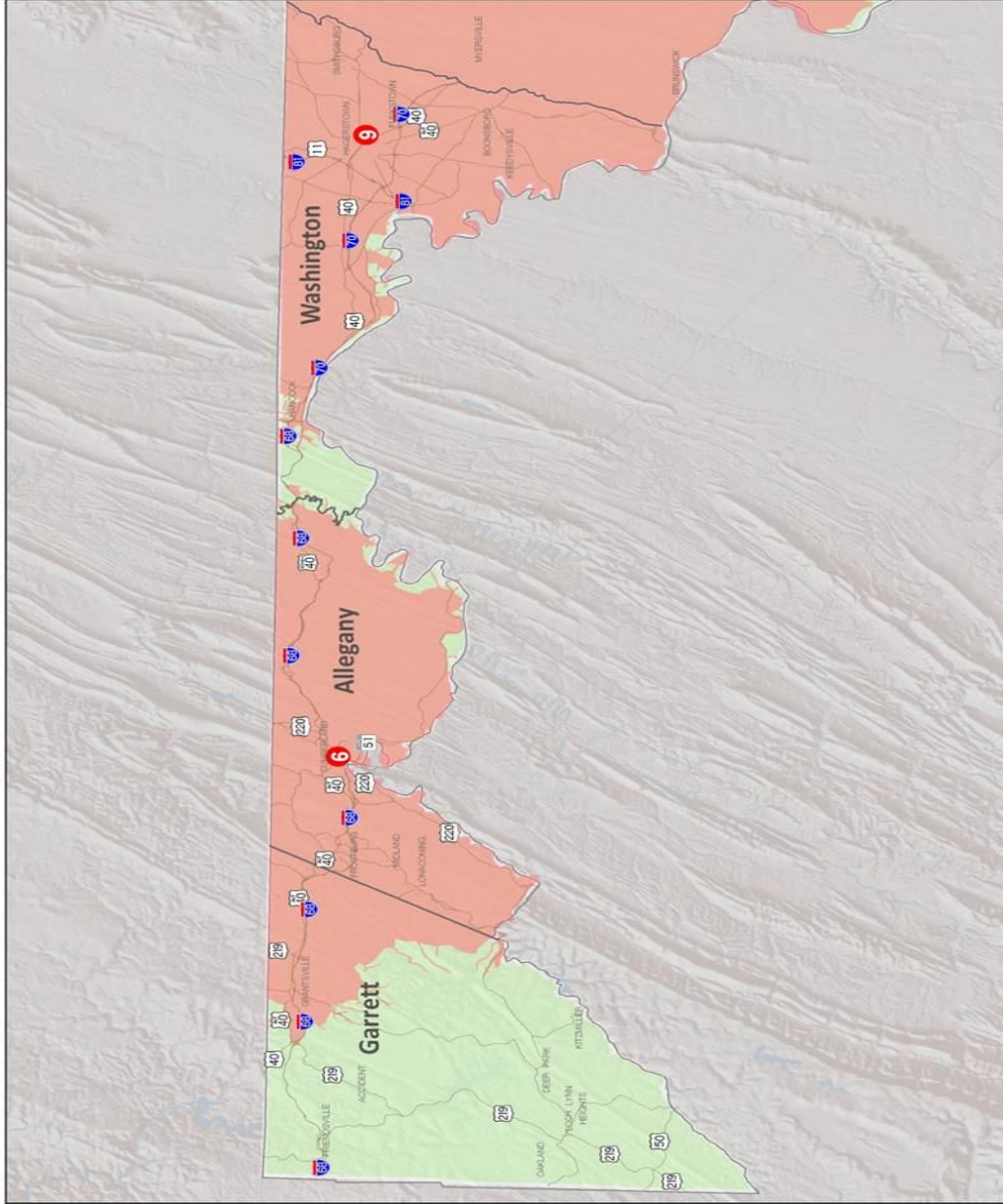
**Veteran Affairs Centers & 30 Mile Drive Distance Southern Maryland**

30 Mile Drive Distance  
 30 Miles



**MDP**  
 Maryland Department of Planning  
<http://www.planning.maryland.gov>

Source: 2008 Maryland Health Care Commission Report  
 VA Business 440  
 Maryland Department of Business & Economic Development



Veteran Facilities	
<b>MARYLAND</b>	
1	Baltimore VA Medical Center
2	Baltimore VA Rehabilitation and Extended Care Center
3	Ferry Post VA Medical Center
<b>VA COMMUNITY CARE DISTRICTS (CCDC)</b>	
4	Cambridge Outpatient Clinic
5	Community Clinic - Greenbelt
6	Cambridge VA Outpatient Clinic
7	Fort Howard VA Outpatient Clinic
8	Green Bunde VA Outpatient Clinic
9	Hagerstown VA Outpatient Clinic
10	Loch Raven VA Outpatient Clinic
11	Poolesville VA Outpatient Clinic
12	Southern Maryland VA Outpatient Clinic
<b>MPT CENTER</b>	
13	Mid Atlantic Regional Clinic Vet Center
14	Abandon Vet Center Outstation 2
15	Baltimore Vet Center
16	Cambridge Vet Center Outstation 1
17	Elkton Vet Center
18	Silver Spring Vet Center
18A	Planned Vet Center - Annapolis
<b>PLANNED CCDC</b>	
19	Andrews AFB
20	Fort Detrick
21	Fort George G. Meade
22	Montgomery County (near Gaithersburg)
<b>VIRGINIA</b>	
23	Community Clinic - Alexandria
24	Harrisonburg Contract Outpatient Clinic
25	Shepherd City VA Outpatient Clinic
26	Alexandria Vet Center
<b>WASHINGTON, D.C.</b>	
27	Community Clinic - Southeast
28	Washington DC VA Medical Center
29	Washington, DC Vet Center
<b>WEST VIRGINIA</b>	
30	Franklin Contract Outpatient Clinic
31	Petersburg Contract Outpatient Clinic
32	Martinsburg VA Medical Center
33	Martinsburg Vet Center

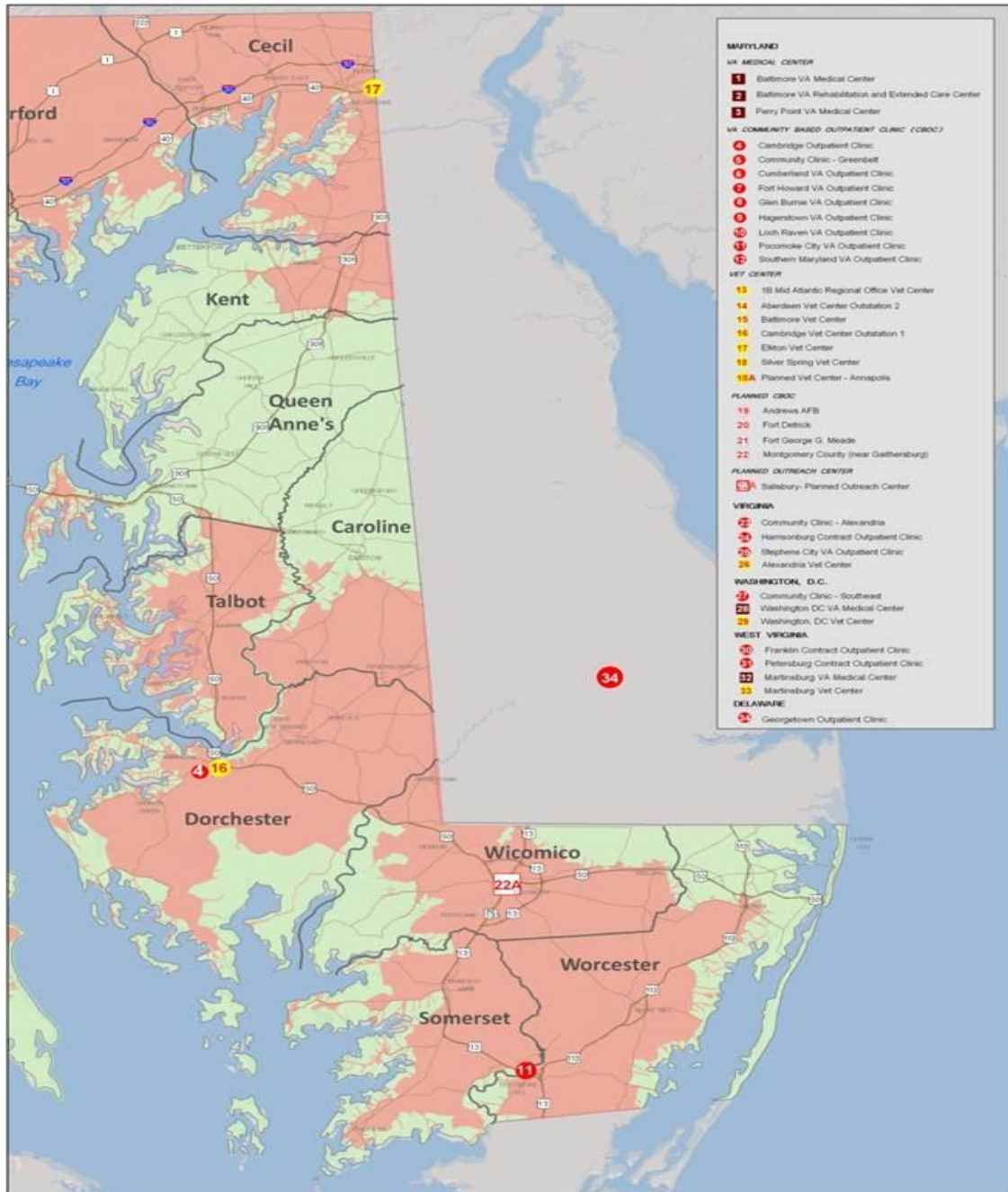
## Veteran Affairs Centers and 30 Mile Drive Distance Western Maryland



30 Mile Drive Distance  
30 Miles

Source: VA facilities, 2008 Maryland Health Care Commission Report  
30 mile drive distance, Maryland Department of Business & Economic Development





### Veteran Affairs Centers and 30 Mile Drive Distance Eastern Shore

Source:  
VA facilities: 2008 Maryland Health Care Commission Report  
30 mile drive distance: Maryland Department of Business & Economic Development

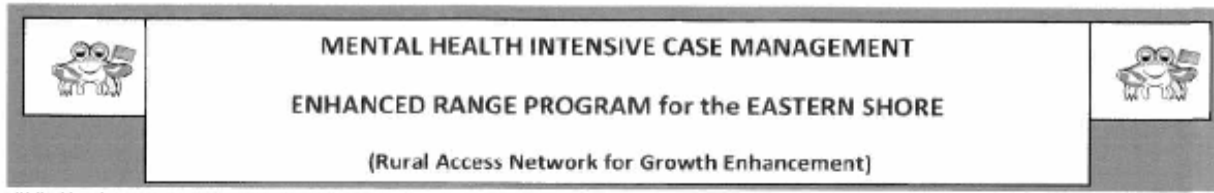
30 Mile Drive Distance

30 Miles



**MDP**  
Maryland Department of Planning  
<http://www.planning.maryland.gov>

## U.S. Department of Veterans Affairs VISN 5 - E-RANGE Brochure



❖ **WHAT IS MHICM ENHANCED RANGE:**

MHICM Enhanced Range is a program staffed by an interdisciplinary team of clinical professionals who provide intensive case management and psychosocial rehabilitation services to Veterans living with severe and persistent mental illness. Services are provided to Veterans who reside on Maryland's Eastern Shore in the following counties: Queen Anne's, Talbot, Caroline, Dorchester, Wicomico, Worcester and Somerset.

❖ **SERVICES PROVIDED BY THE MHICM TEAM:**

Community based care that offers the following: Community Integration with Case Management Services, Assistance with Housing, Medication Management, Symptom Management, Family and Community Relationships, Recreation, Interpersonal Skills, Independent Living Skills, Financial and Budget Management and Transportation.

❖ **TARGET POPULATION & EXCLUSIONS:**

Inclusion Criteria: In addition to living in one of the catchment areas listed in the first section above, the following criteria are required:

1. Veterans must be diagnosed with one of the following serious mental illnesses: Schizophrenia, Schizoaffective, Mood Disorder or Anxiety Disorders/PTSD.
2. Veteran must have recent history of inpatient hospitalization for mental health treatment.
3. Veteran must express the availability and willingness to voluntarily participate in this type of program for an extended period of time and accept a MHICM Clinician as their primary mental health care provider.

Exclusion Criteria:

1. Primary Diagnosis of Substance Abuse
2. Diagnosis of Organic Brain Syndrome or personality disorder (Axis II)
3. Residing outside of Queen Anne's, Kent, Talbot, Caroline, Dorchester, Wicomico, Worcester or Somerset County in Maryland.
4. Veterans with a significant history of violence or if the current treatment team feels that an intensive case management program is contraindicated.

- ❖ **HOW TO MAKE A REFERRAL:** In the VA System you can request a consult in CPRS under the tab for the MHICM Eastern Shore team. The Referral will be reviewed by our Team Leader and a response will be generated within 5 business days. Contact information for the team can be found below.

### Contact Information

John Clow, LCSW-C, Team Leader (443-934-4262)

Team Location: Holly Center Salisbury, MD

Janet Bledsoe, Nurse Practitioner (443-934-4263)

Hours of Operation: M-F 8:00 am to 4:30 pm

Cicely Burrows-McElwain, LCSW-C (443-934-4264)

Chaquinta Sherwood, PSA (443-934-4265)

**HUD-VASH Veterans Affairs Supportive Housing Program**

**Veterans Affairs Supportive Housing (HUD-VASH)  
Fact Sheet**

This fact sheet provides an overview of important information related to Veterans Affairs Supportive Housing (HUD-VASH).

**Purpose**

The HUD-VASH Program combines the Department of Housing and Urban Development (HUD) Housing Choice Voucher (HCV) rental assistance for homeless veterans and their families with case management and clinical services provided by the Department of Veterans Affairs (VA) at its medical centers and in the community.

**Beneficiaries**

HUD-VASH assists homeless veterans and their families afford decent, safe, and sanitary housing through the distribution of housing vouchers. Beneficiaries are selected based on certain requirements including health care eligibility, homelessness status, and income. Since 2008, beneficiaries are no longer required to be chronically mentally ill or have chronic substance abuse disorders. However, chronically homeless veterans are a target population for HUD-VASH.

