Minnesota Veterans Behavioral Health Needs Assessment

Prepared for the Minnesota Department of Veterans Affairs

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Executive summary

Purpose

The Minnesota Department of Veterans Affairs (MDVA) contracted with Wilder Research to conduct a behavioral health needs assessment of Veterans in Minnesota. The assessment was originally commissioned by the Minnesota Legislature in response to recent research and news stories identifying gaps in the Veteran mental and behavioral health system. This assessment set out to identify the mental and behavioral health needs of Minnesota Veterans, the existing mental and behavioral health resources available to them, and the opportunities to address any unmet mental or behavioral health needs of this population.

Methods

Wilder used a mixed methods approach to complete the assessment, including key informant interviews with practitioners who serve Veterans, a survey of Minnesota Veterans, and an analysis of existing data.

Key informant interviews

Wilder Research interviewed 45 practitioners with knowledge of service resources and gaps related to Veteran mental health and behavioral health in their area. These key informants were identified by MDVA, by another interviewee, or through an online search for individuals with relevant knowledge.

All key informants worked with Veterans, as defined by the state. Of the 43 interviews completed, 65 percent focused on an area in greater Minnesota, 33 percent on the Twin Cities metro area, and 2 percent on the entire state of Minnesota.

Minnesota Veteran survey

Veterans across the state were asked to complete a survey about their mental and behavioral health needs, their experiences accessing services for mental and behavioral health needs, and their recommendations for improving the mental and behavioral health system for Veterans. The survey was primarily shared with Veterans using convenience sampling through County Veteran Service Officers, the Minnesota Veteran newsletter,

and the MDVA email listserv.[1] This survey was administered primarily online, with options for paper and telephone surveys available. To be included in the analysis, respondents had to live in Minnesota, have served on active duty in any branch of the military, and have been honorably discharged from military service. For the report, Wilder Research focused on Veterans who met the Minnesota definition of a Veteran (MN Statute 197.447; refer to full report for definition). Of the 1,185 Veterans who completed the survey, 918 met all the requirements for inclusion.

Characteristics of survey respondents were compared to Veterans in the state of Minnesota (Minnesota Department of Veterans Affairs, 2016). Survey participants were more likely to be female (15% compared to 7%), a person of color (12% compared to 9%), live in the Twin Cities metro area (56% compared to 46%), and younger (96% were under age 74 compared to 78%) than Minnesota Veterans, overall. Slightly more than half of survey respondents served in the Army (53%), followed by the Navy (22%), Air Force (19%), Marine Corps (10%), and Coast Guard (1%). A quarter of respondents (25%) had served in the National Guard/Reserve. Survey respondents represent a wide range of service eras with 39 percent serving in the Vietnam era, and approximately 30 percent serving in each era after. Slightly more than half of respondents served in a combat or war zone (55%), and more than half were on active duty for between 2-5 years (57%).

Analysis of existing data

Analysis of existing data focused on the Minnesota Veteran population, common risk and protective factors in Veteran mental and behavioral health, and existing resources available to Veterans. The data sources used for this analysis include published literature and the following: Minnesota Department of Veterans Affairs, U.S. Department of Veterans Affairs, The Center for Disease Control's Behavioral Risk Factor Surveillance System (BRFSS), Substance Abuse and Mental Health Services Administration National Survey on Drug Use and Health (NSDUH), Minnesota College Student Health Survey, Wilder Research's triennial Minnesota Homeless Study Survey, Minnesota Department of Human Services, and Minnesota Department of Health death records.

[1] It should be noted that this survey methodology may have affected who participated in the survey. In particular, the survey conducted for this study used a convenience sample and explicitly described the focus on behavioral health, which may have increased the interest in responding among Veterans with behavioral health experiences or concerns and Veterans who are already connected to Veteran communities and supports. In addition, most respondents chose to use the online survey option, rather than a paper or telephone option, so the respondents may have been younger and/or more comfortable with technology.

Prevalence of mental and behavioral health needs

Mental health diagnoses

- Overall, 47 percent of respondents to the Minnesota Veteran survey had some type of mental health diagnosis. The most common diagnoses included anxiety disorder or panic disorder (33%), followed by major depression (30%) and Post-Traumatic Stress Disorder (PTSD; 28%).
- Over one-quarter of survey respondents screened positive for mental health symptoms at the time of the survey (26% for depression, 27% for anxiety, and 32% for PTSD). Of those who screened positive, approximately two-thirds also had a formal diagnosis.
- Other state and national sources report a smaller proportion of Veterans with mental health diagnoses. Approximately 22 percent of U.S. Department of Veterans Affairs patients nationally had a depression diagnosis, 13 percent had a PTSD diagnosis, and 12 percent had another anxiety disorder in 2014 (U.S. Department of Veterans Affairs, 2016). The over-representation of Veterans with mental health diagnoses in the Minnesota Veteran survey data allows for richer information about mental health service use and needs.

Suicide

- Thirty-five percent of Minnesota Veteran survey respondents reported suicidal ideation at some point in their lives. Of those who reported suicidal ideation, 13 percent were having these thoughts at the time of the survey (4% of all respondents), 25 percent have attempted suicide (9% of all respondents), and 44 percent have sought help at some point because they were suicidal (15% of all respondents).
- The Minnesota Veteran survey showed a strong connection between diagnoses and suicidal ideation. Respondents with both a mental and chemical health diagnosis were at greatest risk for suicidal ideation (70%) compared to those with a mental health diagnosis only (52%), a chemical health diagnosis only (26%), or neither diagnosis (15%).
- The U.S. Department of Veterans Affairs (2016) found that 20 Veterans nationally died by suicide each day in 2014, and this rate was consistent with previous years.
- According to Minnesota death certificates, the number of Veterans who died by suicide in 2013, 2014, and 2015 has stayed consistent at about 100 individuals. However, the overall number of suicides in Minnesota has increased in that time, making the proportion of suicides by Veterans lower over time (Minnesota Department of Health, 2016).

Chemical health diagnoses

- In the Minnesota Veteran survey 18 percent of respondents reported having any chemical health diagnosis. This includes 17 percent with an alcohol abuse disorder and 4 percent with a drug abuse disorder.
- In addition, 29 percent of respondents screened as clinically significant for an alcohol or drug abuse issue. Of those who screened clinically significant, half also reported a chemical health diagnosis, most commonly an alcohol abuse disorder diagnosis.

Key findings

Many Veterans are accessing the supports they need.

Recommendation: Promote the services available throughout the state and continue outreach to the Veterans who have service needs and are not receiving adequate support.

- ✓ Overall, 77 percent of Minnesota Veteran survey respondents felt they have the support they need. This included more respondents who did not receive services in the last two years (53%) than those who did receive services (24%).
- ✓ In addition, the majority of survey respondents who had a mental (63%) or chemical health need (32%), as determined by a reported diagnosis or positive screening, received services since exiting the military (63-65%) and/or in the past two years (50-57%).
- ✓ Nearly all survey respondents who received behavioral health services specifically received individual one-on-one counseling (90%), and most (68%) identified this as their preferred format. In addition, most of the services received (72%) were federal services.

There are statewide shortages in behavioral health providers, which disproportionately affect greater Minnesota.

Recommendation: Provider shortages cannot be addressed by MDVA alone. However, MDVA could enhance collaborations with other efforts to address these concerns. For instance, in 2016, Governor Dayton convened a task force dedicated to addressing capacity challenges within Minnesota's mental health system. The recommendations of this task force will likely impact the Veterans described in this study as well.

- ✓ Many key informants identified a shortage of trained providers (73%), especially psychiatric prescribers (60%), and an inability to retain or recruit prescribers (60%) as some of the primary gaps in services. Key informants in greater Minnesota were more likely to cite these shortages as barriers to service provision than respondents in the Twin Cities metro area.
- ✓ Key informants in greater Minnesota (66%) were significantly more likely than those in the Twin Cities metro area (23%) to report there are no services in their area. In particular, they identified the need for same-day, crisis, and chemical health services for Veterans.
- ✓ Similarly, survey respondents in greater Minnesota were also more likely to say that services were not available in their area (15%) compared to survey respondents in the Twin Cites metro area (5%).
- ✓ Key informants in greater Minnesota discussed reasons for the provider shortage in their area. They endorsed the idea that working in rural areas is less lucrative than working in the same field in the Twin Cities metro area. They also noted that there is a general shortage of mental health professionals affecting all parts of the state.
- ✓ Existing data demonstrate that a number of services exist across Minnesota. However, many services operate at or near capacity, and many areas do not have services available locally. In fact, data from the Minnesota Department of Human Services and the U.S. Department of Health and Human Services have identified a shortage of mental health providers in greater Minnesota.

Veterans encounter barriers to accessing services, including perceived stigma and the need for a formal VA diagnosis.

Recommendation: There is a need to reduce stigma for seeking mental health services, including addressing the belief that seeking help will affect future employment and military service. In addition, there is a need to increase awareness of when a formal VA diagnosis is necessary and what services may be available without a formal diagnosis.

- ✓ Half of all survey respondents (50%) selected at least one barrier that prevented them from accessing services. The barriers they identified included not having a VA diagnosis (34%), being worried about how they will be seen (28%), being worried about the effect on current or future employment (24%), not thinking the services will help (19%), and not being able to pay for services (19%).
- ✓ Key informants identified several barriers that may prevent Veterans from accessing the mental and behavioral health services they need. The top barriers selected were: concern over effect on employment (83%), concern over how the Veteran will be seen by others (79%), concern over effect on future military service (79%), transportation (74%), and not believing that services will help (71%). Over half of key informants (57%) indicated that Veterans may not be accessing services due to not having a VA diagnosis.

Community-based service providers may not provide support appropriate for Veterans.

Recommendation: It is important that mental health and behavioral health providers are trained to identify and address conditions and concerns common to Veterans.

- ✓ Of the survey respondents who received services, most received federal services (72%), followed by private services (38%), nonprofit services (19%), and state services (19%). Although most Veterans are accessing services through agencies such as the U.S. Department of Veterans Affairs (VA), many are accessing support from agencies that may not specialize in working with Veterans.
- ✓ Thirteen percent of survey respondents who encountered a barrier to accessing services named a lack of appropriate supports for Veterans as a barrier.
- ✓ Veteran survey respondents who had served in combat or war zones were more likely to say that services were not good with Veteran-specific issues (18%) than non-combat Veterans (6%) and that services were not available in their area (12% versus 6%).
- ✓ Greater Minnesota key informants were significantly more likely to say there are no good services in their area for Veteran-specific issues (55% in greater Minnesota versus 15% in the Twin Cities metro area).

Informal social supports are essential to Veteran behavioral health.

Recommendation: Increase and improve efforts to prepare families and friends to support Veterans and increase opportunities for Veterans to obtain informal, individual support from peers.

- ✓ The Minnesota Veteran survey found that social connectedness is a strong protective factor for behavioral health. Survey respondents that either reported a strong sense of belonging in their community or reported receiving the social support they need were significantly less likely to report behavioral health diagnoses and symptoms based on standardized screening tools.
- ✓ Survey respondents reported a preference for informal and peer supports. One-third of survey respondents (33%) prefer informal support, such as from family or friends, and over one-quarter (26%) prefer peer-to-peer support, which places these types of services as the second and third most popular (behind individual services 68%).
- ✓ In addition, the most commonly mentioned support that was missing for survey respondents was a form of social support (18%) which includes family support (7%), friend support (4%), community support (4%), and spousal support (3%).
- ✓ Key informants endorsed the need for more services provided to Veterans, by Veterans. They discussed that Veterans know about their own issues, know how to support each other, and need to feel useful even if they are not able to participate in the full-time workforce. Key informants felt that more peer-to-peer mental and chemical health groups would be beneficial for Veterans.
- ✓ Previous studies have also clearly documented the ways in which social supports and community connectedness can protect Veterans from experiencing PTSD and depression symptoms, as well as suicidal ideation and behaviors (Pietrzak, Harpaz-Rotem, & Southwick, 2011; Nock et al., 2013).

Specific populations have increased risk for behavioral health needs.

Recommendation: Provide population-specific behavioral health services for Veterans to increase access and address the intersectionality between identities as Veterans and members of these populations.

- ✓ The Minnesota Veteran survey identified several groups of Veterans at an increased risk for behavioral health issues. In particular, women Veterans, Veterans of color, younger Veterans, and Veterans with a disability or chronic medical condition, including traumatic brain injury, were more likely to report behavioral health diagnoses and symptoms.
- ✓ Some sub-populations of survey respondents were significantly less likely to feel they have the support they need compared to other groups. The sub-populations most likely to be in need of additional support were: survey respondents with a concussion/TBI diagnosis, those with a disability, respondents age 34-55, and women.
- ✓ Most key informants said services for specific sub-groups of Veterans are not available in their area. Some described a need for services tailored to women Veterans, Veterans who have served in the same conflict or era, and Veterans with traumatic brain injury.

Sexual assault experiences increase behavioral health risks for both men and women.

Recommendation:
Specialized services for both men and women experiencing sexual assault are essential. In particular, services for men need to address the decreased likelihood of seeking support and the increased risk of chemical dependency. It is also important to note that many Veterans had a sexual assault experience prior to serving in the military, so supports must address sexual violence that occurred prior to, as well as during, active service.

- ✓ Minnesota Veteran survey respondents who reported experiencing sexual assault (19%) had a greater risk for experiencing mental and chemical health symptoms and diagnoses, including suicidal ideation or behaviors.
- ✓ While the proportion of Minnesota Veteran survey respondents reporting sexual assault was greater for women (62% versus 11%), the number of women and men who experienced sexual assault was roughly equal (84 men and 79 women).
- ✓ Of the survey respondents who were sexually assaulted, 58 percent were assaulted before their military service, 54 percent were assaulted during their military service, and 13 percent were assaulted after their service, indicating that many had multiple assault experiences. Women were more likely to experience sexual assault during their military service, and men were more likely to experience sexual assault prior to their military service.
- ✓ Compared to women, men responding to the survey who experienced sexual assault were more likely to have a diagnosis of alcohol abuse disorder (34% versus 17%) or drug abuse disorder (17% versus 5%) and screen clinically significant for alcohol or drug abuse (48% versus 25%). In addition, men who have experienced sexual assault were less likely to seek help because of their sexual assault experiences (31% versus 54%).
- ✓ Key informants also discussed the need for services specifically for Veterans who have experienced sexual assault, including separate services for men and women. It should be noted that the majority of key informants identified that there are services available for Veterans who have experienced sexual assault, but these programs may not be as accessible or appropriate to address all of the service needs in this area, including the needs of male victims.

Conclusion

This study demonstrates that there is a considerable need for behavioral health services for Veterans in Minnesota. Many Veterans report that the current system is providing the support they need, but there are some important gaps to address. In particular, there is a disproportionate need for support in greater Minnesota and community providers who often fill this gap are not adequately prepared to address Veterans' unique needs. The behavioral health system needs to be able to address complex needs that Veterans present, including dual diagnoses, sexual assault experiences, and needs of specific populations of Veterans. Many Veterans also identify barriers to accessing support, such as stigma and the need for VA diagnoses, as well as a need for both formal and informal support systems. By collaborating with other systems working to address the mental health needs of all Minnesotans, the Minnesota Department of Veterans Affairs can enhance the supports provided to Veterans.

References

Minnesota Department of Veterans Affairs. (2016). *2015 Annual Report.* St. Paul, MN.

Minnesota Department of Health. (2016). *Death certificate data* [Dataset]. St. Paul, MN.

Nock, M. K., Deming, C. A., Fullerton, C. S., Gilman, S. E., Goldenberg, M., Kessler, R. C., . . . Ursano, R. J. (2013). Suicide among soldiers: A review of psychosocial risk and protective factors. *Psychiatry, 76*(2), 97-125. doi:10.1521/psyc.2013.76.2.97

Pietrzak, R. H., Harpaz-Rotem, I., & Southwick, S. M. (2011). Cognitive-behavioral coping strategies associated with combat-related PTSD in treatment-seeking OEF-OIF Veterans. *Psychiatry Research, 189*(2), 251-258.

U.S. Department of Veterans Affairs. (2016). *Suicide among Veterans and other Americans: 2001-2014*. Washington, DC.

Wilder Research. (2015). *Department of Human Services gaps analysis study: Statewide report.* St. Paul, MN.

Background on assessment

Purpose

The Minnesota Legislature commissioned a study on Veterans' unmet needs for behavioral and mental health services. The legislative mandate stated:

> *The commissioner of Veterans Affairs shall perform a study to quantify and describe unmet needs amongst Minnesota Veterans for behavioral and mental health services. The study will include conducting focus groups of stakeholders, including Veterans and their families, representatives of the United States Veterans Administration, community referral centers, and county Veteran Service Officers. The commissioner of Veterans Affairs may contract with a statewide nonprofit organization to conduct the study. The commissioner of Veterans Affairs shall report by February 15, 2017, to the chairs and ranking minority members of the committees in the house of representatives and the senate with jurisdiction over Veterans policy and budget with the findings of the study and with recommendations about how current services provided to Veterans could be expanded to better meet the needs identified by the study.*

The purpose of this study is to identify the mental and behavioral health needs of Minnesota Veterans, the existing mental and behavioral health resources available to them, and the opportunities for improvement to address any unmet mental or behavioral health needs of this population.

Definition of Veterans

There are different definitions of Veteran and these definitions often affect eligibility for services and support. The state of Minnesota's definition of Veteran is:

> *A citizen of the United States or a resident alien who has been separated under honorable conditions from any branch of the armed forces of the United States after having served on active duty for 181 consecutive days or by reason of disability incurred while serving on active duty, or who has met the minimum active duty requirement as defined by Code of Federal Regulations, title 38, section 3.12a, or who has active military service certified under section 401, Public Law 95-202. The active military service must be certified by the United States secretary of defense as active military service and a discharge under honorable conditions must be issued by the secretary. (MN Statute 197.447).*

Methods

In order to fulfill this legislative mandate, the Minnesota Department of Veterans Affairs (MDVA) contracted with Wilder Research. Wilder Research used a mixed methods approach to complete this assessment, including key informant interviews with practitioners who serve Veterans, a survey of Minnesota Veterans, and analysis of existing data.

Key informant interviews

Interviews were conducted with practitioners who have experience working with Veterans to identify and/or address their mental or behavioral health needs (i.e., key informants). These interviews asked key informants how they work with Veterans, what mental and behavioral health services exist and are still needed for Veterans in their area, and how the current mental and behavioral health system is working well and could be improved for Veterans.

In total, 43 interviews were completed with 45 individuals (two interviews included two respondents each). Key informants were identified by MDVA, by another interviewee, or through an online search for individuals with knowledge of service resources and gaps related to Veterans mental health and behavioral health in their area. For most key informants, this was a county, but for some the area was smaller or larger. Key informants represented all regions of the state (see Appendix for additional information on key informants' regions and roles).

In order to better understand the context of their experience, key informants were also asked questions about the organization they worked for and their role in the organization. All key informants worked with Veterans, as defined by the state.

Qualitative data were analyzed for themes. All themes presented in this report were supported by multiple key informants. Themes were considered to be "endorsed" if 15 percent or more of key informants mentioned the idea. In addition, there was "agreement" among key informants on any theme in which at least 33 percent shared the perspective. Throughout this report, the terms "endorsement" and "agreement" refer to the level of support for a particular theme as described here.

Results from the analysis of the quantitative interview data are provided for all key informants, as well as for the Twin Cities metro area and greater Minnesota separately. Chi-square tests were used to assess the statistical significance of differences between the Twin Cities metro area and greater Minnesota (due to the small N, data were not broken down by smaller geographic regions to protect participant confidentiality.) Significant differences are highlighted in the text of the report. Given the small number of key

informants, variations of 20 percentage points or more between greater Minnesota and Twin Cities key informants are highlighted as well, though they may not be statistically significant.

Survey of Minnesota Veterans

A survey was developed to ask Veterans about their own mental and behavioral health needs, their experiences accessing services for mental and behavioral health needs, and their recommendations for improving the mental and behavioral health system for Veterans. This survey was administered primarily online, with options for paper and telephone surveys available. The survey was primarily shared with Veterans using convenience sampling through County Veteran Service Organizations, the Minnesota Veteran newsletter, and the MDVA email listserv. It should be noted that this survey methodology may have affected who participated in the survey. In particular, the survey conducted for this study used a convenience sample and explicitly described the focus on behavioral health, which may have increased the interest in responding among Veterans with behavioral health experiences or concerns and Veterans who are already connected to Veteran communities and supports. In addition, most respondents chose to use the online survey option (99%), rather than the paper (<1%) or telephone option (<1%), so the respondents may have been younger and/or more comfortable with technology.

For this report, Wilder Research focused on Veterans who met the Minnesota definition as described previously under Definition of Veterans. To be included, respondents had to live in Minnesota, have served active duty in any branch of the military, and had an honorable discharge. A total of 1,185 Veterans completed the survey, and 918 met the definition of Veterans in Minnesota and are included in the results. Of the survey respondents, 77 percent met this definition, 16 percent had missing data that prevented determining whether they met the definition, and 6 percent did not meet this definition. It should be noted that we did not ask about the length of service in days, so that was not a consideration for meeting the Minnesota definition of Veteran in this survey.

To compare the rates of respondents currently experiencing symptoms to those that had received a diagnosis for their symptoms, three standardized screening tools were included in the survey.

- **The Patient Health Questionnaire-4 (PHQ-4)** was included to screen for general psychological distress, as well as anxiety and depressive symptoms. The PHQ-4 total scores range from 0 to 12 with categories of psychological distress being None (0-2), Mild (3-5), Moderate (6-8), and Severe (9-12). The first two questions compose the anxiety subscale while the second two questions compose the depression subscale. Both subscales have a score range of 0-6. A psychological distress score of Mild, Moderate,

or Severe merits further follow-up in a clinical setting. On each subscale, a score of 3 or greater is considered positive for screening purposes (Kroenke, Spitzer, Williams, & Lowe, 2009).

- **The Primary Care PTSD Screen (PC-PTSD)** was included to screen for active PTSD symptoms. The PC-PTSD Screen is a validated 4-item measure designed for use in primary care settings. The results are considered "positive" for PTSD if the respondent answers "yes" to any three items (Prins, et al., 2003).

- **The CAGE Questionnaire** was also included in the survey to screen for problem substance use and potential substance use disorders. Named as an acronym for the four screening questions (the need to Cut down, feeling Annoyed by people criticizing your substance use, feeling Guilty about your substance use, and using substances first thing in the morning, i.e., using an Eye opener), item responses are scored 0 or 1. A total score of 2 or more is considered clinically significant (Ewing, 1984).