**Grantees**

For FY2009, 132 Veterans Affairs Medical Centers (VAMCs) and 137 Public Housing Agencies (PHAs) were identified and selected to participate in the HUD-VASH program. Each VAMC is partnered with at least one PHA and there is at least one VAMC-PHA partnership in each state, the District of Columbia, and Puerto Rico.

Specific VAMCs and PHAs were selected based on geographical need for assistance (as identified by the VA Secretary), PHA administrative performance, and other factors determined by the HUD Secretary in consultation with the VA Secretary.

The number of vouchers distributed to each PHA was determined by HUD and the VA.

**Grant Size/Availability**

In 2008, Congress made available \$75 million to fund 10,000 HUD-VASH vouchers and funded an additional 10,000 vouchers in 2009. Approximately 35 rental vouchers were awarded for each professional, full-time HUD-VASH case manager at a local VAMC. HUD-VASH vouchers may be reallocated in the future based on need and usage.

**Program Components**

**Tenant-Based Rental Assistance (PHA)**

HUD-VASH is modeled after the Housing Choice Voucher Program (HCV) where participants are issued a voucher, which they use to search for housing to rent from private-market landlords. Participants typically pay between 30 to 40 percent of their income toward rent and the local PHA pays the difference directly to the landlord. Before the participant moves in, the PHA must inspect the unit to ensure it meets HUD's Quality Standards (HQS), and the monthly rent for the unit must meet the fair-market rent (FMR) and local rent reasonableness standards.

**Project-Based Rental Assistance (PHA)**

According to guidance released in March 2009 by HUD, PHAs, with the support of the partner VAMC, may request that vouchers be project-based allowing PHAs to attach the voucher assistance to specific rehabilitated or newly constructed housing units or to set aside a portion of units in an existing housing development. The PHA enters into an assistance contract with the owner of the specified units for a specified term. The owner agrees to construct or rehabilitate the units, and the PHA agrees to subsidize the units upon satisfactory completion.

**Screening and Case Management Services (VAMC)**

VAMC responsibilities include: 1) screening homeless veterans to determine whether they meet the HUD-VASH program participation criteria established by the VA national office; 2) providing appropriate treatment and supportive services to potential HUD-VASH program participants (if needed, prior to PHA issuance of rental vouchers); 3) providing housing search assistance to HUD-VASH participants with rental vouchers; 4) identifying the social service and medical needs of HUD-VASH participants and

providing, or ensuring the provision of, regular ongoing case management, outpatient health services, hospitalization, and other supportive services as needed throughout this initiative; and 5) maintaining records and providing information for evaluation purposes, as required by HUD and the VA.

#### **Eligible Activities**

HUD-VASH vouchers may be used to provide rental assistance to eligible homeless veterans and their families. Vouchers are generally tenant-based. However, on a case-by-case basis, project-based vouchers may be used. (For more information, review the "Program Components" section.)

Funds may also be used to cover PHA administrative costs related to the HUD-VASH program.

HUD-VASH housing assistance vouchers may be used in conjunction with available [Homelessness Prevention and Rapid Re-Housing Program \(HPRP\) funds](#). Available HPRP funds may be used to cover security deposits, including utility deposits.

#### **Requirements and Responsibilities**

Homeless veterans and their families receiving HUD-VASH rental assistance must receive VA case management services until the VAMC determines that it is no longer necessary.

PHAs must maintain records that make it easy to identify and track all HUD-VASH voucher recipients. Families must be identified in the Public and Indian Housing Information Center (PIC). Record-keeping will help ensure that, in accordance with appropriations renewal language, HUD-VASH vouchers that are in use will remain available for homeless veterans upon turnover.

With some exceptions, all regulatory requirements and HUD directives regarding the HCV tenant-based program are applicable to HUD-VASH vouchers, including the use of all HUD-required contracts and other forms.

#### **Additional Information**

For more detailed information about HUD-VASH, please visit the following sources:

- [HUD VASH Vouchers HUD Website](#)
- [Federal Legislation](#)
- [Federal Register Notice](#)



# VA HEALTH CARE

Fact Sheet 16-8  
March 2010

## Other Than Honorable Discharges Impact on Eligibility for VA Health Care Benefits

### Benefit Description

To be considered a “veteran” eligible for Department of Veterans Affairs (VA) Health Care benefits, a former service-member must have been discharged “under conditions other than dishonorable.” Under VA regulations, administrative discharges characterized by the armed services as “Honorable” or “General Under Honorable Conditions” are qualifying, and punitive discharges (“Dishonorable” or “Bad Conduct”) issued by **general** courts-martial are disqualifying.

The in-between categories, administrative “Other than Honorable” discharges, and punitive “Bad Conduct Discharges” issued by **special** courts-martial, **may or may not** be disqualifying for purposes of general VA benefit eligibility or VA health benefits eligibility specifically. In assessing whether such discharges were issued “under conditions other than dishonorable,” VA must apply the standards set forth in *Title 38 Code of Federal Regulations (C.F.R.) §3.12*.

### “Other than Honorable” Discharges – Special Health Care Rule

An individual with an “Other than Honorable” discharge that VA has determined to be disqualifying under application of title 38 C.F.R. §3.12 still retains eligibility for VA health care benefits for service-incurred or service-aggravated disabilities unless he or she is subject to one of the statutory bars to benefits set forth in *Title 38 United States Code §5303(a)*. *Authority: Section 2 of Public Law 95-126 (Oct. 8, 1977)*.

VA Health Care Benefits: If an individual presents or makes an application for VA health care benefits and has an “other than honorable” or “bad conduct” discharge, eligibility staff may register the individual and place in a Pending Verification Status. A request for an administrative decision regarding the character of service **for VA health care purposes** must be made to the local VA Regional Office (VARO). This request may be submitted using a VA Form 7131, Exchange of Beneficiary Information and Request for Administrative and Adjudicative Action. In making determinations of health care eligibility the same criteria will be used as are now applicable to determinations of service connection when there is no character of discharge bar.

**Reference:** *M21-1 Part IV, Chapter 11 “Special Determinations and Administrative Decisions.”*

**Note:** Emergent treatment may be provided with a signed statement by the veteran (may be on a VA Form 119, Report of Contact) that if s/he is subsequently found to be NOT Eligible for VA Health Care, they agree to pay the Humanitarian Rate for any emergent care or services provided while under this Pending Verification status.

For Further Information: Contact your local VA health care facility's Eligibility office or the Health Eligibility Center at 404-828-5257. This and other eligibility related fact sheets are available at <http://www.va.gov/healtheligibility/Library/pubs/>.

**Authorities:** *Title 38, United States Code, §5303(a); Pub. L. No. 95-126, §2; and Title 38, Code of Federal Regulations, §§3.12.*

Page 2 of 2



**MARYLAND BEHAVIORAL HEALTH SERVICES BY COUNTY**

Maryland Counties	# of Service Provider Organizations*	# of Physicians: Specialty: Psychiatry
Allegany County	21	10
Anne Arundel County	58	42
Baltimore County/City	135	204
Calvert County	15	6
Caroline County	16	1
Carroll County	30	11
Cecil County	10	9
Charles County	19	6
Dorchester County	24	5
Frederick County	30	10
Garrett County	23	2
Harford County	14	17
Howard County	30	53
Kent County	8	◇
Montgomery County	74	290
Prince George 's County	80	◇
Queen Anne's County	18	1
St Mary's County	13	4
Somerset County	10	1
Talbot County	20	7
Washington County	31	14
Wicomico County	30	8
Worcester County	11	2
Baltimore City	163	240

\* Data source: RRC reports-2010. SAMHSA database,& DHMH. Includes substance abuse treatment programs / organizations posted on MD-ADAA website 2010

◇ Data missing from MD Physician Workforce Study, DHMH

**Maryland BHS Resources - including substance abuse treatment providers**

[This list was created by merging data submitted by the RRCs to the Consultant in December 2010, with an Excel spreadsheet from DHMH containing 595 providers, and with data extracted from the MD-ADAA website. It is likely not completely up-to-date and it may be missing some organizations that provide behavioral health services or substance abuse treatment.]

Key:

Blue = US Government

Red = Maryland State or County

Black = Private

**Allegany County: 21**

Cumberland VA Outpatient Clinic

Allegany County Health Dept —4 sites

Archway Station Inc

Associated Catholic Charities

Alternative Drug and Alcohol Counseling (ADAC)

Behavioral Health Services of Western Maryland Health System

Board of Child Care

Christian Counseling Services of Western Maryland

Cumberland Treatment Center

Emergency Mental Health Services

Family Therapy Services

Memorial Hosp & Med

Mental Health Center of Western Maryland, Inc.

MD Dept of Juvenile Services, Drug Treatment Program—2 sites

Pressley Ridge of Western Maryland

Seton Mental Health Practice

Thomas B. Finan Center

Villa Maria OMHC – Mountain Maryland

Western Maryland Health System, BH program—2 sites

Western Maryland Recovery Services—2 sites

WMHS Braddock Hospital Corporation

Anne Arundel Medical Center (Pathways)

Associated Catholic Charities

Baltimore Washington Emergency Physicians

Baltimore Washington Medical Center

Bayside Behavioral Health Clinic

B.N.J. Health Services, LLC

Board of Child Care, Inc. Mental Health Clinic

BPH, Inc. (Starting Point)

Care Connections Inc.

Care Solutions Corp

Christian Counseling Center of Annapolis

Chrysalis House, Inc.

Cornerstone Pastoral Care, Inc.

Covington Diversity Programs

Damascus House, Inc.

Deale One-Step Recovery Program

Doctors Emergency Service Pa

E.J.A.L Health Services, Inc.

Ferry Point Assess & Treatment Services

Foundations Psych Rehab Program

First Step Recovery Center

Glen Burnie VA Outpatient Clinic

Guadenzia/Wms Intensive Treatment Program @ MD Correctional Institute

Hawkes Counseling Services

New Life Addiction Counseling Services, Inc.

Noah's Arc Treatment Center

Oasis the Center for Mental Health

Omni House, Inc.--2 sites

Owensville Primary Care Inc.

Partnership Development Group Inc.

Pascal Substance Abuse Ed & Prev Program

People's Community Addiction Services

Potomac Ridge Behavioral Health

Psychotherapeutic Services of Southern MD

Psychotherapeutic Treatment Services, Inc.

Recovery Resources Group

Samaritan Houses, Inc.

Second Genesis Programs —3 sites

Sheepgate Christian Counseling LLC

Spectrum Behavioral Health

Thomas Associates Foundation Inc.

**Anne Arundel County: 58**

Advocate Support Services Inc.

Addictions Recovery, Inc. (Hope House)

ADEPT (Alc/Drug Educ Prev, & Treatment)

Adventist Behavioral Health at Anne Arundel

A New Way Clinic

Annapolis Vet Center (US DVA)Treatment

Alcohol and Drug Intervention, Inc.

Alcohol and Drug Recovery

Arundel Lodge, Inc. (2 sites)

Associates in Mental Health

Anne Arundel Counseling, Inc.—4 sites

Anne Arundel County Behavioral Health Clinic – Villa Maria Continuum

Anne Arundel General Hospital

Anne Arundel County Health Department (12 sites)



## Anne Arundel County (continued)

Vesta, Inc.  
We Care Arundel Health Services  
Whitehead Institute of Mental Health

## Baltimore County : 135

[Fort Howard VA Outpatient Clinic](#)

[Loch Raven VA Outpatient Clinic](#)

Adolescent Substance Abuse Intervention Program

Addiction Counseling Services—Pikesville

A Helping Hand Health Services

Alliance, Inc.

All Walks of Life, Inc.

Alternatives to Dependency—2 sites

Alternative Network, LLC

1<sup>st</sup> Alternative Counseling

American Substance Abuse Professionals, Inc.

AMP/CEP/Right Way Recovery

Anxiety & Depression Treatment

Associated Catholic Charities (4 sites)

Associated Mental Health Specialists

Associates Mental Health

Awakenings Counseling Program

A.W.A.R.E.

[Baltimore County Health Department \(4 sites\)](#)

Baltimore County Bureau of Substance Abuse

Juvenile Drug Court

[Baltimore Vet Center \(US DVA\)](#)

[Baltimore VA Medical Center](#)

[Baltimore VA Rehab & Extended Care Center](#)

Baltimore Medical System

Bay Life Services Inc.

Bay Region Psychiatric Services—2 sites

BD Health Services, Inc.

Bernie's Place, Inc.

B T Training Institute

Black Mental Health Alliance

Bon Secours Hospital Behavioral Health

Board Of Child Care

Boundless Innovation For Holy Living

Carrington House

Chance 2 Change, Inc.

Chase Brexton Health Services

Center for Mental Health

Chesapeake Treatment Center

Community Behavioral Health Association of Maryland

Community Behavioral Services, Inc.

Crossroads Centers at Milestone

Community Support Services For The Deaf

Community Behavioral Services Inc.

Counseling Resource Associates

Daily Therapy & Cons Services LLC

Dulaney Station, Inc.

Eastside Counseling Services

EMC Emergency Physicians

Epoch Counseling Centers—4 sites

First Step Inc.

Franklin Square Hospital Center Inc.—3 sites

Franklin Sq. Psychiatric & Behavioral Health Services

GAMBARU

Gaudenzia, Inc. at Owings Mills

Gifts

Glass Health Systems-Pikesville

Global Healthcare Systems Inc.

Good Shepherd Center

Grace Health Systems Inc.

Greater Baltimore Medical Center

Harford-Belair Comm. Mental Health Center, Inc.

Havilah Gold Inc.

Health Care Associates

Hebron House Inc.

Hope Health Systems, Inc.

House of Jude Childrens Service

Institute for Family Centered Services

Institute for Life Enrichment

I Can, Inc. – Oasis

Johns Hopkins Bayview Medical Center Community Psychiatry Program

Johns Hopkins Hospital Department of Psychiatry

Kernan Hospital

Keypoint Health Services, Inc. Outpatient Clinic

King Health Systems, Inc.

Kolmac Clinic

Lane Treatment Center

Levindale Hebrew Geriatric Center

Life Choices

Life Care Health Associates

Lifelines Foundation, Inc.