All comparisons between groups of survey respondents presented in the report meet a statistical significance test that were conducted using chi-square tests. Differences are noted in applicable tables and are significant at *p <.05, **p < .01, and ***p < .001. For the survey's open-ended questions, responses were coded into themes, and themes that represent 5 percent or more of respondents are presented in the body of the report. (See Appendix for full list of themes.)

Analysis of existing data

Analysis of existing data focused on the Minnesota Veteran population, common risk and protective factors in Veteran mental and behavioral health, and existing resources available to Veterans. The data sources used for this analysis include published literature and the following:

- **Minnesota Department of Veterans Affairs** data about the Minnesota Veteran population and services provided by the department. This source uses the Minnesota definition of Veteran as described above.

- **U.S. Department of Veterans Affairs** data about the Minnesota Veteran population and services provided by the agency. This source uses a similar definition of Veteran as the Minnesota definition.

- **The Center for Disease Control's Behavioral Risk Factor Surveillance System (BRFSS)**. The BRFSS is a national dataset collected through telephone interviews annually. For this study, the 2013 data from 10,551 Minnesota respondents was used because it included a more comprehensive module on mental health. Veteran is defined in this data by the question "Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit? (Active duty does not include training for the Reserves or National Guard, but DOES include activation, for example, for the Persian Gulf War.)" There were 1,307 identified Veterans in Minnesota in this study.

- **Substance Abuse and Mental Health Services Administration National Survey on Drug Use and Health (NSDUH)**. NSDUH is a national dataset that is administered through face-to-face interviews annually. For this study, a composite of data from 2004 through 2010 was used to ensure adequate Veteran representation of 3,826 interviews. Veterans are identified with the question "Have you ever been in the United States armed forces?" Results are only available at the national level.

- **Minnesota College Student Health Survey**. The survey is administered annually by the University of Minnesota's Boynton Health Service to college students throughout Minnesota. The 2013 survey data are the most recent available specifically for Veteran students, and it included 501 Veteran students from 29 Minnesota colleges and universities. In this survey, Veterans are defined by a compilation of two questions: "Are you currently or have you ever served in the United States Armed Forces?" and "Are you an Operation Iraqi Freedom and/or Operation Enduring Freedom Veteran?"

- **Wilder Research's triennial Minnesota Homeless Study Survey**. Comprehensive data about the homeless population in Minnesota are collected through a one-night statewide survey of people experiencing homelessness. The most recent study was conducted on October 22, 2015. This study used the Minnesota definition of Veteran described above and the data were weighted to a total of 351 Veterans represented in the study.

- **Minnesota Department of Human Services** records to identify the licensed mental and chemical health services available throughout Minnesota.

- **Minnesota Department of Health death records** for deaths categorized as suicide. The death records include a question asking if the deceased "Ever served in the Armed Forces?" and this is usually completed by the deceased's next of kin. It should be noted that not all suicide deaths are able to be categorized as suicides and the Veteran status may not be as reliable as in other data sources.

Population

Demographics

According to the U.S. Department of Veterans Affairs, there are approximately 369,149 Veterans in Minnesota. The majority of Minnesota Veterans are white (92%) and men (93%). In addition, about half are age 65 and over (Figure 1).

Looking at individuals who responded to the statewide Veteran survey, women were overrepresented compared with state data (15%). There were also more people of color responding to the survey while the majority still identified as white (89%). Respondents also tended to be younger than Veterans across the state.

1. Demographic characteristics of Minnesota Veterans and survey respondents

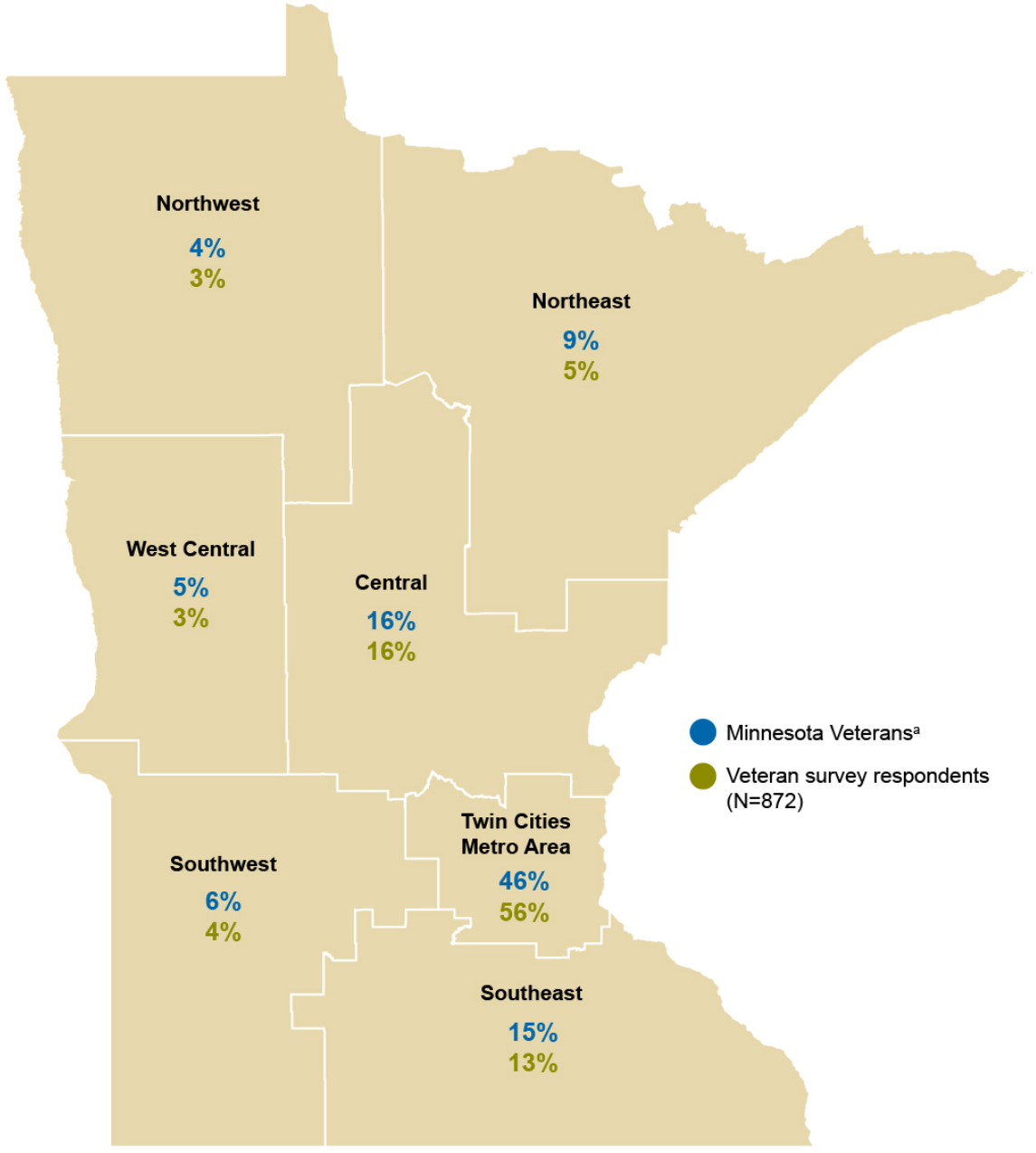
	Minnesota Veterans[a]	Veteran survey respondents
Gender		**(N=881)**
Men	93%	85%
Women	7%	15%
Other	N/A	<1%
Race/ethnicity		**(N=876)**
White/Caucasian	92%	89%
Black/African American	3%	3%
Other/Mixed race	2%	4%
Hispanic (any race)	2%	2%
American Indian	1%	2%
Asian American	1%	1%
Native Hawaiian or Other Pacific Islander	N/A	<1%
Age		**(N=880)**
18 to 34 years	9%	15%
35 to 54 years	24%	29%
55 to 64 years	19%	21%
65 to 74 years	26%	31%
75 years and over	23%	4%

Note. Respondents were asked separately about race and Hispanic ethnicity. Those who report Hispanic ethnicity are not included in the racial categories for data in this figure.

[a] 2014 U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics.

Just under half of Minnesota Veterans live in the Twin Cities metro area (46%) (Figure 2). Survey respondents fell into a similar geographic distribution across the state, with slightly more survey respondents living in the Twin Cities metro area (56%).

2. Regional distribution of Minnesota Veterans and survey respondents



[a] 2014 U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics.

Service characteristics

Slightly more than half of survey respondents served in the Army (53%), followed by Navy (22%), Air Force (19%), Marine Corps (10%), and Coast Guard (1%; Figure 3). Roughly a quarter of respondents (25%) had served in the National Guard/Reserve Component.

3. Survey respondent military branch

Military branch	Percent of survey respondents (N=914)
Army	53%
Navy	22%
Air Force	19%
Marine Corps	10%
Coast Guard	1%
Other	<1%

Note. Respondents were allowed to select more than one response.

Survey respondents represent a wide range of service eras with over one-third serving in the Vietnam era (39%), and approximately 30 percent serving in each era after (Figure 4). Slightly more than half of respondents served in a combat or war zone (55%), and more than half were on active duty between 2-5 years (57%; Figure 5).

4. Survey respondent service era

Service era	Percent of survey respondents (N=918)
September 2001 or later	34%
August 1990 to August 2001 (includes Persian Gulf War)	29%
May 1975 to July 1990	32%
Vietnam era (August 1964 to April 1975)	39%
February 1955 to July 1964	6%
Korean War (July 1950 to January 1955)	1%
January 1947 to June 1950	0%
World War II (December 1941 to December 1946)	<1%
November 1941 or earlier	<1%

Note. Respondents were allowed to select more than one response.

5. Survey respondent time in active duty

Time in active duty	Percent of survey respondents (N=903)
Less than 2 years	7%
2-3 years	29%
4-5 years	28%
6-10 years	14%
11-15 years	5%
16+ years	16%

Note. Column total varies from 100 percent due to rounding.

Prevalence of mental and behavioral health needs

This section of the report summarizes the prevalence of behavioral health issues among the survey of Minnesota Veterans conducted for this report, as well as Veterans based on state and national data.

Mental health diagnoses

Minnesota Veteran survey results

Overall, 47 percent of respondents to the Minnesota Veteran survey had some type of mental health diagnosis (Figure 6). The most common diagnoses included anxiety disorder or panic disorder (33%), followed by major depression (30%) and Post-Traumatic Stress Disorder (PTSD; 28%).

6. Survey respondent mental health diagnoses

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Percent of survey respondents
Anxiety disorder or panic disorder (N=879)	33%
Major depression (N=872)	30%
Post-Traumatic Stress Disorder (PTSD; N=867)	28%
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder (N=848)	12%
Manic episodes or manic depression, bipolar disorder (N=840)	6%
Paranoid or delusional disorder, other than schizophrenia (N=840)	3%
Schizophrenia (N=840)	1%
Any mental health diagnosis (N=908)	47%

Note. Column does not total 100 percent because respondents were able to identify multiple diagnoses.

In addition to asking about diagnoses, survey respondents were also asked a series of screening questions to measure their symptoms of depression, anxiety, and PTSD. According to the PHQ-4 screening, around a quarter of survey respondents screened positive on the subscales for anxiety (27%) and depression (26%; Figure 7). Approximately two-thirds of respondents who screened positive for depression or anxiety also reported a formal diagnosis.