Life Renewal Services Inc.

Main Street Community Mental Health Center

Maryland Behavioral Health Service

Maryland Center for Health Psychology

Maryland Global Health Services, Inc.

Maryland General Hospital Behavioral Health Center

Maxim Healthcare Services Inc.

MBA Southeast Baltimore Co

McNally and Ford Clinical Services

Mentor Clinical Care

Methadone for Business Achievers - Timonium

Middle River Center EPSDT Program

Mid-Atlantic Treatment Services, Inc.

Miracles Health Care Svcs Outpt Mental Health Clinic

Morning Star Baptist Church

Mosaic Community Services Dual Diagnoses Program

## **Baltimore County (continued)**

Next Step of Maryland  
National Pike Health Center, Inc.  
North Baltimore Center, Inc.  
Northwest Hospital Center  
Optimum Health System Inc.  
Osler Drive Emergency  
Partners In Recovery, Inc.  
Phoenix Therapeutic Foundation  
Pressley Ridge Outpatient Mental Health Clinic  
Progressive Life Center Prologue, Inc. Psychiatric Day Program  
Psychiatric Associates Care  
Psycho Community Svcs Associates - Balto Co  
Psychology Consultants Associated P  
Psychotherapeutic Treatment Services  
Rays of Light Substance Abuse Treatment Center  
Recovery Network—multiple sites  
Regional Institute for Children and Adolescents  
Right Turn of Maryland – 3 sites  
Sheppard Pratt Health System Inc.  
Simple Alternatives Inc.  
St. Joseph's Medical Center Behavioral Health Services  
Successful Resolutions  
The Alpha Group LLC  
The Children's Guild, Inc. Outpt Mental Health Ctr  
The Children's Home Inc.  
The Resource Group Counseling & Education Center  
The Woodbourne Center, Inc.  
Towson Addiction Center—2 sites  
Towson University Counseling Center  
Treatment on Demand  
Turnaround, Inc.  
Union Memorial Hospital Behavioral Health  
University Psychological Center  
Vesta Inc.  
Villa Maria Continuum  
We Can Change Rehab Services Inc.  
Xavier Healthcare Service  
Young Adult Institute

## **Baltimore City: 163**

Aba Health Services Inc.  
Adapt Cares  
Addiction Counseling Services  
Addiction Treatment Services of Hopkins Bayview  
Addicts Changing Together Substance Abuse Program  
Angel Foundation  
Apex Counseling Ctr, LLC  
Arthur Flax's Comprehensive Psychosocial Services  
A Step Forward, Inc.

Baltimore Behavioral Healthcare, Inc.  
Baltimore Cares, Inc.  
Baltimore City Detention Center  
Baltimore Community Resource Center—4 sites  
Baltimore Crisis Response Inc.—2 Sites  
Baltimore Medical System  
Barris Counseling Services  
Bayside Medical  
Bridge House, Inc.  
Bright Hope House, Inc.  
Build Fellowship House, Inc. – 3 sites  
By Grace Inc. Counseling Services  
Building Communities Today For Tomorrow  
C A Rushing & Assoc Inc.  
Care Connections Inc.  
Center for Addiction Medicine  
Central Booking and Intake Center  
Change Health System Inc.  
Chase Brexton Health Services Inc.  
Chesapeake Counseling Services  
Childrens Hospital  
Church Hospital  
Compassionate Care Outpatient Treatment  
Co-Occurring Disorders Program  
Cornerstone  
Creative Alternative  
Crossroads Center  
Daybreak Rehab Treatment Center  
Dayspring Programs, Inc.  
Deaf Addiction Service at Maryland (DASAM)  
DeVaughn Inc. Teach and Treat Options  
Eastern Avenue Health Solutions, Inc.  
Eastern Area Treatment Program-Adult  
Echo House Multi-purpose Center  
Elkton Treatment Center  
EMC Emergency Physicians  
Empowering Minds Resource Ctr  
Faith House I-II  
Family Health Centers Of Baltimore  
Family Visions LLC  
First Step, Inc.  
Friendship House  
Guadenzia, Inc. – 2 sites  
Glass Substance Abuse Program  
Glenwood Life Counseling Center  
Good Samaritan Hospital Acute  
Goodwill Industries of the Chesapeake, Inc.  
Hampden Health Solutions at the Rail. Inc.  
Happy Homes Psych. Rehab. Program  
Harambee Treatment Center—2 sites  
HARBEL Prevention and Recovery Center  
Harbor Hospital Center

## **Baltimore City (continued)**

Harford-Belair Community Mental Health Clinic, Inc.,  
Hawkes Counseling Services  
Health Care For The Homeless  
Healthy Minds Resource Services  
Help and Recovery Today (HART)  
Huber and Associates—2 sites  
Hunter Behavioral Health Care Services  
Institutes for Behavior Resources, Inc. R.E.A.C.H.  
Mobile Health Services  
JAI Medical Center  
Jewish Community Services –Addiction Program  
JHH Bayview Center for Addiction and Pregnancy  
JHH Programs Broadway  
Kennedy Krieger Childrens Hospital  
Kennedy Krieger Institute  
Key Point Health Services  
King Health Systems Inc. Lane Treatment Center, LLC  
Levindale Hebrew Geriatric Center Hospital  
Life Choices LLC  
Loyola College Alcohol & Drug Educ.& Support Svcs.  
Man Alive, Inc.  
Martha’s Place  
Maryland DHMH  
Maryland General Hospital  
Mattie B. Uzzle Treatment Center  
MBA Southeast Baltimore County  
MD General Clinical  
Mercy Medical Center  
Methadone for Business Achievers  
Metropolitan Transition Center  
Mitchell Court Assessment Unit  
Mosaic Community Services, Partners In Recovery  
Mount Washington Pediatric Hospital  
Mountain Manor Treatment Centers  
Nalty and Associates, Inc.  
National Pike Health Center Inc.  
New Hope Treatment Center  
New Vision Behavioral Hlth Srvc Inc.  
Next Passage  
Nilsson House  
North Baltimore Center  
Northwest Baltimore Youth Services, Inc.  
No Turning Back  
Oasis Health Center  
Operation Recovery  
Optimum Health System Inc.  
Pastoral Counseling Services of Maryland, Inc.  
People Encouraging People  
Peoples Community Addiction Services—2 sites  
PEP Inc. Substance Abuse/Co-Occurring Disorders  
Program  
Pine Heights Treatment Center

Powell Recovery Center Inc.—2 sites  
Pressley Ridge Outpt Mental Health Clinic  
Quadrant Inc.  
Reality Resource Group  
Recovery in Community, Inc.  
Recovery Network – multiple sites  
Reflective Treatment Center  
Residential Care Incorporated  
Restoration Rehab Services  
Reward Health Services LLC  
Right Turn of Maryland  
Safe Health Services, Inc.  
S.A.F.E House  
Sinai Hospital of Baltimore-Addictions Recovery  
Program  
Senga Health Care System Inc.  
South Baltimore Station  
S & S Counseling Services  
St Agnes Healthcare  
St Agnes Hospital  
Step By Step Of Maryland  
Step Inc.  
Step Up Health Services Inc.  
The Alexanda Foundation, Inc.  
The Bernice E. Meade House of Safe Haven  
The Hart Group (Help and Recovery Today)  
The Hidden Garden Keeper’s Club@ Park West  
The League For People With Disabilities  
The New Fayette House, Inc.  
The Regeneration Project LLC  
Time Organization Inc.  
Total Health Care  
Transitioning Lives, Inc.—2 sites  
Treatment Resources for Youth  
Tuerk House, Inc.  
Turning Corners, Inc.—2 sites  
Turning Point Clinic  
Union Memorial Hospital  
University of Maryland Medical Center-ADAP  
Universal Counseling Services Inc.—2 Sites  
University Of Maryland Med Systems—3 Sites  
University Specialty Hospital  
Urban Behavioral Assoc Pa  
Valley House, Inc.  
Volunteer Of America  
Weisman/Kaplan  
Wholistic Resolve Around People Services –2 sites  
William Donald Schaefer House  
Wilson House  
Woodbourne Center—2 Sites  
Yardmore Emergency Physicians  
Zenith Healthcare Services Inc.

## Calvert County : 13

Barstow Acres Childrens Center  
Bayside Therapy, Inc.  
[Calvert County Health Department - Mental Health Clinic](#)  
Calvert Substance Abuse Services –5 sites, including Health Dept  
Calvert Memorial Hospital – Behavioral Health Unit  
Center For Children, Inc.  
Certified Counseling Services of Dunkirk, Inc.  
Chesapeake Christian Counseling Center  
Chesapeake Counseling Network  
Courage to Change of Southern MD  
Living Waters Program  
Southern MD Comm Network Inc.  
The Carol M. Porto Treatment Center

## Caroline County: 16

[Caroline County Health Department / Department of Social Services](#)  
[Caroline County Mental health Clinic](#) Caroline Counseling Center  
Chesapeake Center  
Channel Marker, Inc.  
Choptank Community Health Service / Denton Medical Center  
Dorchester General Hospital Inc.  
Family Support Center  
For All Seasons, Inc.  
Federalsburg Medical Center  
Goldsboro Medical Center  
Mid Shore Council on Family Violence  
South County Addiction Services  
St. Martin’s Barn  
Regional Midshore Mental Health Clinic  
Samaritan House

## Carroll County: 31

Adapt Counseling, Inc.  
Associated Catholic Charities  
Behavioral Health Service  
BH Health Services, Inc.  
Carroll Hospital Center-- Behavioral Health Services  
Carroll Counseling Center  
[Carroll County Health Department, Bureau of Addictions—2 sites](#)  
Carroll County Long Term Treatment Facility  
Catoctin Counseling Center  
Destilee Health Care  
Emergency Medicine Association  
Eldersburg Mental Health Center  
Finksburg Plaza Counseling

Genesis Treatment Services  
Granite House Inc.  
Guadenzia Inc. Residential Sub Abuse Treatment  
Integrative Counseling, LLC  
Junction, Inc.  
Keystone Service Systems, Inc.  
Network Health Services  
Mosaic Community Behavioral Health Center  
Mountain Manor Treatment Center  
North Carroll Addictions Recovery Program (NCARP)  
Prologue Inc.  
Psychiatric Services & Health System, Inc.  
Re-entry Mental Health & Substance Abuse Services  
Sheppard Pratt Physicians Pa  
Shoemaker Center  
The Haven Counseling Services, LLC  
Villa Maria  
Westminster Recovery Center

## Cecil County: 11

Alcohol and Drug Recovery Center  
Cecil County Health Department  
Cecil County Alcohol and Drug Recovery Center  
Elkton Treatment Center  
[Elkton Vet Center \(US DVA\)](#)  
Family Services Assoc.--Addiction Outpt. Program  
Haven House, Inc.  
[Perry Point VA Medical Center](#)  
Union Hospital Behavioral Health Services  
Upper Bay Counseling & Support Services  
West Cecil Health Center

## Charles County: 19

Alcohol and Drug Recovery—2 sites  
Be-Lite Horizon Medical Center  
Charles County Freedom Landing, Inc.  
Charles County Mental Health Center  
Charles County Substance Abuse Services  
Civista Medical Center  
Clean Slate Recovery  
Center for Children, Inc.  
Huguley Child EPSDT  
Institute for Family Centered Services  
Mid-Atlantic Mental health Center  
Open ARMMS Inc.  
Psychotherapeutic Services of So. Md  
Rhema Counseling Services  
Sol Purpose, LLC  
The Jude House, Inc.  
Vesta, Inc.  
Vance Mental Health Services  
Washington Pastoral Counseling Services-Substance Abuse Services—2 sites

## **Dorchester County: 23**

Adventist Behavioral Health – Eastern Shore  
[Cambridge Vet Center \(US VA\)](#)  
[Cambridge VA Outpatient Clinic](#)  
Channel Marker, Inc.  
Chesapeake Youth Center  
Choices Family Services  
Choptank Community Health System  
Crest Therapeutic Community  
Delmarva Family Resources  
[Dorchester City/County Health Department—3 sites](#)  
Dorchester General Hospital Shore Behavioral Health  
Dorchester Detention Center  
Eastern Shore Hospital Center  
Fassett-Magee Community Health Center  
For All Seasons, Inc.  
Hurlock Medical Center  
Maple Shade Youth & Family Services  
Marshy Hope Family Services  
Mid-Shore Council on Family Violence  
Potomac Ridge Behavioral Health  
Sailwinds Family Center LLC  
Vision Quest Morning Star Youth Academy  
Warwick Manor Behavioral Health Inc.

## **Frederick County : 28**

Allied Counseling Group, Inc.—2 sites  
ARTS: Alternative Rehab and Treatment Services  
Associated Catholic Charities  
Behavioral Health Partners—2 sites  
Blue Ridge Behavioral Health Services  
Brook Lane Health Services  
Catoctin Counseling Centers—2 sites  
Crossroads Center-Frederick  
Emergency Phys Assoc Pa  
Family Service Foundation, Inc.  
Frederick Counseling Center  
[Frederick County Health Dept: Community Mental Health Services—3 sites](#)  
Frederick Memorial Hospital Psychiatric Services  
Frederick Psych Medicine  
Gale House  
Institute For Family Centered Services – 2 sites  
Intervention Resources  
Maryland Counseling Centers, Inc.  
Maxim Healthcare Services Inc.  
Monocacy Counseling Center  
Mountain Manor Treatment Center  
MRB Counseling Services, Inc.  
Olsen House  
Safe Harbor and New Horizons at Mountain Manor  
Serenity Treatment Center, Inc.  
Sheppard Pratt Health Systems – Jefferson School

Villa Maria of Frederick County – Villa Maria Continuum  
Way Station, Inc.

## **Garrett County: 18**

[Aberdeen Vet Center \(US DVA\)](#)  
Bel Air Center for Addictions  
Craig E Abrahamson and Assoc Pa  
Family Therapy Services  
Garrett County Lighthouse Inc.  
[Garrett County Community Mental Health Svc](#)  
Garrett County Memorial Hospital  
Garrett County Center for Behavioral Health—4 sites  
Maryland Department of Juvenile Svcs – 2 programs  
Mental Hlth Ctr Of Western Md Inc.  
Mountain Top Mental Health Associates  
Key Point Health Services, Inc.  
Partners In Recovery  
Safe Sober Recovery, Inc.  
Skyeia Holistic Services  
Upper Bay Counseling Services  
Upper Chesapeake Health – Behavioral Health Services  
Villa Maria Harford County

## **Harford County: 25**

Alliance Inc.  
Associated Catholic Charities  
Community Behavioral Services Inc.  
Emmorton Treatment Services—2 sites  
Emmorton Psych  
Father Martin’s Ashley—2 sites  
[Harford County Mental Health Services](#)  
[Harford County Adol Substance Abuse Services/Juvenile Drug Court](#)  
[Harford County Drug Abuse Program](#)  
Harford Counseling, LLC  
Harford Memorial Hospital Behavioral Health  
Harford Primary Care LLC  
Homecoming Project, Inc.  
Joppa Health Services, Inc.  
Key Point Health Services  
Mann House, Inc.  
MATT Program  
Phoenix Recovery Center  
Safe Harbor Christian Counseling  
S&S Counseling Services  
Serenity Health LLC  
Sheppard Pratt Physicians PA  
Together Recovery Works Associates  
Turning Corners  
Upper Chesapeake Medical Center

## Howard County: 28

A Better Way Counseling Services  
Access Counseling Services  
Addiction Recovery Services of Columbia  
Alliance, Inc. Howard County Targeted Case Management Program  
Associated Mental Health Specialists  
Central MD Addiction Counseling, LLC  
Century Mental Health  
Chase Brexton Health Services – Columbia Center  
Columbia Addictions Center  
Congruent Counseling Services, LLC  
Counseling Resources, Inc.  
Greenspring Mental Health Services  
Halfway Home  
**Howard County Health Department—2 sites**  
Howard County General Hospital Behavioral Health  
Humanim Health Services LLC  
Integrative Counseling, LLC  
J.A.E.L Health Services, Inc.  
Johns Hopkins Emergency Medical Sys  
Kolmac Clinic  
Maryland Coalition of Family  
Msa The Child And Adolescent Center  
MPB Group, Inc. Outpatient Mental Health Clinic  
Sheppard Pratt - Ellicott City /Taylor Manor Hospital  
S&S Counseling Services  
Silverman Treatment Solutions  
The Starr Center  
Way Station, Inc.

## Kent County : 8

A.F. Whitsitt Center  
Chester River Behavioral Health, LLC  
Chester River Hospital  
Crossroads Community, Inc.  
For All Seasons, Inc.  
**Kent County Health Dept: Behavioral Health**  
Mid Shore Council on Family Violence  
Regional Mid Shore Mental Health Clinic

## Montgomery County: 72

Adventist Behavioral Health  
Adventist Physician Services  
Affiliated Community Counselors Inc.  
Affiliated Sante Group  
Alliance Mental Health  
Another Way, Inc.  
Avery Road Treatment Center- 3 programs  
Behavioral Healthcare Of MD  
Bethesda Mental Health  
Bilingual Counseling Center

Capital Counseling Services  
CBH Health, Inc.  
Chesapeake Counseling Assocs LLC  
Chestnut Lodge Hospital  
Child Center & Adult Svc, Inc.  
Circle Treatment Center  
Cognitive Therapy  
Community Connections Inc.  
Community Clinic Inc.  
Community Psychiatric Clinic  
Congressional Psychiatric Clinic  
Counseling Institute of Suburban MD  
Counseling Plus, Inc.  
D.A. Wynne & Associates, Inc.—2 sites  
Emergency Medicine Association—3 Sites  
Ephesians Life Ministries  
Family Health Center, Inc.  
Family Services Agency, Inc. – Montgomery Station  
Outpatient Mental Health Clinic  
Family Trauma Services Inc.  
Gambro Healthcare  
Holy Cross Hospital  
Institute For Family Centered Services—2 Sites  
Integrative Counseling  
Jewish Social Service Agency—2 Sites  
John L. Gildner Reg. Inst. For Children & Adolescents  
Journey to Self Understanding Outpatient Substance Abuse Program—2 sites  
Journeys Treatment Program – 2 programs  
Kensington Mental Health Associates  
KHI Services, Inc. Step Ahead Program  
Kolmac Clinic—2 sites  
Lawrence Court Halfway House  
Maryland Counseling Centers Inc.  
Maxim Healthcare Services Inc.  
Metro Counseling Services, Inc.  
**Montgomery County Dept of Health & Human Svs -2 Sites**  
Montgomery General Hospital Addiction & Mental Health Center  
Montgomery Recovery Service  
Mountain Manor Treatment Centers—2 Sites  
MRB Counseling Services, Inc.  
National Center for Children & Families – Future Bound Independent Living Program  
New Beginnings at Potomac Valley  
New Horizons Health Services  
OACES- Outpatient Alcohol Counseling and Education Services  
Potomac Ridge Behavioral Health  
Resources for Human Development Inc.  
Rock Creek Foundation  
Ryan Rehabilitation



## Montgomery County (continued)

Second Genesis OP Adolescent Program  
Shady Grove Adventist Hospital  
[Silver Spring Vet Center \(US DVA\)](#)  
St. Luke's House, Inc.  
Saint Luke Institute  
Suburban Hospital Behavioral Health  
Suburban Hospital Addiction Treatment Center  
The Reginald S. Lourie Center for Infants & Young Children—2 sites  
Thomas Comprehensive Counseling  
THR Mental Health  
Threshold Services, Inc. – 3 sites  
Vesta, Inc.  
Vocational Support Systems Inc.  
Washington Adventist Hospital Mental Health Services  
White Flint Recovery, Inc.

## Prince George's County: 80

AARS Insight Treatment Centers—2 sites  
A P Counseling Services Inc.  
Act II Counseling Services, Inc.  
Advance Health System Inc.  
Affiliated Sante Group  
Alcohol and Drug Recovery  
Aleks House Llc  
All Thats Therapeutiinc  
Allied Behavioral Services  
Another Spring Counseling Services  
Arms Reach Llc  
Arundel Lodge Inc.  
Baltimore Washington Institute  
CA Mayo & Associates, Inc.  
Care Connections Inc.  
CARE Consultants Treatment Center  
Center For Addiction And Pregnancy  
Center For Therapeutic Concepts Inc.  
Child And Family Home Based Program  
Clinton Family & Child Center  
Community Counseling & Mentoring Service  
Comprehensive Treatment Services, Inc.  
Contemporary Therapeutic Svc Inc.  
Crawford Conseling & Mental Health Services  
Doctors Community Hospital  
Dr Wadeson Psychiatric Center  
Edgemead Psych Rehab Services  
Essential Therapeutic Perspectives  
Family Behavioral Services LLC  
Family Health Center, Inc.  
Family Service Foundation, Inc.  
Family Trauma Services Inc

Fields and Fields Treatment Center  
Ft Washington Medical Center  
Guadenzia at Landover  
Gilead Quantum Health System, Inc.  
Laurel Regional Hospital Behavioral Health  
Independent Psychiatric Srvcs LLC  
Institute For Family Centered Services  
Institute of Life and Health  
Insight Treatment Service  
Institute for Life Enrichment  
Langley Park Youth and Family Counseling  
Laurel Beltsville Oasis  
Maryland Family Resource Inc  
Maxim Healthcare Services Inc  
Mentor Clinical Care  
Metropolitan Mental Health Clinic  
Morgan-Pfuhl Psych Services, LLC  
Mountain Manor Treatment Centers  
MRB Counseling Services, Inc.  
New Pathways Therapy Service, Inc.  
Next Level Community Services, LLC  
Pathfinder Project  
Prime Healthcare LLC  
[Prince George's County Addictions and Mental Health](#)  
[Prince George's County Dept of Corrections—Impact Program Phase I](#)  
[Prince George's County Government Department of Corrections A- Impact Program Phase II](#)  
[Prince George's County Health Department—3 sites](#)  
Prince Georges Hospital Center  
Progressive Therapeutic Srvcs Llc  
PRS Day Program  
Psychotherapeutic Rehabilitation Services, Inc.  
Psychotherapeutic Services of Southern Md  
Reality, Inc – 2 programs  
Recovery Network  
Reflections Clinical Counseling, LLC  
Renaissance Treatment Center  
Resolutions Rehabilitation  
Rims Center for Enrichment And Develop LLC  
Safe Journey House  
Second Genesis, Inc  
Southern Maryland Hospital Center Behavioral Health Services  
Stepping Stone Treatment Program  
University of Maryland University Health Center  
Vesta, Inc  
Village Family Network  
Washington Assessment and Therapy Service  
We Care Health Services, Inc.  
Young Women's Facility of MD at Waxter Center

## Queen Anne's County: 19

American Red Cross  
Anne Arundel Counseling Inc.  
Certified Counseling Services of Centreville  
Crossroads Community, Inc  
Delmarva Family Resources  
Families First  
Family Resource Center  
Family Support Center  
For All Seasons, Inc.  
Judy Center  
Kent Island Alcohol & Drug Abuse Counseling Center  
Lower Shore Clinic  
Nielson Center  
Mid Shore Council on Family Violence  
**Queen Anne's County Health  
Department/Department of Social Services  
Queen Anne's County Dept of Health: Alcohol and  
Drug Abuse Services—2 sites**  
Queen Anne's County Kent Island Counseling Center  
Regional Midshore Mental Health Clinic  
Salvation Army

## St. Mary's County: 14

Anchor of Walden  
Alternatives For Youth And Families  
Center For Children Inc  
Certified Counseling Services, Inc.  
Compass of Walden Sierra  
Counseling Services of Hollywood  
Marcey Halfway House  
Pathways  
PSSM Inc. Clinic Program  
Psychotherapeutic Services of So Maryland  
[Southern Maryland VA Outpatient Clinic – Charlotte  
Hall](#)  
St. Mary's Hospital of St Mary's County--Psychiatric  
Unit  
Walden Jail-based and Outpt Treatment Program—2  
sites  
Walden Sierra, Inc. Outpatient Treatment Program

## Somerset County: 10

Center 4 Clean Start  
Eastern Shore Psychological Serv  
Edward Mccready Memorial  
Go Getters, Inc.  
HANDS  
House Next Door- Hudson Health Services  
Insights Counseling Services  
Maple Shade Mental Health Clinic—2 sites

**Somerset County Behavioral Health- 4 sites**  
Three Lower Counties Community Services, Inc.

## Talbot County: 20

Bay Health Center  
Channel Marker, Inc.  
Choptank Community Health System  
Delmarva Family Resources  
Dorchester General Hospital Inc  
Eastern Shore Psychological Services  
For All Seasons, Inc.  
Labcorp A Easton Md  
Lcs Latino Counseling Services  
Maple Shade Youth & Family Services  
Mid Shore Mental Health Services (CSA)  
Mid-Shore Council on Family Violence  
Mentor Clinical Care  
Mental Health Association  
Neighborhood Service Center  
Regional Midshore Mental Health Cli  
Suicide Survivors Support Group – Talbot Hospice  
House  
Shore Behavioral Health Services  
Shore Health System Memorial Hospital  
Talbot County Addictions Program—2 sites

## Washington County: 29

Alternative Drug and Alcohol Counseling (ADAC)  
Arc of Washington Co  
Associated Catholic Charities  
Behavioral Health Services Of Wchs  
Brook Lane Health Services  
CAMEO House  
Catocin Counseling Center- 2 programs  
Guadenzia, Inc. in Hagerstown  
Hagerstown Therapy Center  
Hagerstown Treatment Center  
[Hagerstown VA Outpatient Clinic](#)  
Jail Substance Abuse Treatment Program  
Mental Hlth Ctr Of Western Md I  
Mid Maryland Medical Transport LLC  
MRB Counseling Services, Inc.  
Potomac Case Management Svcs  
Quality Care Internet Llp  
San Mar Childrens Home, Inc. / Jack E. Barr  
Therapeutic Group Home  
Safe Haven Counseling Center  
The Mental Health Center of Western Maryland, Inc.  
The W House Foundation, Inc.  
Villa Maria OMHC – Hagerstown  
Walnut Street Community Hlth Ctr



## **Washington County (continued)**

Washington County Hospital Association  
Washington Co Health Department  
Way Station Inc  
Wells House East and North – 2 sites  
Women in Treatment Services (WITS)

## **Wicomico County: 28**

Addictions Associates  
Catholic Charities, Inc.  
Center 4 Clean Start  
Children's Choice Inc  
Counseling Associates, Inc.  
Delmarva Counseling Center  
Delmarva Family Resources  
Dove Pointe Inc  
Eastern Shore Psychological Services  
Family Service Foundation Inc  
Go Getters, Inc.  
Homeless Addicts Never Denied Services (HANDS)  
Hudson Health Services – 3 sites  
Lower Shore Clinic  
Maple Shade Youth & Family Services, Inc.  
Maxim Healthcare Services Inc  
Peninsula Addictions Services  
Peninsula General  
Peninsula Regional Medical Center Behavioral Health  
Peninsula Mental Health Services  
Second Wind, Inc.  
Wicomico Behavioral Health Clinic  
Warwick Manor Behavioral Health  
[Wicomico County Core Service Agency](#)  
[Wicomico County Health Department Behavioral Health Services](#)  
[Wicomico County Health Department Addictions Services](#)  
White Flint Recovery  
[Worcester County Health Dept in Salisbury](#)

## **Worcester County: 13**

Atlantic General Hospital  
Center 4 Clean Start  
Counseling Associates, Gateway Behavioral Health Division  
Go-Getters Inc.  
HANDS  
House Next Door – Hudson Health Services  
[Pocomoke City VA Outpatient Clinic](#)  
White Flint Recovery Eastern Shore  
[Worcester County Health Department/Department of Social Services](#)  
[Worcester County Mental Health Department](#)  
[Worcester County Alcohol and Other Drugs Program](#)  
[Worcester County Health Dept – 5 sites](#)  
Worcester Youth And Family Counseling Service