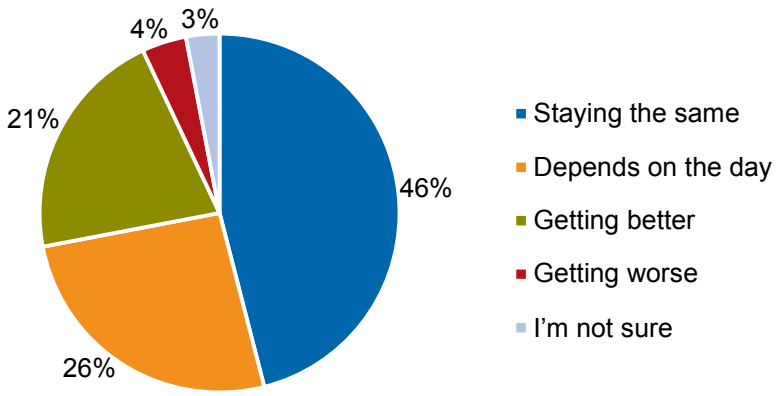
In addition, 32 percent of survey respondents screened positive for active PTSD symptoms (Figure 7). Of the respondents who screened positive, 65 percent of them reported a PTSD diagnosis, and 80 percent reported that they sought help because of their experiences. Over half of those who screened positive reported that they had an experience leading to the PTSD symptoms that occurred during their service (55%), and 86 percent also reported they had an experience leading to PTSD symptoms after their service.

7. Survey responses on standardized mental health screening tools

	Percent of survey respondents
Depression subscale	
Percent of all respondents that screened positive for depression (N=897)	26%
Of those who screened positive for depression, percent reporting a diagnosis of major depression (N=223)	68%
Anxiety subscale	
Percent of all respondents that screened positive for anxiety (N=898)	27%
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety (N=227)	69%
PTSD scale	
Percent of all respondents that screened positive for PTSD (N=906)	32%
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD (N=280)	65%

Overall, when asked about their mental well-being, slightly less than half of survey respondents reported that it is staying the same (46%) (Figure 8). Roughly a quarter of respondents (26%) reported that it depends on the day, while around a fifth (21%) reported it is getting better.

8. Survey respondent changes in mental well-being, N=885



Additional data from existing sources

Other state and national sources report a smaller proportion of Veterans with mental health diagnoses. According to the national 2013 BRFSS, 14 percent of Minnesota respondents who have served on active duty in the U.S. armed forces reported having a diagnosed depressive disorder (Centers for Disease Control, 2013). In addition, 9 percent reported receiving medication or treatment from a health provider for a mental health issue, and 11 percent scored as having at least a mild mental health disorder on a standardized screening tool. These rates are similar to the civilian population completing the survey.

According to the U.S. Department of Veterans Affairs (VA)(2016), approximately 22 percent of patients nationally had a depression diagnosis in 2014. This is an increase from approximately 14 percent in 2001. In addition, about 13 percent of patients had a PTSD diagnosis and 12 percent had another anxiety disorder in 2014, which also represent increases from 2001 (6-7%).

Suicide

Minnesota Veteran survey results

Thirty-five percent of Minnesota Veteran survey respondents reported suicidal ideation at some point in their lives. Of those who reported suicidal ideation, 13 percent were currently having these thoughts (4% of all respondents). Of those who reported suicidal ideation, 25 percent have attempted suicide, and 44 percent have sought help at some point because they were suicidal (9% and 15% of all respondents, respectively).

Additional data from existing data sources

Once a person attempts suicide, they are approximately 40 times more likely to eventually die by suicide than those without a history of attempts (Harris & Barraclough, 1997).

According to the VA, 20 Veterans died by suicide each day in 2014. At that time, Veterans accounted for 18 percent of all deaths by suicide, though they only account for 9 percent of the overall U.S. adult population (U.S. Department of Veterans Affairs, 2016). The suicide rate among VA patients nationally has remained stable at approximately 39 percent.

According to Minnesota death certificates in 2015, approximately 14 percent of individuals whose deaths were ruled as suicide had served in the armed forces, based on descendent report (Minnesota Department of Health, 2016). The number of Veterans who died by suicide in 2013, 2014, and 2015 has stayed consistent at about 100 individuals, however,

the overall number of suicides in Minnesota has increased in that time, making the proportion of suicides by Veterans lower over time.

Substance use

Minnesota Veteran survey results

In the survey conducted for this report, 18 percent of respondents reported having any chemical health diagnosis (Figure 9). This includes 17 percent with an alcohol abuse disorder and 4 percent with a drug abuse disorder. In addition, 29 percent of respondents screened as clinically significant for an alcohol or drug abuse issue. Of those who screened clinically significant, half also reported a chemical health diagnosis, most commonly an alcohol abuse disorder diagnosis.

9. Survey respondent chemical health diagnosis and screening

	Percent of survey respondents
Alcohol abuse disorder diagnosis (N=861)	17%
Drug abuse disorder diagnosis (N=842)	4%
Any chemical health diagnosis (N=867)	18%
Screened as clinically significant for alcohol/drug abuse (N=896)	29%
Of those who screened clinically significant for alcohol/drug abuse	
A chemical health diagnosis (N=250)	50%
An alcohol abuse disorder diagnosis (N=250)	48%
A drug abuse disorder diagnosis (N=232)	13%

Additional data from existing data sources

Previous studies completed on the topic show similar rates of chemical health diagnoses and symptoms to those of respondents to the Minnesota Veteran survey. About 10 percent of VA patients had a diagnosed substance use disorder consistently from 2001 through 2014 (U.S. Department of Veterans Affairs, 2016). In the National Survey on Drug Use and Health (NSDUH), most Veterans reported using alcohol in the past 30 days (75%), while 44 percent reported binge drinking in the past 30 days, and 15 percent had a diagnosed alcohol abuse disorder (Golub, Vazan, Bennett, & Liberty, 2013). Few Veterans reported using illicit drugs in the past month (1-11%), and 5 percent had a substance use disorder involving illicit drugs.

In two national surveys, Veterans reported similar levels of binge drinking, illicit drug use, and alcohol or drug use disorders as civilians (Centers for Disease Control, 2013; Golub, Vazan, Bennett, & Liberty, 2013). Both Veterans and civilians were also similarly likely to have unmet substance use treatment needs (Golub, Vazan, Bennett, & Liberty, 2013). Specifically, 18 percent of Veterans met the criteria for a substance use disorder, but only 2 percent received treatment. However, only 1 percent thought they had an unmet treatment need, which may indicate that some Veterans are unaware of their need for treatment.

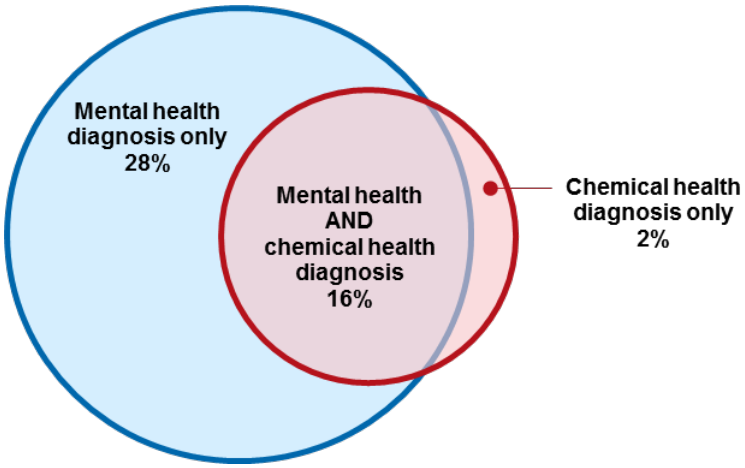
Co-occurring issues

Mental health and chemical health

Minnesota Veteran survey results

In the Minnesota Veteran survey, nearly half (46%) had either a mental health or chemical health diagnosis (Figure 10). These respondents were most likely to have only a mental health diagnosis (28%), followed by a dual mental and chemical health diagnosis (16%). Only 2 percent of respondents had a chemical health diagnosis without a mental health diagnosis.

10. Survey respondent co-occurring diagnoses



Note. Neither mental health nor chemical health diagnosis: 54%.

Additional data from existing data sources

Approximately 5 percent of Veterans in the NSDUH survey had both a substance use disorder and a serious psychological disorder, but this overlap accounts for 29 percent of those with a substance use disorder, and 38 percent of those with a serious psychological disorder (Golub, Vazan, Bennett, & Liberty, 2013).

Mental health and suicide behaviors

Minnesota Veteran survey results

The Minnesota Veteran survey showed a strong connection between diagnoses and suicidal ideation. Respondents with both a mental and chemical health diagnosis were at greatest risk for suicidal ideation and a history of suicide attempts (Figure 11).

11. Survey respondent suicidal ideation by mental and chemical health diagnosis

	Mental health diagnosis only (N=238)	Chemical health diagnosis only (N=19)	Mental and chemical health diagnosis (N=133)	Neither diagnosis (N=451)
Has had thoughts of suicide***	52%***	26%***	70%***	15%***
Has current thoughts of suicide	14% (7% of total)	0/5	15% (11% of total)	7% (1% of total)
Has attempted suicide***	28%*** (14% of total)	0/5***	40%*** (28% of total)	6%*** (1% of total)
Has sought help because of suicidal ideation***	49%*** (25% of total)	2/5***	56%*** (39% of total)	14%*** (2% of total)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001.

Additional data from existing data sources

Similar to the findings in the Minnesota Veteran survey, several other studies have demonstrated a strong connection between mental health diagnoses and suicidal ideation or attempts (U.S. Department of Veterans Affairs, 2016; Corson, et al., 2013; Cox, et al., 2016; Nock, et al., 2013). In particular, 75 percent of Veterans with diagnosed PTSD and/or depression had suicidal thoughts, and 13 percent had a suicide plan (Maguen, et al., 2015). Similarly, psychological autopsies have revealed that over 90 percent of people who died by suicide had a diagnosable mental disorder at the time of their death (Cavanagh, Carson, Sharpe, & Lawrie, 2003).

It appears that different types of mental health diagnoses affect suicidal ideation differently. Nock and colleagues (2009; 2010), found that depression symptoms are more likely to be associated with suicidal ideation, while anxiety disorders, including PTSD, are more likely to be associated with suicide attempts. Veterans with both PTSD and depression symptoms were at higher risk for suicidal ideation than Veterans with PTSD or depression symptoms alone (Lemaire & Graham, 2011). It is important to note, though, that a mental health disorder alone is not sufficient to predict suicidal behavior and most people with a mental health disorder never display suicidal behavior (Nock, et al., 2013).

Assets and resources

Behavioral health services available

This portion of the report includes a description of key mental and chemical health services offered in Minnesota. Many private mental health service providers, such as therapists or counselors, and informal services, such as peer support groups, exist throughout the state, but a comprehensive list of these services was not available. This section also includes survey and key informant interview respondent reports of the services they are aware of or have used.

It should be noted that because a service is available, it does not necessarily mean the service is appropriate or accessible for a specific individual. Barriers to accessing services are described in the next section of this report.

Veteran-specific services

The MDVA Health Care Division operates five Veterans Homes across Minnesota that provide both medical and behavioral health care in a residential setting (Minnesota Department of Veterans Affairs, 2016). These homes have a variety of specialties, ranging from long-term dementia care to rehabilitative and therapeutic care to assist with increased independence. Therefore, there is a wide range of primary diagnoses associated with patient care across locations. In the Hastings home, which has 200 beds, 17 percent of residents had a primary diagnosis of depression, 27 percent had a primary diagnosis of another mental health condition, and 17 percent had a substance abuse primary diagnosis in 2015. The other homes had between 2 and 9 percent of patients with a mental or chemical health issue as their primary diagnosis.