**Data on Violent Deaths Among Veterans - Years 2004 - 2008 combined**

-- Provided by George Thorpe, Maryland Department of Health & Mental Hygiene

**Homicide:** Age distribution of Veteran & Non-Veteran victims\*

<u>Age</u>	<u>Veteran</u>		<u>Non-Veteran</u>		<u>Total Freq</u>
	<u>Frequency</u>	<u>Row %</u>	<u>Frequency</u>	<u>Row %</u>	
18-19	2	1.00%	198	99.00%	200
20-24	9	1.50%	593	98.50%	602
25-29	11	2.50%	429	97.50%	440
30-34	10	3.58%	269	96.42%	279
35-39	13	5.73%	214	94.27%	227
40-44	9	5.20%	164	94.80%	173
45-49	22	15.94%	116	84.06%	138
50-54	14	15.05%	79	84.95%	93
55-59	14	27.45%	37	72.55%	51
60-64	6	26.08%	17	73.92%	23
65+	17	30.91%	38	69.09%	55
Age Unknown		0.00%	2	100.00%	2
<b>Grand Total</b>	<b>127</b>	<b>5.56%</b>	<b>2156</b>	<b>94.44%</b>	<b>2283</b>

\*Table contains only those Homicide victims aged 18 and older for whom the Veteran Status was known. 56 Homicide Victims (2.39% of all 2339 victims 18 or older) were not included in the table because Vet status not known.

~~~~~

**Suicide:** Age distribution of Veteran & Non-Veteran victims\*\*

| <u>Age</u>         | <u>Veteran</u>   |               | <u>Non-Veteran</u> |               | <u>Total Freq</u> |
|--------------------|------------------|---------------|--------------------|---------------|-------------------|
|                    | <u>Frequency</u> | <u>Row %</u>  | <u>Frequency</u>   | <u>Row %</u>  |                   |
| 18-19              | 2                | 3.78%         | 51                 | 96.22%        | 53                |
| 20-24              | 17               | 8.95%         | 173                | 91.05%        | 190               |
| 25-29              | 16               | 9.36%         | 155                | 90.64%        | 171               |
| 30-34              | 17               | 9.94%         | 154                | 90.06%        | 171               |
| 35-39              | 23               | 11.67%        | 174                | 88.33%        | 197               |
| 40-44              | 38               | 13.87%        | 236                | 86.13%        | 274               |
| 45-49              | 36               | 14.12%        | 219                | 85.88%        | 255               |
| 50-54              | 42               | 17.80%        | 194                | 82.20%        | 236               |
| 55-59              | 48               | 29.27%        | 116                | 70.73%        | 164               |
| 60-64              | 45               | 34.35%        | 86                 | 65.65%        | 131               |
| 65+                | 207              | 53.08%        | 183                | 46.92%        | 390               |
| <b>Grand Total</b> | <b>491</b>       | <b>22.00%</b> | <b>1741</b>        | <b>78.00%</b> | <b>2232</b>       |

\*\*Table contains only those Suicide victims aged 18 and older for whom the Veteran Status was known. 54 Suicide Victims (2.36% of all 2286 victims 18 or older) were not included in the table because Vet status not known.

**Homicide:** Gender distribution(s) of Veteran & Non-Veteran victims\*\*\*

| <u>Gender</u>      | <u>Frequency</u> | <u>Row %</u> | <u>Frequency</u> | <u>Row %</u>  |             |
|--------------------|------------------|--------------|------------------|---------------|-------------|
| Female             | 7                | 2.25%        | 304              | 97.75%        | 311         |
| Male               | 120              | 6.08%        | 1852             | 93.92%        | 1972        |
| <b>Grand Total</b> | <b>127</b>       | <b>5.56%</b> | <b>2156</b>      | <b>94.44%</b> | <b>2283</b> |

|                    | Veteran          |              | Non-Veteran      |              | Total Freq  |
|--------------------|------------------|--------------|------------------|--------------|-------------|
| <u>Gender</u>      | <u>Frequency</u> | <u>Col %</u> | <u>Frequency</u> | <u>Col %</u> |             |
| Female             | 7                | 5.51%        | 304              | 14.10%       | 311         |
| Male               | 120              | 94.49%       | 1852             | 85.90%       | 1972        |
| <b>Grand Total</b> | <b>127</b>       | <b>100%</b>  | <b>2156</b>      | <b>100%</b>  | <b>2283</b> |

\*\*\*Tables contain only those Homicide victims aged 18 and older for whom the Veteran Status was known. 56 Homicide Victims (2.39% of all 2339 victims 18 or older) were not included in the table because Vet status not known.

~~~~~

**Suicide:** Gender distribution(s) of Veteran & Non-Veteran victims\*\*\*\*

	Veteran		Non-Veteran		Total Freq
<u>Gender</u>	<u>Frequency</u>	<u>Row %</u>	<u>Frequency</u>	<u>Row %</u>	
Female	16	3.64%	423	96.36%	439
Male	475	26.49%	1318	73.51%	1793
<b>Grand Total</b>	<b>491</b>	<b>22.00%</b>	<b>1741</b>	<b>78.00%</b>	<b>2232</b>

	Veteran		Non-Veteran		Total Freq
<u>Gender</u>	<u>Frequency</u>	<u>Col %</u>	<u>Frequency</u>	<u>Col %</u>	
Female	16	3.26%	423	24.30%	439
Male	475	96.74%	1318	75.70%	1793
<b>Grand Total</b>	<b>491</b>	<b>100%</b>	<b>1741</b>	<b>100%</b>	<b>2232</b>

\*\*\*\*Table contains only those Suicide victims aged 18 and older for whom the Veteran Status was known. 54 Suicide Victims (2.36% of all 2286 victims 18 or older) were not included in the table because Vet status not known.

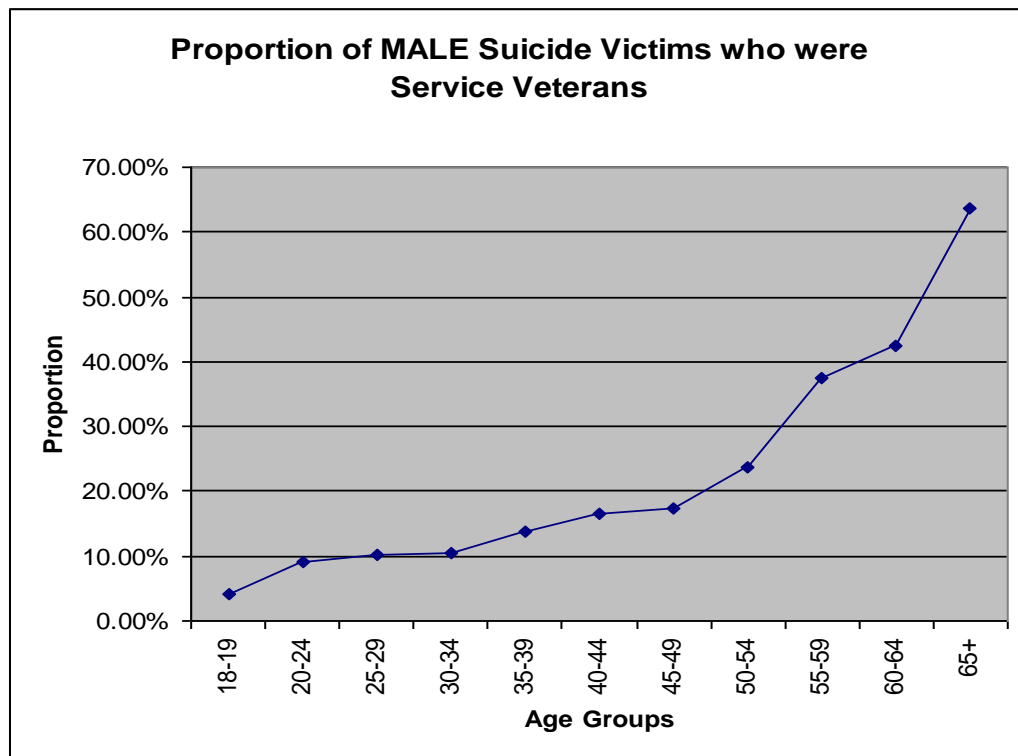
~~~~~

**Special Case of Male Suicide Victims\*\*\*\*\***

Proportion of Male Suicide Victims, 18 and over, who were Veterans... by age group: Five years 2004-2008

| <u>Age Group</u>   | <b>Veteran</b>   |               | <b>Non-Veteran</b> |               | <b>Total Freq</b> |
|--------------------|------------------|---------------|--------------------|---------------|-------------------|
|                    | <u>Frequency</u> | <u>Row %</u>  | <u>Frequency</u>   | <u>Row %</u>  |                   |
| 18-19              | 2                | 4.17%         | 46                 | 95.83%        | 48                |
| 20-24              | 15               | 9.15%         | 149                | 90.85%        | 164               |
| 25-29              | 15               | 10.07%        | 134                | 89.93%        | 149               |
| 30-34              | 15               | 10.42%        | 129                | 89.58%        | 144               |
| 35-39              | 21               | 13.72%        | 132                | 86.28%        | 153               |
| 40-44              | 35               | 16.67%        | 175                | 83.33%        | 210               |
| 45-49              | 34               | 17.35%        | 162                | 82.65%        | 196               |
| 50-54              | 42               | 23.73%        | 135                | 76.27%        | 177               |
| 55-59              | 47               | 37.59%        | 78                 | 62.41%        | 125               |
| 60-64              | 45               | 42.46%        | 61                 | 57.54%        | 106               |
| 65+                | 204              | 63.55%        | 117                | 36.45%        | 321               |
| <b>Grand Total</b> | <b>475</b>       | <b>26.49%</b> | <b>1318</b>        | <b>73.51%</b> | <b>1793</b>       |

\*\*\*\*\*Table contains only those MALE Suicide victims aged 18 and older for whom the Veteran Status was known. 49 Suicide Victims (2.66% of all 1842 male victims 18 or older) were not included in the table because Vet status not known.



**Annual totals for Homicide #**

| <u>Data Year</u>   | Veteran          |              | Non-Veteran      |               | Total Freq  |
|--------------------|------------------|--------------|------------------|---------------|-------------|
|                    | <u>Frequency</u> | <u>Row %</u> | <u>Frequency</u> | <u>Row %</u>  |             |
| 2004               | 22               | 5.38%        | 387              | 94.62%        | 409         |
| 2005               | 29               | 5.87%        | 465              | 94.13%        | 494         |
| 2006               | 41               | 8.49%        | 442              | 91.51%        | 483         |
| 2007               | 18               | 3.97%        | 435              | 96.03%        | 453         |
| 2008               | 17               | 3.83%        | 427              | 96.17%        | 444         |
| <b>Grand Total</b> | <b>127</b>       | <b>5.56%</b> | <b>2156</b>      | <b>94.44%</b> | <b>2283</b> |

#Table contains only those Homicide victims aged 18 and older for whom the Veteran Status was known. 56 Homicide Victims (2.39% of all 2339 victims 18 or older) were not included in the table because Vet status not known.

~~~~~

**Annual totals for Suicide ##**

<u>Data Year</u>	Veteran		Non-Veteran		Total Freq
	<u>Frequency</u>	<u>Row %</u>	<u>Frequency</u>	<u>Row %</u>	
2004	98	22.07%	346	77.93%	444
2005	107	25.18%	318	74.82%	425
2006	93	20.22%	367	79.78%	460
2007	100	21.98%	355	78.02%	455
2008	93	20.76%	355	79.24%	448
<b>Grand Total</b>	<b>491</b>	<b>22.00%</b>	<b>1741</b>	<b>78.00%</b>	<b>2232</b>

##Table contains only those Suicide victims aged 18 and older for whom the Veteran Status was known. 54 Suicide Victims (2.36% of all 2286 victims 18 or older) were not included in the table because Vet status not known.

## 9. REFERENCES AND RESOURCES

1. **Defense Centers of Excellence (DCoE): *InTransition*** telephonic coaching program available worldwide. DCoE provides *inTransition*, a voluntary program to assist service members moving between health care systems or providers while receiving behavioral health care. The purpose of the program is to provide continuity of care for service members who are transitioning – separating from the military, relocating or returning to civilian life. With the assistance of a transition support coach, the service member is provided with guidance, resources and tools in order to empower them to make healthy life choices during their transition.  
<http://www.dcoe.health.mil/blog/article.aspx?ID=1&postID=180>.
2. **National Council for Community Behavioral Healthcare, Policy Action Center.** Veterans are a specific policy topic on this website. Good source of info for Federal grant info/deadlines, legislation passed or pending relating to Veterans issues, repository for language of federal bills relating to Vets. Also link to state policy focus page -- **States Respond to Veterans' Call: Overview of Veterans Behavioral Healthcare Legislation in 2007.**  
<http://www.thenationalcouncil.org/cs/veterans>
3. **US Senate Committee on Veterans' Affairs.** Hearing transcript re the Department of Veterans Affairs response to the mental health needs of America's Veterans.  
[http://veterans.senate.gov/hearings.cfm?action=release.display&release\\_id=0608c8d9-d3ca-437c-912c-743b8ad9d2bd](http://veterans.senate.gov/hearings.cfm?action=release.display&release_id=0608c8d9-d3ca-437c-912c-743b8ad9d2bd).
4. **US Department of Veterans Affairs: VISN 5 MIRECC** supports and facilitates research, educational programs, and clinical demonstration projects in the key areas of scientific interest, including: substance abuse, psychopharmacology, neurocognitive factors in rehabilitation, health behaviors and medical comorbidity, recovery-oriented and family services, and service delivery systems. Given the breadth of expertise on schizophrenia in their system, they will also support projects on other topics that are consistent with their mission, including work with families of Veterans with schizophrenia and on homelessness.  
<http://www.mirecc.va.gov/visn5/about.asp>.
5. **Vermont Vet-to-Vet:** The importance of Vermont Vet-to-Vet peer support is that these Veterans will trust and talk to a fellow Veteran in most cases before they will a psychiatrist, psychologist, social worker, or VA doctor. Peers offer each other an understanding that comes from having experienced a similar situation or problem. <http://vtvettovet.org/>.
6. **Montgomery College Combat to College (C2C)** program website: referenced in this report.  
<http://cms.montgomerycollege.edu/edu/tertiary1.aspx?urlid=53>
7. **Substance Abuse and Mental Health Services Administration (SAMHSA)** website / DASIS report 1995-2000: data pertaining to veterans in treatment.  
<http://www.oas.samhsa.gov/2k3/VetsTX/VetsTX.htm>.
8. **United States Veterans Initiative** – D.C. offers 39 units of single room occupancy permanent housing in a clean and sober therapeutic community context; partners with The Community Partnership for the Prevention of Homelessness, the Washington D.C. Veterans Affairs Medical Center, and the Fareshare program, as well as many other local partners to provide care and services to veterans. [www.usvetsinc.org](http://www.usvetsinc.org).

9. **“VA Case Managers Must Help Caregivers.”** A revealing new survey sheds light on thousands of people caring for severely disabled veterans. 77 percent say they have no life of their own; 72 percent feel isolated; 63 percent suffer from depression.  
<http://www.airforcetimes.com/community/opinion/military-editorial-va-case-managers-must-help-caregivers-112910w/>
10. **TX Mental Health Transformation** website. Effort supported TexVet.  
<http://www.mhtransformation.org/>
11. **TexVet: Partners Across Texas** website. This collaborative effort of federal, state, and local organizations focuses on bringing military members and those that care about them a wealth of resources, including information about behavioral health issues. [www.texvet.com](http://www.texvet.com).
12. State of **Maryland Task Force to Study State Assistance to Veterans 2008**- document.  
<http://mlsd.sirsi.net/uhtbin/cgiirsi/IQvPa5tdjO/x/79620042/8/64886/Task+Force+to+Study+State+Assistance+to+Veterans.+Maryland>.
13. **Tri County Council for Southern Maryland Final Report** (June 2009) Veterans Integrated Healthcare Recommendations. <http://www.tccsmd.org/downloads/VACFinal-2FDrive.pdf>.
14. Miami Herald article--The program, called **“Florida Vets Connect”** relies on existing resources to alert veterans to the programs available to them through state and federal programs. Veterans who identify their veteran status when renewing their driver licenses or applying for an ID card will be contacted by the Department of Veteran's Affairs.  
<http://www.miamiherald.com/2010/11/10/1919639/state-look-to-contact-veterans.html>.
15. NY Times article July 2009: contains **Behavioral Health statistics for returning veterans**; A new study has found that more than one-third of Iraq and Afghanistan war veterans who enrolled in the veterans' health system after 2001 received a diagnosis of a mental health problem, most often post-traumatic stress disorder or depression.  
[http://www.nytimes.com/2009/07/17/health/views/17vets.html?\\_r=1](http://www.nytimes.com/2009/07/17/health/views/17vets.html?_r=1).
16. Science Daily Sept 2010 article about **returning women veterans having more problems than men**. <http://www.sciencedaily.com/releases/2010/09/100920081330.htm>.
17. Senate Bill 65, State of MD, **Maryland Veterans Trust Fund** – Income Tax Check off Jan 2010.  
<http://mlis.state.md.us/2010rs/bills/sb/sb0065f.pdf>.
18. FedBizOpps.gov. Feb 2010 **VA solicitation for the acquisition of rural mental health services** within targeted areas of VISNs 1, 19 and 20 , for eligible OEF/OIF Veterans who are enrolled in the Veterans Health Administration and who reside in rural areas and do not have ready access to mental health services through VA Medical Centers and Clinics, or Vet Centers.  
[https://www.fbo.gov/index?s=opportunity&mode=form&tab=core&id=3ee37482cef510a14fe00486823a78d3&\\_cvview=0](https://www.fbo.gov/index?s=opportunity&mode=form&tab=core&id=3ee37482cef510a14fe00486823a78d3&_cvview=0).
19. Institute of Medicine website: **Qualifications of Professionals Providing Mental Health Counseling Services under TRICARE**.  
<http://www.iom.edu/Activities/MentalHealth/TRICAREMentalHealth.aspx>.
20. RAND.org website. Veterans Health newsletter, January 2009 Highlights: **Predicting Demand for Veterans' Health Care: An Assessment of the VA's Forecasting Tools**  
<http://www.rand.org/congress/veterans.html>
21. RAND.org report: **Recent Trends in Veteran Unemployment as Measured in the Current Population Survey and the American Community Survey**.  
[http://www.rand.org/pubs/technical\\_reports/2008/RAND\\_TR485.pdf](http://www.rand.org/pubs/technical_reports/2008/RAND_TR485.pdf)
22. Science Daily report **“PTSD Associated with Dementia in Older Veterans”** "The finding that PTSD is associated with a near doubling of the risk of dementia has important public health, policy and biological implications," the authors conclude.  
<http://www.sciencedaily.com/releases/2010/06/100607165623.htm>

23. ScienceDaily report about **PTSD being associated with heart disease and death**.  
<http://www.sciencedaily.com/releases/2010/11/101117104448.htm>
24. ScienceDaily report about **PTSD may increase heart disease risk in older men**.  
<http://www.sciencedaily.com/releases/2007/01/070102092240.htm>.
25. ScienceDaily report about **PTSD being primary suicide risk factor** for veterans.  
<http://www.sciencedaily.com/releases/2009/08/090825151341.htm>
26. ScienceDaily follow-up article about **dementia/PTSD**.  
<http://www.sciencedaily.com/releases/2010/08/100831073805.htm>
27. Article about **Veterans being moved off Medicaid / PARIS program in Washington State**. WA State saved more than \$16.2 million since the project went statewide in 2003. It has transferred about 4,400 veterans and their dependents from Medicaid to VA or U.S. DOD care. Veterans also receive better benefits from the VA than Medicaid — and in many instances, they are not even aware they qualify for such care.  
<http://www.stateline.org/live/details/story?contentId=376237>.
28. Article about **“Healing Ajax” program that relies mostly on veterans to guide returning soldiers who are struggling with mental health issues**. This peer-to-peer approach creates a basis of trust; funding for Healing Ajax currently comes from a social service provider called Resources for Human Development. The program is available in the Philadelphia region, and is being expanded throughout the country. <http://why.org/cms/news/health-science/behavioral-health-health-science/2009/11/30/program-aims-to-reach-vets-seeking-mental-health-treatments/24174>.
29. **Veterans Court in Philadelphia** as reported by “Pavement Pieces” online newspaper, Dec 2010: Veterans court is a type of treatment court that caters specifically to the unique needs of justice-involved veterans. Like other treatment courts the goal of Veterans Court is to have the records of the veterans expunged, to help them move past their substance abuse or emotional problems. The program, which is about a year old, is a joint effort between the municipal court, the district attorney’s office, the public defender and the Philadelphia Veterans Affairs Medical Center. <http://pavementpieces.com/philadelphia-life-veterans-court-gives-a-second-chance-to-vets/>.
30. **New York State Health Foundation website: The NYS Health Initiative for Returning Veterans and Their Families** seeks to underscore that the health and mental health issues returning veterans and their families face are not solely military issues, but public and community health issues that should be addressed by local and national government agencies, community-based organizations, and health funders.  
[http://www.nyshealthfoundation.org/section/priority\\_areas/integrating\\_mental\\_health\\_substance\\_use\\_services/nyshealth\\_initiative\\_for\\_returning\\_veterans\\_and\\_their\\_families](http://www.nyshealthfoundation.org/section/priority_areas/integrating_mental_health_substance_use_services/nyshealth_initiative_for_returning_veterans_and_their_families).
31. **New Jersey Governor’s Council on Mental Health Stigma** website: info for Veterans, BHS providers, etc. <http://www.state.nj.us/mhstigmacouncil/community/military/>.
32. **Newswise** article about a team of researchers at Mount Sinai School of Medicine that has developed the first **web-based screening tool for Traumatic Brain Injury (TBI)**.  
<http://www.newswise.com/articles/mount-sinai-develops-first-screening-tool-for-war-veterans-to-assess-traumatic-brain-injury>.
33. **Army Times** article: **349 service members committed suicide in 2009**, more than the combined 259 combat deaths in Afghanistan and 76 in Iraq, thus four lawmakers have formed a congressional caucus called Invisible Wounds to push for improvements in military and veterans mental health services.  
[http://www.armytimes.com/news/2010/01/military\\_invisible\\_wounds\\_caucus\\_012110w/](http://www.armytimes.com/news/2010/01/military_invisible_wounds_caucus_012110w/)



34. **Maryland Vital Statistics Annual Report 2009:** 246 pages.  
<http://vsa.maryland.gov/doc/09annual.pdf>
35. **US Department of Veterans Affairs website, mental health** home page.  
<http://www.mentalhealth.va.gov/>.
36. **Widener University website: Military and Veteran Behavioral Health Post-Master's Certificate Program** that teaches best clinical practices to mental health professionals who are addressing the behavioral health needs of military personnel, veterans and their families.  
<http://www.widenerconferences.com/MVBH/>.
37. MD State Dept of Education website: **military support websites are posted on a “programs” page.** <http://www.marylandpublicschools.org/MSDE/programs/brac/military>.
38. My Army Benefits website: The State of **Maryland offers special benefits for its military service members and veterans** including retired military pay exemptions, education and tuition assistance, employment services, special military vehicle tags, as well as hunting and fishing license privileges.  
[http://myarmybenefits.us.army.mil/Home/Benefit\\_Library/State\\_Territory\\_Benefits/Maryland.html](http://myarmybenefits.us.army.mil/Home/Benefit_Library/State_Territory_Benefits/Maryland.html).
39. **National Resource Directory** website : Maryland page contains lots of resource/referral info for military service members/families. BHS info is behind the “health” tab.  
<http://www.nationalresourcedirectory.gov/state/maryland>.
40. **State of Maryland** website; **population data** with 2010, 2020, 2030 projections.  
<http://www.msa.md.gov/msa/mdmanual/01glance/html/pop.html>
41. **Maryland Department of Veterans Affairs** website: VBHAB description, meeting minutes/member info. <http://www.mdva.state.md.us/VBHAB/board.html>.
42. **Maryland Mental Health Transformation State Incentive Grant-Comprehensive Mental Health Plan** Year 4 Update (2009). <http://www.dhmfh.maryland.gov/mt/pdfs/Reference%20-%20Departmental%20-%20September%202009%20Comprehensive%20Mental%20Health%20Plan.pdf>.
43. **Maryland Department of Planning** website/ MD state data center (2010-2040 projections page) [http://www.mdp.state.md.us/msdc/S3\\_Projection.shtml](http://www.mdp.state.md.us/msdc/S3_Projection.shtml).
44. Michie’s Legal Resources website: contains **Maryland Code and Rules.**  
<http://michie.lexisnexis.com/maryland/lpext.dll?f=templates&fn=main-h.htm&cp>
45. ScienceDaily Article: Sept 09: **Iraq Troops' PTSD Rate As High As 35 Percent.**  
<http://www.sciencedaily.com/releases/2009/09/090914151629.htm>
46. Report: “A Second Progress Report on A New Way Home for Veterans Experiencing Homelessness in New York City” - **Joint NYC-VA Task Force.** November 2009.  
[http://www.nyc.gov/html/dhs/downloads/pdf/vets\\_ProgReport2009.pdf](http://www.nyc.gov/html/dhs/downloads/pdf/vets_ProgReport2009.pdf).
47. **Ohio Cares.gov** website: a collaboration of state and local agencies supporting the behavioral health of returning OIF/OEF veterans and their families. Although the VA is the primary source of services for veterans, this partnership **identifies community based resources also available to veterans and their families.** <http://www.ohiocares.ohio.gov/index.htm>.
48. **Maryland HB 1475** Dept of Legislative Service, Fiscal and Policy Note regarding expansion of MD Veterans Behavioral Health to all veterans.  
[http://mlis.state.md.us/2009rs/fnotes/bil\\_0005/hb1475.pdf](http://mlis.state.md.us/2009rs/fnotes/bil_0005/hb1475.pdf).

49. **Caregivers of Veterans - Serving on the Home Front**, Report of Study Findings. The three-part study provides information for policymakers, the VA, community agencies, non-profit organizations, and business and industry to better target programs to the needs of this special group of caregivers who are caring for those who have sacrificed so much for our country. November 2010. [http://www.caregiving.org/data/2010\\_Caregivers\\_of\\_Veterans\\_FULLREPORT\\_WEB\\_FINAL.pdf](http://www.caregiving.org/data/2010_Caregivers_of_Veterans_FULLREPORT_WEB_FINAL.pdf).
50. Copy of House Bill 1561: **Maryland Veterans Trust Fund**. <http://mlis.state.md.us/2009rs/bills/hb/hb1561t.pdf>.
51. Maryland State Archives - Organizational page for **Maryland Department of Health and Mental Hygiene**. <http://www.msa.md.gov/msa/mdmanual/16dhmh/html/dhmf.html>.
52. “**Health Behavior: Emerging Research Perspectives**” book by David Gochman, 1988. [http://books.google.com/books?id=6bkgqiot7Q0C&printsec=frontcover&dq=david+gochman+health+behavior&source=bl&ots=xNbg\\_nWJaY&sig=A5RGs2uBuPJ7jWVgIFvR5J6zuDg&hl=en&ei=AiAxTdeYLI\\_pgAfglZGCCw&sa=X&oi=book\\_result&ct=result&resnum=1&ved=0CBgQ6AEwAA#v=onepage&q&f=false](http://books.google.com/books?id=6bkgqiot7Q0C&printsec=frontcover&dq=david+gochman+health+behavior&source=bl&ots=xNbg_nWJaY&sig=A5RGs2uBuPJ7jWVgIFvR5J6zuDg&hl=en&ei=AiAxTdeYLI_pgAfglZGCCw&sa=X&oi=book_result&ct=result&resnum=1&ved=0CBgQ6AEwAA#v=onepage&q&f=false).
53. Florida State University website: a **\$17 million federal grant has been awarded to FSU and the Denver Veterans Affairs Medical Center** to establish the Military Suicide Research Consortium. The consortium is the first of its kind to integrate DOD and civilian efforts in implementing a multidisciplinary research approach to suicide prevention (10/2010) <http://www.fsu.com/Featured-Stories/Florida-State-to-help-military-wage-war-on-suicide>.
54. ScienceDaily report: Oct 2010: The trauma from hard combat can devastate veterans until old age, even as it influences others to be wiser, gentler and more accepting in their twilight years, a new **University of Florida study** finds. <http://www.sciencedaily.com/releases/2010/10/101006120138.htm>.
55. **Rehabbing with the Troops (RWTT)** is the newest program of Pro vs. GI Joe, the non-profit organization that connects American troops all over the world with their favorite professional athletes and celebrities through live video game competitions and webcams. In partnership with the Wounded Warrior Project and the USO, and sponsored by Armed Forces Insurance. <http://www.facebook.com/pages/Rehabbing-with-the-Troops-Wounded-Warrior-Arena/119227758111657?v=info>.
56. Data.gov website: current population survey, veterans supplement, containing information on **service-connected disability, compensation for the disability**, the effect of the disability on the person's labor force status, and participation in veterans' programs. <http://www.data.gov/tools/2170>.
57. **DAV (Disabled American Veterans) Department of Maryland** website: not quite current but full of links to other vet resources/websites. <http://www.davmembersportal.org/md/default.aspx>.
58. **Pennsylvania Department of Military and Veterans Affairs website**: this site provides veterans and their families with information on behavioral health resources with the goal of assisting Veterans and their families maintain healthy mental and emotional health. <http://www.milvet.state.pa.us/DMVA/801.htm>.