MDVA has also partnered with Lutheran Social Services to provide community-based services to Veterans and their families in 11 regional locations across the state. From July 2014 through June 2015, the program served 498 clients in 62 counties, including 324 Veterans, as well as spouses and children of Veterans. The most common service provided was in-office counseling (32%), followed by group counseling (28%) and case management (22%).

The VA provides a variety of behavioral health support services (U.S. Department of Veterans Affairs, 2012; St. Cloud VA Health Care System, n.d.; Minneapolis VA Health Care System, n.d.). The national VA provides a 24-hour crisis line and all VA medical centers are required to either directly provide or contract with a local hospital to provide around-the-clock emergency mental health care, including telephone evaluations. There are 14 community-based outpatient clinics and three VA health systems that can provide mental health services to Minnesota Veterans. Services include outpatient mental health

clinics, acute psychiatric care, and programs specifically focused on PTSD and MST. The medical centers use evidence-based programs, such as Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), Prolonged Exposure Therapy (PE), and Interpersonal Therapy (IPT). The VA has also been expanding the use of telehealth services to provide support to Veterans who are unable to access the medical centers.

The Minneapolis VA hospital provides a wide range of programming from social skill building and mindfulness activities to inpatient psychiatry. This includes several groups addressing specific needs or populations, such as depression management; recovery; dual mental and chemical health diagnosis; grief and loss; gender identity; and lesbian, gay, and bisexual issues. The Minneapolis medical center also provides 24 inpatient psychiatry beds (Minneapols VA Health Care System, n.d.).

The St. Cloud VA medical center provides 15 beds for acute inpatient psychiatry and 148 residential substance abuse and psychiatric residential rehabilitative treatment programs (RRTP) beds for patients with substance abuse and mental health disorders (St. Cloud VA Health Care System, n.d.).

The Fargo VA medical center is located in North Dakota, but serves patients in the northwestern portion of Minnesota. In FY16, the Fargo VA medical center served 11,319 unique Minnesota patients, of which 2,021 (18%) were seen for a mental health issue (Z. Leon, personal communication, December 19, 2016).

Key informants were asked what mental and behavioral health services for Veterans they are aware of in their area. Based on their responses, in general, outpatient services are more common than inpatient services (Figure 12). In addition, mental health services were more available than chemical health services.

In terms of specific services, key informants most commonly reported that outpatient mental health counseling existed in their area (83%), followed by outpatient group mental health counseling (68%) and peer-to-peer mental health support (63%; Figure 12). The services most commonly identified as unavailable were inpatient individual chemical dependency treatment (29%), inpatient group mental health counseling (37%) inpatient individual mental health counseling (39%), and supportive housing (42%).

Key informants in the Twin Cities metro area were more likely than key informants in greater Minnesota to say they have inpatient individual mental health counseling (54% versus 32%) and inpatient group mental health counseling (54% versus 32%; Figure 12). These differences exceeded the report criteria of 20 percentile points, but were not statistically significant.

12. Key informant reported services specifically for Veterans in the county/area

Services available in area	All key informants (N=41)	Greater MN key informants (N=28)	Twin Cities metro key informants (N=13)
Outpatient individual mental health counseling	83%	79%	92%
Outpatient group mental health counseling	68%	64%	77%
Peer-to-peer mental health support	63%	64%	62%
Peer-to-peer chemical dependency support	54%	57%	46%
Outpatient group chemical dependency treatment	51%	46%	61%
Recovery services	51%	54%	46%
Supportive housing (sober housing, mental health)	42%	36%	54%
Inpatient individual mental health counseling	39%	32%	54%
Inpatient group mental health counseling	37%	29%	54%
Inpatient individual chemical dependency treatment	29%	32%	23%
Other[a]	21%	18%	23%

Note. Total exceeds 100 percent because respondents were asked to select all that apply. Significance tests were conducted using chi-square tests. No statistically significant differences were found.

[a] "Other" responses included: individual and group counseling services that periodically travelled to area (n=4) and Veterans court (n=5).

Services for specific Veteran populations

Key informants were asked if they were aware of any mental health or behavioral health services in their area for specific populations of Veterans. Key informants were most likely to be aware of services for Veterans of a specific era or conflict, such as Vietnam, or Operations Iraqi and Enduring Freedom (67%; Figure 13). In addition, about half said they have specific mental health or behavioral health options for Veterans who have experienced sexual assault (52%) and for female Veterans (49%). Customized mental health or behavioral health services were less often available for Veterans with a traumatic brain injury or a physical disability (36% each), for Veterans based on their branch of the military (30%), and for Veterans of color (12%).

Key informants from the Twin Cities metro area were more likely than those from greater Minnesota to report the existence of mental health or behavioral health services specifically for Veterans who have experienced sexual assault (73% versus 41%) and for female Veterans (64% versus 41%), although the differences were not statistically significant (Figure 13).

13. Key informant reported availability of services for specific Veteran populations in county/area

Specific population	All key informants (N=33)	Greater MN key informants (N=29)	Twin Cities metro key informants (N=14)
Veterans of a specific era/conflict	67%	64%	73%
Veterans who have experienced sexual assault	52%	41%	73%
Female Veterans	49%	41%	64%
Veterans with traumatic brain injury	36%	36%	36%
Veterans with physical disabilities, including vision or hearing loss	36%	36%	36%
Specific branches of the military	30%	27%	36%
Veterans of color	12%	14%	9%
Other[a]	18%	14%	21%

Note. Total exceeds 100 percent because respondents were asked to select all that apply. Significance tests were conducted using chi-square tests. No statistically significant differences were found.

[a] "Other" includes services for Veterans with PTSD (n=5).

If at least one of the mental health or behavioral health services asked about was not available in the area, key informants were asked if there were any public transportation options to reach these services in another areas. Eighty-two percent of key informants said there is transportation to at least one of the services at least some of the time, while the remainder said they were not sure (Figure 14). Key informants in greater Minnesota were more likely than those in the Twin City metro to know of a transportation option to services outside of their area (89% versus 67%).

14. Key informant reported transportation to services outside of the county/area

If services don't exist in area, is there transportation to at least one of the services in another area	All key informants (N=39)	Greater MN key informants (N=27)	Twin Cities metro key informants (N=12)
Yes	82%	89%	67%
Don't know	18%	11%	33%
No	0%	0%	0%

Note. Significance tests were conducted using chi-square tests. No statistically significant differences were found.

Transportation logistics

In discussing the transportation to services available for Veterans in their area, many key informants noted who provides the transportation services. The following reached the level of agreement or endorsement:

- **The County** (n=23). Over half of key informants noted that their county provides transportation services, typically on weekdays during daytime work hours. Some county vans strictly visit VA facilities, while others are able to take Veterans to other appointments as needed. Some respondents noted that their county transportation has eligibility requirements, based on income, physical disability status, or some other criteria. A few respondents noted that most county vans are not wheelchair accessible, and often are prohibited from transferring patients in an emergency.

- **Nonprofit organizations and groups** (n=22). Key informants noted several nonprofit organizations and groups that provide transportation to Veterans. Some of the organizations specifically serve Veterans, such as Beyond the Yellow Ribbon, and others were focused on community health, such as a local health clinic. Within this theme, several key informants noted that most of the rides are provided by volunteers and, thus, are limited by their availability.

- **Disabled American Veterans** (DAV; n=14). DAV oversees a national transportation system with services in certain areas of Minnesota. Key informants noted that the system provides rides to VAs, with transportation provided by volunteers, and, thus, limited to their availability although MDVA staff noted that volunteer coordination does not interfere with transportation scheduling

- **VA provided** (n=9). Several key informants discussed transportation provided by VA facilities to and from appointments at their center. In addition, in some cases, transportation is offered to other service providers approved by the VA.

Services for the broader community

In addition to the services specifically for Veterans, Minnesota has an array of behavioral health services available throughout Minnesota, including the following residential (more intensive) and community-based (less intensive) services identified through existing data sources.

Residential services

Residential services are more intensive services that are provided to individuals with serious mental or chemical health needs that cannot be addressed through community-based services. In some cases, residential services are accessed through mental health commitments.

- **Intensive residential treatment services (IRTS)** are time-limited mental health services provided in a residential setting. These services are specifically for individuals who require 24-hour access to mental health services. Each facility has a maximum of 16 beds. In Minnesota, there are currently 38 licensed IRTS facilities with 494 beds, including nearly half (47%) in greater Minnesota (Minnesota Department of Human Services, 2016).

- **Residential crisis stabilization services** are intended to restore independence to individuals experiencing a mental health crisis. Residential stabilization services require 24-hour access to staff and a mental health professional. In Minnesota, DHS licenses 20 residential crisis service providers, for a total of 418 beds. The majority of these beds (69%) are in the Twin Cities metro area (Minnesota Department of Human Services, 2016).

- **Minnesota's community hospitals** have 960 adult inpatient mental health beds statewide. More than 80 percent of the inpatient mental health beds were occupied in 2014, compared to 40 percent occupancy for all hospital beds, demonstrating the high demand for inpatient mental health beds (Minnesota Hospital Association, 2015).

- **Anoka Metro Regional Treatment Center (AMRTC)** provides inpatient and transitional services to patients with severe mental illness. AMRTC is licensed for 175 beds, but they have not been serving patients at capacity. In 2015, AMRTC served 278 patients, total, which is a significant decrease from 696 patients in 2007 (Minnesota Department of Human Services, 2016). AMRTC attributes this decrease to a decrease in capacity and an increase in patient complexity, length of stay, and discharge delays. During that same period, the proportion of patients served from greater Minnesota has increased from 11 percent in 2007 to 53 percent in 2015. AMRTC was originally intended to serve primarily Twin Cities metro patients, and AMRTC attributes the change to shifts in the overall DHS Direct Care and Treatment delivery system.

- **Community Behavioral Health Hospitals (CBHH)** provide short-term, acute inpatient psychiatric services at seven 16-bed sites located throughout greater Minnesota. In recent years, these facilities have been operating at capacities of 8 to 11 beds (Minnesota Office of the Legislative Auditor, 2016), but during the 2016 legislative session, resources were shifted to increase these facilities to full capacity. These hospitals have also been increasingly serving persons who are civilly committed and persons from across the state, rather than community members from within the region (Minnesota Office of the Legislative Auditor, 2016).

- **Residential facilities for substance abuse treatment licensed by DHS**. There are currently 111 licensed facilities with 3,377 beds, 57 percent of which are in greater Minnesota (Minnesota Department of Human Services, 2016). Over half of these facilities (51%) and two-thirds of these beds (65%) are licensed to provide treatment for dual diagnosis patients with chemical and mental health diagnoses.

Community-based services

Community-based services are less intensive than residential services, and they are intended to allow individuals to remain in their homes and communities. These services can vary in the frequency or intensity of contact, and providers can often serve more individuals than they are able to in residential services. These services are also more likely to be provided by a range of individuals with a wide array of skills and experience, and the Department of Human Service only licenses the types of services listed below.

- **Assertive Community Treatment (ACT)** are intensive, comprehensive, non-residential rehabilitative mental health services that are (a) provided by multidisciplinary, qualified staff; (b) directed to persons with a serious mental illness who require intensive services; and (c) offered at any time without time limits. DHS licenses 26 ACT teams throughout Minnesota, including roughly half in greater Minnesota (46%).

- **Adult Rehabilitative Mental Health Services (ARMHS)** are support services for individuals with mental health issues that include four components: basic living and social skills, community intervention, medication education, and transitioning to community living (Minnesota Department of Human Services, 2016). In Minnesota, there are 390 licensed ARMHS providers, two-thirds of which are in greater Minnesota.

- **Outpatient mental health centers or clinics licensed by DHS** across Minnesota. Over half of these 65 organizations are in the Twin Cities metro area (58%) (Minnesota Department of Human Services, 2016). In addition, DHS licenses 46 state certified providers to specifically conduct Dialectical Behavior Therapy (DBT), which is an evidence-based comprehensive treatment for individuals exhibiting symptoms of suicidal behaviors, self-harm, and/or a borderline personality disorder (Minnesota Department of Human Services, 2016).

- **Crisis response and stabilization services**. These services assist a person who is experiencing a mental health crisis to cope with that crisis and stay in their own home and community (Minnesota Department of Human Services, 2016). Every county in Minnesota has an emergency mental health telephone number that connects an individual to a mental health crisis responder who assesses the crisis, assists with immediate coping, and provides follow-up and referrals, as needed.

Key informants were asked whether a list of mental health and behavioral health services exist in their area that are not specific to Veterans, but Veterans could access. As with Veteran-specific services, outpatient services were more common than inpatient services. Unlike Veteran-specific services, mental health services and chemical health services were more similarly available.

In terms of specific services, outpatient individual mental health counseling was most common (88%) followed by outpatient group chemical dependency treatment (79%), peer-to-peer chemical dependency support (79%), and outpatient group mental health counseling (77%; Figure 15). Inpatient individual and group mental health counseling were least commonly reported as available (54% and 49%, respectively).

Key informants from greater Minnesota were more likely than key informants from the Twin Cities metro area to report having outpatient group chemical dependency treatment (90% versus 57%), peer-to-peer chemical dependency support (86% versus 64%) and recovery services in their area (76% versus 50%; Figure 15). Key informants from the Twin Cities metro area were more likely to say they have inpatient group mental health counseling (64%), compared to those from greater Minnesota (41%).

15. Key informant reported services for the community at large in the county/area

Services	All key informants (N=43)	Greater MN key informants (N=29)	Twin Cities metro key informants (N=14)
Outpatient individual mental health counseling	88%	93%	79%
Outpatient group chemical dependency treatment	79%	90%	57%
Peer-to-peer chemical dependency support	79%	86%	64%
Outpatient group mental health counseling	77%	76%	79%
Recovery services	67%	76%	50%
Supportive housing (sober housing, mental health)	65%	66%	64%
Peer-to-peer mental health support	61%	59%	64%
Inpatient individual chemical dependency treatment	56%	55%	57%
Inpatient individual mental health counseling	54%	48%	64%
Inpatient group mental health counseling	49%	41%	64%
Other[a]	26%	28%	21%

Note. Total exceeds 100 percent because respondents were asked to select all that apply. Significance tests were conducted using chi-square tests. No statistically significant differences were found.

[a] "Other" include crisis center/walk-in counseling (n=5), outreach mental health services (n=4), and domestic violence-related services (n=3).

Services used by Veterans

Survey respondents were asked if they have received mental and chemical health services since exiting the military and in the past two years. Less than half of survey respondents said they have received any mental or chemical health services since exiting the military (44%), and fewer had received services in the past two years (38%). Of those who said they had received services in the past two years, the majority said they received individual mental health counseling (90%; Figure 16) and 72 percent said they were Federal services (Figure 17).

16. Types of services received by survey respondents in the past two years

In the past two years, what type of services did you receive?	Mental health services (N=334)	Chemical health services (N=334)
Individual counseling (outpatient)	90%	11%
Group counseling (outpatient)	23%	7%
Peer-to-peer support	22%	9%
Inpatient counseling or treatment	17%	7%

16. Types of services received by survey respondents in the past two years (continued)

In the past two years, what type of services did you receive?	Mental health services (N=334)	Chemical health services (N=334)
Crisis line	11%	3%
Recovery services	8%	8%
Supportive housing	7%	4%
Faith-based support services	16%	3%
Other services	13%	2%
NONE	3%	81%

Note. If a respondent did not select any type of service for a column they were marked as 'None.'

17. Service origin for services received by survey respondents

Of all the services you have used, were any of them…	Percent of survey respondents (N=334)
Federal services	72%
State services	19%
County services	17%
Local government services	7%
Private services	38%
Nonprofit services	19%
NONE	3%

Note. If a respondent did not select any type of service they were marked as 'None.'

Use of mental and chemical health services since exiting the military and in the past two years varied by sub-groups. The following groups were significantly more likely to use mental and chemical health services in the past two years and since exiting the military (see appendix for full results by group):

- Survey respondents with a concussion/TBI diagnosis (73% since leaving the military; 67% in the past two years)
- Survey respondents with a disability (57% since leaving the military; 51% in the past two years)
- Survey respondents who have experienced sexual assault (70% since leaving the military; 62% in the past two years)

- Women (62% since leaving the military; 55% in the past two years)
- Survey respondents with a weak sense of community belonging (65% since leaving the military; 57% in the past two years)
- Veterans of color (55% since leaving the military; 55% in the past two years)

The type of mental and chemical health services received in the past two years also varied by sub-groups. Below are descriptions of the statistically significant variations between groups (see appendix for full results by group):

- **Combat status.** Combat Veterans were more likely to have received individual mental health counseling in the past two years (94%) than non-combat Veterans (82%).
- **Concussion/TBI diagnosis**. Survey respondents with a concussion/TBI diagnosis were more likely to have received mental health group counseling (35% compared to 20% for those without a diagnosis) and mental health recovery services (16% compared to 6% for those without a concussion/TBIU diagnosis).
- **Disability.** Survey respondents with a disability were more likely to have received individual mental health counseling (92%) and mental health recovery services (10%) than those without a disability (80% and 1%, respectively).
- **Experienced sexual assault.** Survey respondents who have experienced sexual assault were more likely to have used a mental health crisis line (19% versus 7% of those who have not experienced sexual assault). Among those who experienced sexual assault, men were more likely than women to have received mental health supportive housing services (17% versus 2%) and were more likely to have received individual chemical health counseling (19% versus 6%).
- **Social Support.** Survey respondents who said they "always" or "usually" get the support they need were more likely to have received faith-based mental health services (19%) compared to those who sometimes (13%) or rarely or never (13%) receive the support they need.
- **Length of Service.** Service use varied by the length of time a survey respondent had served. Respondents who hadn't served as long were more likely to have received mental health supportive housing services (10% for those who served less than two years and 14% of those who served 2-3 years, compared to 2% of those serving 6-10 years and 3% of those serving 11+ years). Similarly, those who served less than 2 years were more likely to have received chemical health recovery services (25% versus 5% to 7% for those who served longer).

- **Race.** Survey respondents of color were more likely to have received peer–to-peer mental health support services (34% compared to 20% of white respondents) and mental health supportive housing services (17% compare to 5% of white respondents). They were also more likely to have received chemical health services in the form of individual counseling (21%) compared to white respondents (9%).

- **Sense of belonging.** Survey respondents with a strong sense of belonging were more likely to have received a variety of services than those with a weak sense of belonging. These included: mental health group counseling (29% versus 19%), peer-to-peer mental health services (28% versus 18%), faith-based mental health support services (23% versus 11%), and peer-to-peer chemical health services (13% versus 6%). Survey respondents with a weak sense of belonging were more likely to have received individual mental health counseling services (94%) than those with a strong sense of belonging (84%).

Strengths of services

Key informants and survey respondents were all asked an open-ended question about what is working well in terms of mental and behavioral health services for Veterans. This portion summarizes the key themes of those responses.

Key informants' perceptions of what is working well

Key informants were asked to describe what is going well in regard to mental and behavioral health services in their geographic area. The following themes were endorsed:

- **Collaborations** (n=14). Many key informants described strong collaborations related to serving Veterans in their area. The details of the collaborations varied, with some being within an organization, some within a sector, and some across sectors. Most were described as effective because of strong communication between the entities involved, as well as a commitment to meeting shared goals.

> *Being a County Veterans Services Officer, I am working with people in my county. We are referring back and forth to each other. A surviving spouse who shows up at [a county office], a social worker will refer them to me. We are very connected to bridge the gaps between our services. Trying to maximize the potential to access these resources.*
>
> *Great working relationship between VA, VA regional office, county VA, and national offices. Sense of working together that doesn't exist in all places in this country. We look at problems and try to solve them.*

> *We've got a good working relationship with other county agencies - we cross talk with each other…because we have a lot of mutual clients. Same with law enforcement - county sheriff and local police department. We've been contacted by local officers working with Veterans who are in crisis in that moment - officers reach out to us and we reach out to the Veterans. Not that we keep them out of trouble or out of the courtroom, but there's enough connection between the agencies to get them in contact with [Veteran-specific services].*

- **Variety of resource options** (n=11). Some key informants identified the range of resources available in their area for Veterans as a strength. Most were speaking to having options that address a wide range of needs, while a few discussed multiple choices in one specific area, such as mental health, or in one specific organization, such as the VA. Key informants in the Twin Cities metro area were more likely than those in greater Minnesota to identify resource options as an asset.

> *I think what's working well is there are options in some of the different areas of mental health services, and I think that's good. … They can find something that works well for them, and there's an effective solution to their mental health needs. It's good to have options for them. That's working well. There's more than one provider for mental health services for Veterans. There's more than one option for them, be it a mental health service provider or a peer-to-peer option, if they want that. There's institutional and non-institutionalized settings for them to address mental health needs in their life. I think that's good… It's not a one-size-fits-all solution for everyone. There are options for them. It's important to maintain that, because not every need is going to be the same, and they can find the solution that works for them.*
>
> *I think largely the fact that we have a large VA facility in our area with pretty much any and all resources under the sun.*
>
> *[Veterans] have access to a vast range of resources from 1:1 to group to individual and hospital [care]. All of the housing spectrum is available. All recovery services are available. Largely, if you need it, it can be gotten in some way.*

- **Individual providers** (n=9). Within this theme, key informants discussed service providers that are assets to their area because of their knowledge about and skills working with Veterans and their commitment to providing Veterans with quality services. The individuals discussed were most often county Veterans Service Officers and mental health providers. The words used to describe the quality of providers ranged from "fairly good" to "exceptional."

> *Our CVSOs are second to none in the state – exceptional.*
>
> *I've heard good reports about [the provider at the clinic].*

- **The VA Health Care System** (n=9). The local VA was noted by several key informants as an important strength. Key informants cited the range and quality of services the VA offers, as well as the ease of getting to services through different transportation options.

> *When I can get people connected with the St. Cloud or Brainerd VA, they've loved it… It's been very effective. I have to give kudos to St. Cloud and Brainerd VA. They are doing an outstanding job.*
>
> *The VA medical center is fantastic. It provides great services and is incredibly convenient, including being on the light rail.*

Survey respondents' perceptions of what is working well

If a survey respondent said they received any service for their mental or chemical health in the past two years they were also asked what was most helpful. Nearly all of the survey respondents who received services provided an answer (97%). The most common responses were individual counseling (33%) and VA-based services (32%). Other common responses included medication (13%), private/civilian/local services (10%), and group counseling (6%; Figure 18).