59. **VHA-Community Based Outpatient Clinics**, Jan 2010. This report provides an overview of VA's rationale in establishing CBOCs, describes how they are managed and administered, discusses medical services provided at CBOCs, and summarizes what is known about the quality and cost of providing care in CBOCs compared to primary care clinics at VA Medical Centers.  
[http://docs.google.com/viewer?a=v&q=cache:m0c\\_AxPLW0UJ:assets.opencrs.com/rpts/R41044\\_20100128.pdf+veterans+policy+issues+1995&hl=en&gl=us&pid=bl&srcid=ADGEESjh5A6GtQPjSUT6io\\_NLmPrqcQ9q6YJz679wv7ri0hvLv42iuQqf1tKXr-IMgvEzkwSY9QJNBnRjdLsekUI8-urO\\_0elByoDhzLLr\\_OY5UY2gS4yJXoTgL2dulGw5Ls8QSZkrwj&sig=AHIEtbRGLvY0MWTtUi6kMXFiQShtd9MsEA](http://docs.google.com/viewer?a=v&q=cache:m0c_AxPLW0UJ:assets.opencrs.com/rpts/R41044_20100128.pdf+veterans+policy+issues+1995&hl=en&gl=us&pid=bl&srcid=ADGEESjh5A6GtQPjSUT6io_NLmPrqcQ9q6YJz679wv7ri0hvLv42iuQqf1tKXr-IMgvEzkwSY9QJNBnRjdLsekUI8-urO_0elByoDhzLLr_OY5UY2gS4yJXoTgL2dulGw5Ls8QSZkrwj&sig=AHIEtbRGLvY0MWTtUi6kMXFiQShtd9MsEA).
60. Colorado Criminal Lawyer Blog: Veteran's "Mental Health" Courts Show the Proper Compassion and Understanding July 2010. **Veterans' courts follow the drug court model** - instead of jail, the defendant is diverted to mental health treatment. <http://www.colorado-criminal-lawyer-online.com/mental-health-issues-in-crimin/>.
61. ScienceDaily article: Aug 2010. **Combat Veterans Face More Lifelong Socioeconomic Challenges**, Sociologist Finds.  
<http://www.sciencedaily.com/releases/2010/08/100802141909.htm>.
62. BrynMawr: **Internet Resources for Human Services Professionals Working with Military and Veterans Issues**, prepared by: James (Jim) A. Martin, Ph.D., BCD.  
<http://serendip.brynmawr.edu/exchange/martin08>.
63. MD Bill Info House Bill 639: **Task Force on Military Service** Members, Veterans, and the Courts; requires the Task Force to study specified military service-related mental health issues and substance abuse problems and to make recommendations concerning the establishment of a special court for defendants who are military members or veterans.  
<http://mlis.state.md.us/2010rs/billfile/Hb0639.htm>.
64. **Americas Heroes at Work** website: contains a toolkit designed to assist and educate employers who have made the proactive decision to include transitioning Service Members, Veterans and wounded warriors in their recruitment and hiring initiatives.  
<http://www.americasheroesatwork.gov/forEmployers/HiringToolkit>.
65. Army website: **Army Health Promotion, Risk Reduction and Suicide Prevention Report, 2010**. This report is intended to inform and educate Army leaders on the importance of recognizing and reducing high risk behavior related to suicide and accidental death, and reducing the stigma associated with behavioral health and treatment. <http://www.army.mil/news/2010/07/28/42934-army-health-promotion-risk-reduction-and-suicide-prevention-report/index.html.US>.
66. VA website: Report from the Office of Inspector General entitled "Healthcare Inspection: **Access to VA Mental Health Care for Montana Veterans**". <http://www.va.gov/oig/54/reports/VAOIG-08-00069-102.pdf>.
67. **Rural Policy Research Institute** website (RUPRI): The state demographic and economic profile series presents up to date demographic and economic data for each state by county, with special focus on the rural differential within each state.  
<http://www.rupri.org/dataresearchviewer.php?id=6>.
68. **Psychcentral.com** website article re: a new study that has found that more than 40 percent of U.S. soldiers returning from the wars in Iraq and Afghanistan who sought treatment from a Veterans Administration hospital suffer from a mental disorder or a related behavioral problem.  
<http://psychcentral.com/news/2009/07/18/veterans-mental-health-concerns-rising/7199.html>.

69. **Community News of Virginia** online article stating that Governor Bob McDonnell announced today his legislation to continue his effort to make Virginia the most veteran-friendly state in America. <http://www.wpcva.com/articles/2011/01/14/chatham/news/news40.txt>.
70. **Veteran's Health Administration Mental Health Program Evaluation Technical Manual**. The VA Office of Policy and Planning contracted with Altarum Institute and the RAND–University of Pittsburgh Health Institute (RUPHI) to conduct an independent study to evaluate its mental health services. [http://www.rand.org/pubs/working\\_papers/WR682.html](http://www.rand.org/pubs/working_papers/WR682.html).
71. **Warrior Gateway web portal** blog (Aug 2010): The Department of Veterans Affairs will pilot a new program in Denver, Colorado and four other cities to help decrease the number of homeless veterans. The program is funded with a \$33 million grant that will create a 40-bed program for unceasingly homeless veterans over the next five years. <http://www.warriorgateway.info/tag/veterans-affairs/>.
72. VA website copy of Presidential Budget Submission for Medical Programs and Information Technology Programs - **FY 2011 Funding and 2012 Advance Appropriations Request** (430 pgs). [http://www.va.gov/budget/docs/summary/Fy2011\\_Volume\\_2-Medical\\_Programs\\_and\\_Information\\_Technology.pdf](http://www.va.gov/budget/docs/summary/Fy2011_Volume_2-Medical_Programs_and_Information_Technology.pdf).
73. **Analysis of VA Health Care Utilization** among Operation Enduring Freedom(OEF) and Operation Iraqi Freedom(OIF) Veterans, VA Office of Public Health and Environmental Hazards, February 2010. [http://docs.google.com/viewer?a=v&q=cache:qMRFyC5PI2wJ:vaccineliberationarmy.com/wp-content/uploads/2011/01/VA2010-4thQtrFY09OEF-OIFHCU03-01-2010.pptx+age+distribution+of+visn+5+veterans&hl=en&gl=us&pid=bl&srcid=ADGEEShal4jFoZYHhBKZVuzl7w1-nyZt3eM6LNMKBljiwV30vllundQ5iaZHfbliW1DqNbuJnHVQYQMyw4DMJKAYnnefzALnERoKo2JYrRNOuj7eFvf1GZZUTQnevU1963482cdFx0zF&sig=AHIEtbTrCuhAN3z-KVszyhQ-DDsU\\_8up-A](http://docs.google.com/viewer?a=v&q=cache:qMRFyC5PI2wJ:vaccineliberationarmy.com/wp-content/uploads/2011/01/VA2010-4thQtrFY09OEF-OIFHCU03-01-2010.pptx+age+distribution+of+visn+5+veterans&hl=en&gl=us&pid=bl&srcid=ADGEEShal4jFoZYHhBKZVuzl7w1-nyZt3eM6LNMKBljiwV30vllundQ5iaZHfbliW1DqNbuJnHVQYQMyw4DMJKAYnnefzALnERoKo2JYrRNOuj7eFvf1GZZUTQnevU1963482cdFx0zF&sig=AHIEtbTrCuhAN3z-KVszyhQ-DDsU_8up-A).
74. **Site map of US Vets locations**, including contact information for office in Washington, D.C. <http://www.usvetsinc.org/locations/>.
75. U.S. Senate Committee on Appropriations Press Release, **Summary of 2011 Military Construction, Veterans Affairs, and related Agencies Appropriations**. [http://docs.google.com/viewer?a=v&q=cache:YuKvlPRSONwJ:appropriations.senate.gov/news.cfm%3Fmethod%3Dnews.download%26id%3Db752f071-cc6e-4cc4-9c46-99315f6e8f8a+veterans+affairs+advance+appropriation+fy+2010&hl=en&gl=us&pid=bl&srcid=ADGEEsjkp45lvHwXOFIhr289wEpiPSH0fgZf3qbAF7tVX9wA5C\\_rIUdyepsOD-lx9ASsUgMYdOBApwl1FP5UOL8rIFWazHqBfGGoaHnYcyHDVLIo\\_MLkH45TvPv\\_pSwh1VqamF0xay&sig=AHIEtbQlnZJcfJgP7YsbVY0vc1W7GriCQQ](http://docs.google.com/viewer?a=v&q=cache:YuKvlPRSONwJ:appropriations.senate.gov/news.cfm%3Fmethod%3Dnews.download%26id%3Db752f071-cc6e-4cc4-9c46-99315f6e8f8a+veterans+affairs+advance+appropriation+fy+2010&hl=en&gl=us&pid=bl&srcid=ADGEEsjkp45lvHwXOFIhr289wEpiPSH0fgZf3qbAF7tVX9wA5C_rIUdyepsOD-lx9ASsUgMYdOBApwl1FP5UOL8rIFWazHqBfGGoaHnYcyHDVLIo_MLkH45TvPv_pSwh1VqamF0xay&sig=AHIEtbQlnZJcfJgP7YsbVY0vc1W7GriCQQ).
76. VA Caregivers Benefits and Services PPT slides, presented by Heather Mahoney-Gleason (USVA) at the RCI National Summit and Training Institute **“Averting the Caregiver Crisis”** at Georgia Southwestern State University, October 20-22, 2010. <http://www.rosalynncarter.org/UserFiles/VA.pdf>.
77. Cornell University Law School website, US Code, **Title 38-Veterans Benefits**. [http://www.law.cornell.edu/uscode/html/uscode38/usc\\_sup\\_01\\_38.html](http://www.law.cornell.edu/uscode/html/uscode38/usc_sup_01_38.html).
78. **Maryland Veterans Trust Fund Use Statute description**. <http://www.dsd.state.md.us/comar/comarhtml/35/35.05.01.04.htm>.
79. “The Changing Veteran Poses Challenges for the VA” 1<sup>st</sup> of 5 part series on **All Things Considered**, NPR public radio, May 10, 2010. <http://www.npr.org/templates/story/story.php?storyId=126672675>.

80. December 17, 2010 Federal Register notice: The Department of Veterans Affairs (VA) is announcing the availability of funds for **supportive services grants** under the Supportive Services for Veteran Families Program. <http://edocket.access.gpo.gov/2010/pdf/2010-31742.pdf>.
81. Website containing **data about homeless Veterans**. <http://www.standown.org/homeless.html>.
82. This NGA Center Backgrounder (October 2007) provides information on what governors are doing to meet **the challenges of reintegration** of National Guard and other armed services personnel returning from overseas. <http://www.score.org/pdf/National%20Guard%20State%20Resources.pdf>.
83. Senate Bill 2162- **Veterans' Mental Health and Other Care Improvements Act of 2008** "... to improve the treatment and services provided by the Department of Veterans Affairs to veterans with post-traumatic stress disorder and substance use disorders, and for other purposes." <http://www.govtrack.us/congress/bill.xpd?bill=s110-2162>.
84. A comprehensive list of websites, book, speakers, etc. provided by Mental Illness Research, Education and Clinical Centers (**MIRECC**) at the Department of Veterans Affairs. [http://www.mirecc.va.gov/Recovery\\_Resources.asp](http://www.mirecc.va.gov/Recovery_Resources.asp).
85. "**Peer Support, Returning Service Members and Vets**" PowerPoint presentation from 11/2010 SAMHSA teleconference. [http://webcache.googleusercontent.com/search?q=cache:wtClvwjLDIsJ:gainscenter.samhsa.gov/html/resources/presentation\\_materials/pdfs/November\\_16\\_VPS\\_PowerPoint.pdf+peer+to+peer+support+veterans+affairs&cd=11&hl=en&ct=clnk&gl=us](http://webcache.googleusercontent.com/search?q=cache:wtClvwjLDIsJ:gainscenter.samhsa.gov/html/resources/presentation_materials/pdfs/November_16_VPS_PowerPoint.pdf+peer+to+peer+support+veterans+affairs&cd=11&hl=en&ct=clnk&gl=us).
86. Patient Centered Primary Care Collaborative website. The PCPCC has become one of the major developers and advocates of the **patient centered medical home (PCMH) model** in America. <http://www.pcpcc.net/index.php>.
87. Web article "**Not Your Father's VHA**" Oct 2006. [http://www.fortherecordmag.com/archives/ft\\_10302006p10.shtml](http://www.fortherecordmag.com/archives/ft_10302006p10.shtml).
88. HSR&D Service at the USVA--Forum article entitled "**Posttraumatic Stress Disorder in Women Veterans**" Nov 2008. <http://www.hsr.d.research.va.gov/publications/forum/nov08/Nov08-4.cfm>.
89. Website for the **National Call Center for Homeless Veterans** sponsored by US Department of Veterans Affairs. <http://www.va.gov/HOMELESS/NationalCallCenter.asp>.
90. National Center for **PTSD website** sponsored by the VA. <http://www.ptsd.va.gov/>.
91. Background and **statistics about homeless veterans** provided by the National Coalition for Homeless Veterans website. <http://www.nchv.org/background.cfm#facts>.
92. The [**North Carolina**] **Governor's Focus on Servicemembers, Veterans and their Families** website. Their mission is to promote evidence-based and best practices in the screening, assessment, and treatment of active duty, National Guard, Reservists, and veterans who served in the military and their families. <http://www.veteransfocus.org/our-mission/>.
93. **New Jersey Governor's Council on Mental Health Stigma** website—Military and Veterans Affairs page. <http://www.state.nj.us/mhstigmacouncil/community/military/>.
94. Maryland Motor Vehicle Administration website—**Maryland's Military Related Plates** page. [http://www.mva.maryland.gov/Vehicle-services/SpecialtyPlates/MilitPlates\\_Entry.asp](http://www.mva.maryland.gov/Vehicle-services/SpecialtyPlates/MilitPlates_Entry.asp).
95. March 2009 **VISN 5 Newsletter** with information about enrolling in Priority Group 8. [http://docs.google.com/viewer?a=v&q=cache:3mDuCtJ30EsJ:www.va.gov/VISN5/docs/voice/mar09.pdf+planetree+veterans&hl=en&gl=us&pid=bl&srcid=ADGEEsIu1\\_yGEXVsAb-ZErzYl38kFrnagxIA6KJrNueBlSf6Cs5eNI-KE4KqkzzF4D3SbTDkdI8dMj8spqxTXye45TFyDCSlweD5\\_sUxrE7b2fg96kt7JI71rjT6VsFknJEsCtdfMbB5&sig=AHIEtbSc\\_IMv\\_a-ISFIoB5ki2hVBYG0TpA](http://docs.google.com/viewer?a=v&q=cache:3mDuCtJ30EsJ:www.va.gov/VISN5/docs/voice/mar09.pdf+planetree+veterans&hl=en&gl=us&pid=bl&srcid=ADGEEsIu1_yGEXVsAb-ZErzYl38kFrnagxIA6KJrNueBlSf6Cs5eNI-KE4KqkzzF4D3SbTDkdI8dMj8spqxTXye45TFyDCSlweD5_sUxrE7b2fg96kt7JI71rjT6VsFknJEsCtdfMbB5&sig=AHIEtbSc_IMv_a-ISFIoB5ki2hVBYG0TpA).

96. Maryland Department of Labor, Licensing, and Regulation website page that describes **PROVET** (Promoting Reemployment Opportunities for Veterans) Health Care, a Department of Labor pilot program in Maryland. <http://www.dllr.state.md.us/provets/hc/hcgovt.shtml#provets>.
97. VA Maryland Healthcare System **2008 Guide: VA Services and Information for Returning Combat Veterans**.  
[http://docs.google.com/viewer?a=v&q=cache:nVGSud9i5IYJ:www.mdva.state.md.us/pdfs/VAServicesInformation4ReturningCombatVets08.pdf+maryland+veterans+enhanced+eligibility+health+care+january+27&hl=en&gl=us&pid=bl&srcid=ADGEEsiosgvrrfDgpZi0vgR5FT9qCarALS4B2\\_hm dDQ4OEYfWJX-o9HI5VKTeGYNWkdtKAAJmn\\_inY5FqDXvxjtFbsJtMouXquhzviXtCal2Vw8QRdssOuRaRKzxMf3dIQpGGgUc12j&sig=AHIEtbTlz89x6ZUEvAaBbO9xJrn\\_cmMfdQ](http://docs.google.com/viewer?a=v&q=cache:nVGSud9i5IYJ:www.mdva.state.md.us/pdfs/VAServicesInformation4ReturningCombatVets08.pdf+maryland+veterans+enhanced+eligibility+health+care+january+27&hl=en&gl=us&pid=bl&srcid=ADGEEsiosgvrrfDgpZi0vgR5FT9qCarALS4B2_hm dDQ4OEYfWJX-o9HI5VKTeGYNWkdtKAAJmn_inY5FqDXvxjtFbsJtMouXquhzviXtCal2Vw8QRdssOuRaRKzxMf3dIQpGGgUc12j&sig=AHIEtbTlz89x6ZUEvAaBbO9xJrn_cmMfdQ).
98. Website for the movie "**Lioness**," a Room 11 Productions Film, which is about female combat veterans. <http://www.lionessthefilm.com/>.
99. Census Bureau publication, Ch. 10--National Defense and Veterans Affairs, including data re: federal budget outlays, active duty military deaths, etc.  
<http://www.census.gov/prod/2004pubs/O3statab/defense.pdf>.
100. Link to Google Books, entitled "**Home to War: A History of the Vietnam Veterans' Movement**."  
[http://books.google.com/books?id=5hq2\\_JFvV0kC&pg=PA651&lpg=PA651&dq=book+history+of+veterans+mcmichael+cleland&source=web&ots=VDTVInPsBA&sig=4aYOlA8XkV4mjhQGyBwWF30tUbQ&hl=en&sa=X&oi=book\\_result&resnum=1&ct=result#PPT1,M1](http://books.google.com/books?id=5hq2_JFvV0kC&pg=PA651&lpg=PA651&dq=book+history+of+veterans+mcmichael+cleland&source=web&ots=VDTVInPsBA&sig=4aYOlA8XkV4mjhQGyBwWF30tUbQ&hl=en&sa=X&oi=book_result&resnum=1&ct=result#PPT1,M1).
101. NY Times article, October 2008-- a Connecticut American Legion Post and its 167 members have applied for a **\$5.2 million Connecticut Housing Finance Authority loan** to build 18 one-bedroom apartments for homeless and disabled veterans.  
[http://www.nytimes.com/2008/10/05/nyregion/connecticut/05vetsct.html?\\_r=1](http://www.nytimes.com/2008/10/05/nyregion/connecticut/05vetsct.html?_r=1).
102. **Military Sexual Trauma** blog, November 1, 2010.  
[http://www.healingcombattrauma.com/military\\_sexual\\_trauma/](http://www.healingcombattrauma.com/military_sexual_trauma/).
103. Maryland **Governor's Commission on Suicide Prevention**, official language of the Executive Order, January 1, 2009. <http://www.dsd.state.md.us/comar/comarhtml/01/01.01.2009.13.htm>.
104. **Grants Office website**, with postings of recent grant opportunities, links to partner orgs, etc.  
<http://www.grantsoffice.com/default.aspx>.
105. **NY Times article "Making it Home"** October 8, 2008, about a young disabled combat vet whose new home was retrofitted w/USVA funding and nonprofit help.  
<http://www.nytimes.com/2008/10/09/garden/09vets.html>.
106. US Senate Committee on Appropriations website: December 19, 2010 press release containing highlights of the **Senate amendment to H.R. 3082, a Continuing Resolution (C.R.)** that would allow continued government operations through March 4, 2011.  
<http://appropriations.senate.gov/news.cfm?method=news.view&id=4841b7f6-bbac-486b-959f-43b1979a60ff>.
107. Bureau of Labor Statistics, Economic News Release: March 12, 2010. The **unemployment rate for Veterans** who served in the military since September 2001--a group referred to as Gulf War-era II Veterans--was 10.2 percent in 2009. <http://www.bls.gov/news.release/vet.nr0.htm>.
108. VA website page containing Veterans Compensation **Benefits Rate Tables** - Effective 12/1/09.  
<http://www.vba.va.gov/bln/21/Rates/comp01.htm>.
109. Department of Defense **State Personnel data** for 2009.  
[http://siadapp.dmdc.osd.mil/personnel/M02/fy09/m02\\_2009\\_personnel.pdf](http://siadapp.dmdc.osd.mil/personnel/M02/fy09/m02_2009_personnel.pdf).
110. DoD **Active Military Duty Personnel Strengths** by Regional Area and Country data for 2010.  
<http://siadapp.dmdc.osd.mil/personnel/MILITARY/history/hst1009.pdf>.



111. CRS Report for Congress, January 2008, **National Guard Personnel and Deployments**: Fact Sheet. <http://www.fas.org/spp/crs/natsec/RS22451.pdf>.
112. Bureau of Justice Statistics special report: **Veterans in State and Federal Prison, 2004**. <http://bjs.ojp.usdoj.gov/content/pub/pdf/vsfp04.pdf>.
113. CNN website article, January 19, 2011, “**Army to Implement New Mental Health Screening Procedures**” before they ship out to a war zone. <http://edition.cnn.com/2011/US/01/19/military.mental.health/>.
114. CNN website video/article, January 19, 2011, stating the U.S. Army will report that while the number of suicides in the active-duty force declined in 2010, **the number of suicides in the Army Reserve and National Guard increased**. <http://edition.cnn.com/2011/US/01/18/army.suicide.report/>.
115. Research article entitled “Alcohol & Drug Abuse: The **Transformation of the Veterans Affairs Substance Abuse Treatment System**,” posted on American Psychiatric Publishing website. <http://psychservices.psychiatryonline.org/cgi/content/full/50/11/1399>.
116. American Council on Education (ACE) website press release (April 22, 2009): ACE and the Wal-Mart Foundation announced the award of \$2 million in **Success for Veterans Award Grants**; University of MD is one of 20 recipients. [http://www.acenet.edu/AM/Template.cfm?Section=Press\\_Releases2&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=32199](http://www.acenet.edu/AM/Template.cfm?Section=Press_Releases2&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=32199).
117. Statement of **Harold Kudler, MD**, Co-Chair, VA Under Secretary for Health’s Special Committee on PTSD at the USVA, presented to the Committee on Veterans’ Affairs Subcommittee on Health, March 11, 2004. <https://docs.google.com/leaf?id=1O6xsEp9vzGyAeIeqnTYJz35ED627yc9c0o3Fh2RdY6AjRo4C5cNr4VWUJvix&hl=en>.
118. Congressional Budget Office Summary: **Potential Costs of Veterans’ Health Care**, October 2010. [https://docs.google.com/leaf?id=1gRZmmvS3o5d89\\_vdud9TTVuC6fhiQpaQV74tZuli-SN0UwWGytTw9SMIEur\\_&hl=en](https://docs.google.com/leaf?id=1gRZmmvS3o5d89_vdud9TTVuC6fhiQpaQV74tZuli-SN0UwWGytTw9SMIEur_&hl=en).
119. National Council for Community Behavioral Healthcare document entitled “Frequently Asked Questions about **Federally-Qualified Behavioral Health Centers**.” <https://docs.google.com/leaf?id=1HyZxvNzvC908cP53qWg-5UQB5YtczU6qbqNzGgRzVVbxBWYvppSGSHQdhvrQ&hl=en>.
120. Maryland Department of Veterans Affairs **Response to DLS Budget Analysis, Fiscal Year 2011** Operating Budget. <https://docs.google.com/leaf?id=17a2zPoieFuzSu3V-WseT7nY4LzMkINcmNhGE232BsJhKgKztsQx5qfgIO9Qk&hl=en>.
121. Presentation materials from DCoE Warrior Resiliency Conference, November 2009, entitled “**National Guard Psychological Health**.” [https://docs.google.com/leaf?id=1WgwJh655ROKbpQfv00KdXdnfXpaqLgQDX59IHgRCnD63\\_YPSCewsYR0pXDXa&hl=en](https://docs.google.com/leaf?id=1WgwJh655ROKbpQfv00KdXdnfXpaqLgQDX59IHgRCnD63_YPSCewsYR0pXDXa&hl=en).
122. Presentation materials about the New Hampshire **Deployment Cycle Support Program**, New Hampshire Department of Health & Human Services, 2009. <https://docs.google.com/leaf?id=1HwrvseWloneFotn36XLIuWGBU-8qdlcvHKtiRARThVIZkif3yIDSoyWRCcco&hl=en>.
123. Final Report for Veterans Disability Commission. Center for Naval Analysis. August 2007. [https://www.1888932-2946.ws/vetscommission/e-documentmanager/gallery/Documents/Reference\\_Materials/CNA\\_FinalReport\\_August2007.pdf](https://www.1888932-2946.ws/vetscommission/e-documentmanager/gallery/Documents/Reference_Materials/CNA_FinalReport_August2007.pdf)
124. National Association of Social Workers [NASW] Fact Sheet: **Social Workers Speak on Veterans Issues** June 2009. [https://docs.google.com/leaf?id=1iAcSx9cFLh53QExCEv5ic0faLi8IN8jP-jh8Jt5JK\\_4H195SNwChjoYOVmx&hl=en](https://docs.google.com/leaf?id=1iAcSx9cFLh53QExCEv5ic0faLi8IN8jP-jh8Jt5JK_4H195SNwChjoYOVmx&hl=en).

125. Fordham Law Review, Vol 77, Essay entitled “Combat Veterans, Mental Health Issues, And the Death Penalty: **Addressing the Impact of Post-Traumatic Stress Disorder and Traumatic Brain Injury,**” by Anthony E. Giardino, January 6, 2009.  
<https://docs.google.com/leaf?id=1I78K8sDvtzCEL9q2YXqRKsLPgpXjj-effXohdXYxbg2uum2b-YKw7ilpw21e&hl=en>.
126. The **O’Malley/Brown Transition Report**, by the Transition Work Group for the Maryland Department of Veterans Affairs, February 2007.  
[https://docs.google.com/leaf?id=1fyDoHwNEal8bYnLhX7yMryKaRspkCf8TpkEkxcUkjbhAoO7MBW\\_JpUhPh2EE&hl=en](https://docs.google.com/leaf?id=1fyDoHwNEal8bYnLhX7yMryKaRspkCf8TpkEkxcUkjbhAoO7MBW_JpUhPh2EE&hl=en).
127. **Congressional Commission on Servicemembers and Veterans Transition Assistance** – Final Report. January 1999.  
<http://www.va.gov/vetbiz/library/Transition%20Commission%20Report.pdf>
128. **Honoring the Call to Duty: Veterans’ Disability Benefits in the 21<sup>st</sup> Century**. Final report of the Veterans Disability Commission. October 2007. <http://www.co.st-lawrence.ny.us/data/files/Departments/Veterans/VetDisBenefitComm9-27.pdf>
129. **Guidebook for Incarcerated Veterans**, February 2009. VISN 5.  
[http://www.va.gov/HOMELESS/docs/Reentry/09\\_md\\_dc.pdf](http://www.va.gov/HOMELESS/docs/Reentry/09_md_dc.pdf)
130. **VA Office of Rural Health 2010 –2014 Strategic Plan**.  
[http://www.ruralhealth.va.gov/docs/VHA\\_ORH\\_StrategicPlan2010\\_2014.pdf](http://www.ruralhealth.va.gov/docs/VHA_ORH_StrategicPlan2010_2014.pdf)