18. Most helpful aspect of services for those survey respondents who received services

What was most helpful?	Percent of survey respondents (N=323)
Individual counseling	33%
VA based services	32%
Medication	13%
Private/civilian/local services	10%
Group counseling	6%
Nothing	5%

Note. This table provides coded themes rather than verbatim responses. Themes with < 5 percent of respondents are included in the Appendix.

Service needs

Survey respondents' service needs

Survey respondents were also asked whether they feel like they have the support they need. Seventy-seven percent of respondents who answered the question felt like they have the support they need. This included more respondents who did not receive services in the last two years (53%) than those who did receive services (24%; Figure 19).

Sub-groups where they were significantly less likely to feel they have the support they need compared to other groups were (see appendix for full results by group): survey respondents with a concussion/TBI diagnosis (64%), those with a disability (70%), respondents with a very or somewhat weak sense of belonging (55%), respondents ages 34-55 (69%), women (66%), those who have experienced sexual assault (62%), and those who rarely or never receive the social and emotional support they need (38%).

19. Survey respondents support and services needed

	Percent of survey respondents (N=874)
Feel like have support needed, have NOT received services in last 2 years	53%
Feel like have support needed, have received services in last 2 years	24%
Feel like do NOT have support needed, have received services in last 2 years	13%
Feel like do NOT have support needed, have NOT received services in last 2 years	10%

Survey respondents were deemed to be in need of mental health services if they had been diagnosed with any mental health condition or if they screened positive for PTSD, depression, anxiety, or suicidal ideation. When further examining those respondents who are deemed in need of mental health services, 65 percent said they have received some form of mental health service since exiting the military. For chemical health, survey respondents were deemed to be in need of services if they had been diagnosed with an alcohol or drug abuse disorder or they screened positive for an alcohol or drug abuse disorder. Similar to mental health services, 63 percent of survey respondents deemed in need of chemical health services said they have received some form of chemical health service since exiting the military (Figure 20).

20. Service need by survey respondent services received

Of those who had a mental health service need, the percent who…	Percent of survey respondents (N=918)
Mental health services needed (composite variable)	**63% (N=577)**
Received any services since exiting military	65%
Has not received any services since exiting military	34%
Received any services in last 2 years	56%
Has not received any services in last 2 years	44%
Of those who had a chemical health service need, the percent who…	
Chemical health services needed (composite variable)	**32% (N=291)**
Received any services since exiting military	63%
Has not received any services since exiting military	37%
Received any services in last 2 years	50%
Has not received any services in last 2 years	50%

Survey respondents' preferred service formats

Survey respondents were asked what type of services they would prefer to receive if they sought services. The majority of survey respondents selected at least one service format that they would prefer (82%). Two-thirds of those who selected a preferred service format said they would prefer one-on-one services with a professional care provider (68%). One-third would prefer informal support (33%) and one-quarter would prefer peer-to-peer (26%) or group support (24%; Figure 21).

21. Survey respondents' preferred service format

What service format would you prefer?	Percent of survey respondents (N=749)
Individual (one-on-one services with a professional care provider)	68%
Informal support (such as support from family, friends, etc.)	33%
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social, or practical help to each other)	26%
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	24%
Online (services provided online)	18%
Text (services provided through text messaging)	8%
Other	8%

Note. Column total exceeds 100 percent because respondents were asked to select all that apply.

Preferred service format varied by sub-groups. Below are descriptions of the statistically significant variations between groups (see appendix for full results by group):

- **Gender.** Women were more likely to prefer services by text (13%) than men (7%).
- **Age.** Survey respondents age 18-34 were less likely to prefer one-on-one services with a professional care provider (18%) than respondents ages 35-54 (74%) and 55-64 (72%). Survey respondents age 65 and older were less likely to prefer services by text message (3%) any other age group (8-11%).
- **Concussion/TBI diagnosis.** Survey respondents with a concussion/TBI diagnosis were more likely to prefer a group format (35%) and services by text (16%) than those without a diagnosis (22% and 7%, respectively).
- **Social support.** Survey respondents who rarely or never received the support they need were more likely to prefer online services (19%) than those who always or usually received the support they need (6%).
- **Race.** White respondents were more likely to prefer informal support (34%) than respondents of color (19%).
- **Sense of belonging.** Survey respondents with a weak sense of belonging were more likely to prefer peer-to-peer services (30% compared to 23% of those with a strong sense of belonging), individual services (75% versus 63%), online services (24% versus 14%), and text services (10% versus 6%), while survey respondents with a strong sense of belonging were more likely to prefer informal support (36% versus 29%).
- **Geography.** Those living in the Twin Cities metro area were more likely to prefer a peer-to-peer format (30%) than those living in greater Minnesota (22%).

Survey respondents' perceptions of what can be improved

If a survey respondent said they received any service for their mental or chemical health in the past two years they were also asked what was most and least helpful. More than three-quarters of the survey respondents who received services shared an answer about what was least helpful (78%). The most common responses were VA-based services/Federal services (19%) and individual counseling (11%). Some survey respondents also shared why the services were least helpful. The most common reasons mentioned included that the service did not care about individual issues or the treatment was not personalized (9%), the provider was not good with Veterans' issues or doesn't understand (7%), and the services don't help or aren't getting to the root of the problem (7%; Figure 22).

22. Least helpful about services for survey respondents who received services

What was least helpful?	Percent of survey respondents (N=260)
VA-based services/Federal services	19%
Individual counseling	11%
Medication	5%
Private/civilian/local services	5%
If so, why?	
Service did not care about individual issues/treatment not personalized	9%
Provider not good with Veterans' issues/doesn't understand	7%
Services don't help/Not getting to root of problem	7%

Note. This table provides coded themes rather than verbatim responses. Themes with < 5 percent of respondents are included in the Appendix.

Survey respondents' perceptions of missing supports

When asked what supports are missing, less than half of the respondents shared a response (40%). The most commonly mentioned support that was missing was a form of social support (18%) which includes family support (7%), friend support (4%), community support (4%), and spousal support (3%). Another commonly mentioned missing support included financial support (5%; Figure 23).

23. Missing supports

What supports are missing?	Percent of survey respondents (N=367)
Social support (combined codes of family, friends, community, and spousal)	18%
Financial support	5%

Note. This table provides coded themes rather than verbatim responses. Themes with < 5 percent of respondents are included in the Appendix.

Key informants' perceptions of unmet service needs

Key informants were asked what mental and behavioral services for Veterans were missing in their geographic area. Key informants endorsed the following:

- **Same day/crisis services** (n=8). Key informants discussed the need for same day services and crisis services, particularly in greater Minnesota. They mentioned that Veterans who need immediate assistance for mental and chemical health crises often have nowhere to stay locally and cannot find safe transportation to a location that may have crisis beds available.

  > *Right now the wait list for the VA can be three or four weeks. If someone is willing to go in, telling them it is a three to four week wait can be a big barrier. Then the other rural setting is an hour away and has a three to four week wait. Add chemical dependency and they could have a relapse during that time.*
  >
  > *If a Veteran has a crisis, it won't get resolved three days from now. It needs to get resolved now.*

- **Peer-to-peer groups** (n=7). Key informants endorsed the need for more services provided to Veterans, by Veterans. They discussed that Veterans know about their own issues, know how to support each other, and need to feel useful even if they are not able to participate in the full-time workforce. Key informants felt that more peer-to-peer mental and chemical health groups would be beneficial for Veterans.

  > *We just need a support group led by Veterans. Veterans talking to Veterans.*
  >
  > *More peer-to-peer [is needed] and it needs to stay peer-to-peer, not a clinical model. Minnesota is trying to make it so you need a college degree to be a peer-to-peer counselor. Veterans are used to a peer-to-peer approach. That is how they work. Don't change that.*

- **Geographically closer services in general** (n=7). Key informants also endorsed the need for more mental and behavioral health services for Veterans located in their area more generally. They noted that Veterans may be able to access certain services in other parts of the state, but that long travel times can be a barrier in Veterans seeking out those services. It was also noted that Veterans may not want to travel to the metro for services even if transportation were available to them.

  > *It would be awesome if we had inpatient and outpatient mental health care that was easy for Veterans to access within a reasonable distance from where they live.*
  >
  > *Access to all outpatient services within the county is something that is needed. Having to drive 60+ miles is a huge barrier. The number one thing we need in greater Minnesota is to have counseling available. Veterans need to be able to see someone without having to travel long distances.*

- **Transportation** (n=11). Key informants also endorsed the need for more transportation options, particularly in greater Minnesota. They noted that current transportation options are sporadic and do not meet the needs of all Veterans. Many programs are volunteer-run, or drivers need advance notice to pick up a Veteran. In addition, transportation services will often not transport a Veteran who is experiencing a mental health crisis. Some key informants also mentioned that many transport options are not accessible for Veterans with physical disabilities.

  > *The vans won't provide transportation to someone who is suicidal. Concerns about liability of picking up someone who is suicidal. Transportation is available in the most stable situations. In the most critical and urgent needs, most service officers, like myself, have driven someone because need is so great and services aren't available.*
  >
  > *I'm on a limited budget for van rides so transportation is a problem. I have a Veteran in a wheelchair that it took us forever to find transportation that would take him to the VA and that was for mental health.*
  >
  > *Transportation is disjointed in the county. Large county with urban, rural, and suburbia and expectation is most people drive. This isn't the case though.*

Key informants' perceptions of special populations in need of services

Key informants were asked about what mental and behavioral services for Veterans were missing in their geographic area for specific groups of Veterans. They endorsed needing additional mental and behavioral health services for the following groups of Veterans:

- **Women Veterans** (n=10). Key informants suggested more services specific to women Veterans as being useful. Reasons for this included women having different issues and concerns compared to their male counterparts and women feeling less intimated in a woman-only space.

  > *The VA has a much larger issue with female Veterans than they did in the past. So yes, those services are needed.*
  >
  > *Specific services for women: group services, group counseling, group support services. They are in the area, but not specific to Veterans.*

- **Veterans of a specific era** (n=9). Key informants noted that Veterans may have different mental and behavioral health concerns based on their age and the conflict in which they served. They noted that Veterans would benefit from services specific to those concerns.

  > *Continuing to focus on younger vets to make sure that programming and services age with them.*
  >
  > *Probably the Vietnam Veterans could use specific services. I think they are retiring and they are struggling with what is going on in their mind. They are figuring out what to do with that.*
  >
  > *Smaller support groups of people exposed to the same thing [are needed].*

- **Veterans who have experienced sexual assault** (n=9). Key informants discussed the need for more mental health services for Veterans, both men and women, who have experienced sexual assault. They noted the need for more services in order to meet the needs of Veterans quickly.

  > *Counseling services are definitely needed for this group. Both individual and group.*
  >
  > *This is a huge area of need. It is important to continue adding programs and dollars in this area.*
  >
  > *I think there needs to be program for men as well. The percentage of men that come in for this is much higher than I would have expected.*

- **Veterans with traumatic brain injury (TBI)** (n=8). Key informants discussed how many Veterans have some degree of traumatic brain injury and there is a need for services to address any accompanying mental health issues. They discussed the need for more provider training to recognize TBI.

  > *You have a lot of cognitive challenges that often accompany TBI. You have things like depression and anxiety and things like that linked to TBI.*
  >
  > *All individual providers should be trained to recognize TBI.*

Barriers to accessing services

Key informants and survey respondents were asked about barriers to service access. Survey respondents were asked if they had attempted to access any mental or behavioral health services in the past two years and if anything had prevented them from doing so. Key informants were asked about potential reasons why Veterans may not be able to access needed services. They were also asked to describe barriers to service provision in their area.

Survey respondents' perceptions of barriers

Eleven percent of survey respondents said they had attempted to obtain services for their mental health in the past two years and had been unable to do so. Sub-groups where they were more likely to have attempted to obtain services and been unable to were (see appendix for full results by group): survey respondents who said they rarely or never receive the support they need (24%;), survey respondents with a concussion/TBI diagnosis (22%), survey respondents of color (21%), survey respondents who have experienced sexual assault (20%), survey respondents age 18-34 (20%), women (18%), respondents with a weak sense of belonging (18%), those who served from September 2001 or later (17%), and respondents with a disability (15%).

Half of all of the survey respondents (50%) selected at least one barrier that prevented them from accessing services. Of those who did select barriers, not having a VA diagnosis was most common (34%), followed by being worried about how they will be seen (28%), being worried about the effect on current or future employment (24%), not thinking the services will help (19%), and not being able to pay for services (19%; Figure 24). The other half of survey respondents did not select any barriers and we do not know whether this is because they so not have barriers in accessing services, if they did not feel comfortable responding, or a different reason. Of those who selected "other" for a barrier, 37 percent wrote in that the question was not applicable.

24. Survey respondent barriers to accessing services

Have any of the following barriers prevented you from accessing services?	Percent of survey respondents (N=463)
I don't have a VA diagnosis	34%
I was worried about how I would be seen	28%
I was worried about the effect on my current or future employment	24%
I don't think the services will help	19%
I could not pay for the services	19%
I cannot financially afford to take time off for treatment	16%
The wait time was too long	14%
Their services were not good with Veteran-specific issues	13%
I was worried about my family finding out	12%
I was not eligible for the services	11%
The service I needed was not available in my area	9%
I was worried about the effect on my current or future military service	5%
I could not find transportation to get to services	4%
The people who provide it don't speak my language/I could not get an interpreter	<1%
Other*	22%

Note. Total exceeds 100 percent because respondents were asked to select all that apply.

* "Other" responses mentioned by at least 5 percent of respondents included: Not applicable (10%).

Some sub-groups of survey respondents selected different barriers. Listed below are all variations between groups that were statistically significant (see appendix for all results by group):

- **Age.** Survey respondents age 65 and older were less likely to select several barriers when compared to younger respondents including: being worried about the effect on their current or future military service (0%) or employment (4%), being worried about how they would be seen (16%), the wait time was too long (4%), and they could not pay for services (6%). Survey respondents age 55 to 64 and 65 and older were less likely to select that services were not good with Veteran-specific issues (11% of those age 55 to 64 and 6% of those age 65 and older) and that services were not available in their area (8% of those age 55 to 64 and 8% of those age 65 and older). Survey respondents age 35 to 54 were more likely to select that they could not find transportation as a barrier (26%).

- **Combat status.** Veterans who had served in combat or war zones were more likely to say that services were not good with Veteran-specific issues (18%) than non-combat Veterans (6%) and that services were not available in their area (12% versus 6%). They were also more likely to select that they were worried about how they would be seen (32%) compared to non-combat Veterans (23%). Combat Veterans were less likely to say not being eligible for services was a barrier (5%) than non-combat Veterans (17%).

- **Concussion/TBI diagnosis.** Respondents with a concussion/TBI diagnosis were more likely to select that services were not available in their area (18% compared to 8% for those without a diagnosis) and that the wait time was too long (23% compared to 14% for those without a diagnosis).

- **Disability**. Survey respondents with a disability were more likely to select the following barriers than respondents without a disability: the service was not available in my area (13% versus 3%), services were not good with Veteran-specific issues (16% versus 5%), they were worried about how they would be seen (32% versus 20%), the wait time was too long (18% versus 7%), and they did not think the services will help (23% versus 11%). In contrast, survey respondents without a disability were more likely to select not having a VA diagnosis as a barrier (43% compared to 29% for those with a disability).

- **Gender.** Women were more likely to say they cannot financially afford to take time off (28%) than men (13%) and that they cannot pay for services (29%) than men (17%). Women were also more likely to select that services were not available in their area (20% compared to 7% of men), the wait time was too long (27% compared to 12% of men), and they were worried about the effect on their current or future military service (11% compared to 4% of men). Men were more likely to select that they so not have a VA diagnosis as a barrier (36%) than women (23%).

- **Experienced sexual assault.** Survey respondents who have experienced sexual assault were more likely to select the following barriers: cannot financially afford to take time off (27% compared to 12% of those who have not experienced sexual assault), was not eligible for services (17% versus 9%), could not pay for services (27% versus 17%), and could not find transportation to get to services (10% versus 3%). Those who have experienced sexual assault were also more likely to say the service was not available in their area (17% versus 7%).

- **Social support.** Survey respondents who rarely or never felt they get the support they need were more likely to select the following barriers compared to respondents who always or usually get the support they need: was not eligible for services (19%), could not find transportation (10%), the service was not available in their area (12%), the wait time was too long (21%), services were not good with Veteran-specific issues (23%), worried about how they would be seen (34%), worried about the effect on current or future employment (26%), worried about their family finding out (19%), cannot financially afford to take time off (28%), and did not think the services will help (32%) .

- **Length of service.** Survey respondents who had served 11 years or more were more likely to select that they were worried about how they would be seen (41%) and they were worried about the effect on their current or future military service (13%) as barriers compared to those who had not served as long. In contrast, survey respondents who had served less than two years were more likely to select that they were not eligible for services as a barrier (19%) compared to those who had served longer.

- **Geography.** Survey respondents in greater Minnesota were more likely to select that services were available in their area as a barrier (15%) than respondents in the Twin Cities metro area (5%).

- **Sense of belonging.** Survey respondents with a weak sense of belonging were more likely to select several barriers compared to those with a strong sense of belonging. These barriers included: not being able to pay for services (25% versus 14%), being worried about how they will be seen (34% versus 21%), the wait time was too long (18% versus 10%), services were not good with Veteran-specific issues (18% versus 7%), concern about the effect on current or future employment (30% versus 17%), worry about family finding out (16% versus 8%), cannot financially afford to take time off (22% versus 8%), and did not think the services will help (24% versus 14%).

Key informants' perceptions of barriers for Veterans

Key informants were asked about reasons that may be currently preventing Veterans from accessing the mental and behavioral health services they need. The top barriers selected by respondents across the state were: concern over effect on employment (83%), concern over how the Veteran will be seen by others (79%), concern over effect on future military service (79%), transportation (74%), and not believing that services will help (71%; Figure 25).

There was overlap between the top barriers identified by key informants and those identified by survey respondents. Both key informants and survey respondents identified concern over how they/I will be seen and don't think the services will help as main barriers to survey access. However, just over half of key informants (57%; Figure 25) indicated that Veterans may not be accessing services due to not having a VA diagnosis while survey respondents reported that as the top reason for not accessing services (34%; Figure 25).

There were some slight differences based on geographic region. Less than half of Twin Cities metro area key informants (46%) felt that cost is a barrier for Veterans seeking care while key informants in greater Minnesota were more likely to cite this as a barrier (72%). Less than half (48%) of key informants in greater Minnesota felt that eligibility requirements prevent Veterans from accessing the care they need, while 77 percent of those in the metro area felt that this was a barrier (Figure 25). Sixty-six percent of greater Minnesota key informants noted that wait times for getting an appointment were a barrier to service access, while 39 percent of Twin Cities metro area key informants thought so. Key informants in greater Minnesota (66%) were significantly more likely than those in the Twin Cities metro area (23%; $p<.05$) to report there are no services in their area. Greater Minnesota key informants were also significantly more likely to say there are no good services in their area for Veteran-specific issues (55% in greater Minnesota versus 15% in the Twin Cities metro; $p<.05$.)

25. Key informant reported barriers to service access

Barriers to service access	All key informants (N=43)	Greater MN key informants (N=29)	Twin Cities metro key informants (N=14)
Concern over effect on employment	83%	83%	85%
Concern over how they will be seen/stigma	79%	76%	85%
Concern over effect on future military service	79%	76%	85%
Transportation	74%	69%	85%
Do not believe services will help	71%	76%	62%
Cost	64%	72%	46%
Eligibility	57%	48%	77%
Wait times for getting an appointment	57%	66%	39%
No VA diagnosis	57%	59%	54%
Concern over family finding out	55%	52%	62%
There are no services in their area	52%	66%*	23%*
Services are not good for Veteran-specific issues	43%	55%*	15%*
Other[a]	26%	28%	23%

Note. Total exceeds 100 percent because respondents were asked to select all that apply.
Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001.
[a] "Other" barriers to service access include lack of services overall (n=3), lack of awareness of services that exist (n=2), lack of trust in system/providers (n=2), difficulty navigating the system/bureaucracy (n=2), and services only open during business hours (n=2).

Key informants' perceptions of barriers for service providers

Key informants were asked to address possible barriers to service provision in their area. The top barriers selected by respondents across the state were: funding in general (73%), shortage of trained providers (73%), issues and restrictions around reimbursing private providers (65%), shortage of providers who are able to prescribe medication (60%), and inability to recruit or retain providers and staff (60%; Figure 26).

There were some differences based on geographic region. Key informants in greater Minnesota were more likely to cite a shortage of prescribers and inability to recruit and retain providers and staff as barriers to service provision than respondents in the Twin Cities metro area (69% versus 36% for both). Key informants in greater Minnesota (38%) were also more likely to report provider difficulty in obtaining specialized training as a barrier compared to metro informants (18%; Figure 26). There were no statistically significant differences in the responses of greater Minnesota key informants and those in the Twin Cities metro area.

26. Barriers to service provision

Barriers to service provision	All key informants (N=40-42)	Greater MN key informants (N=29)	Twin Cities metro key informants (N=11-13)
Funding	73%	76%	64%
Shortage of other trained providers	73%	76%	64%
Provider reimbursements	65%	69%	55%
Shortage of prescribers	60%	69%	36%
Inability to retain/recruit providers/staff	60%	69%	36%
Shortage of facility space	48%	48%	46%
Inconsistent/insufficient demand for services	35%	35%	36%
Provider difficulty obtaining specialized training	33%	38%	18%
Other[a]	41%	41%	39%

Note. Total exceeds 100 percent because respondents were asked to select all that apply. Significance tests were conducted using chi-square tests. No statistically significant differences were found.

[a] "Other" barriers to service access include rules and regulations about service provision (n= 3), low salaries in rural areas (n=2), lack of services overall (n=2), and difficulty navigating the system/bureaucracy (n=2).

Key informants were asked an open-ended question about which types of providers are most needed in their area. Greater Minnesota informants in particular noted that psychiatrists are lacking in their area (n=12). They also noted that mental health providers in general are in shortage in their areas (n=11).

> *Someone who can actually diagnose. This is one of the biggest issues we have. This is a huge, huge barrier-having access to someone in proximity who can give a diagnosis.*
>
> *Psychiatric services [are needed]. I know of no providers.*
>
> *We need more mental health and chemical dependency providers. We don't have access to psychiatrists at all.*
>
> *I would say any mental health providers [are needed]. There is no psychiatrist, no psychologist. We may have some social workers who have some training in mental health but as far as mental-health-specifically trained people, we do not have any.*

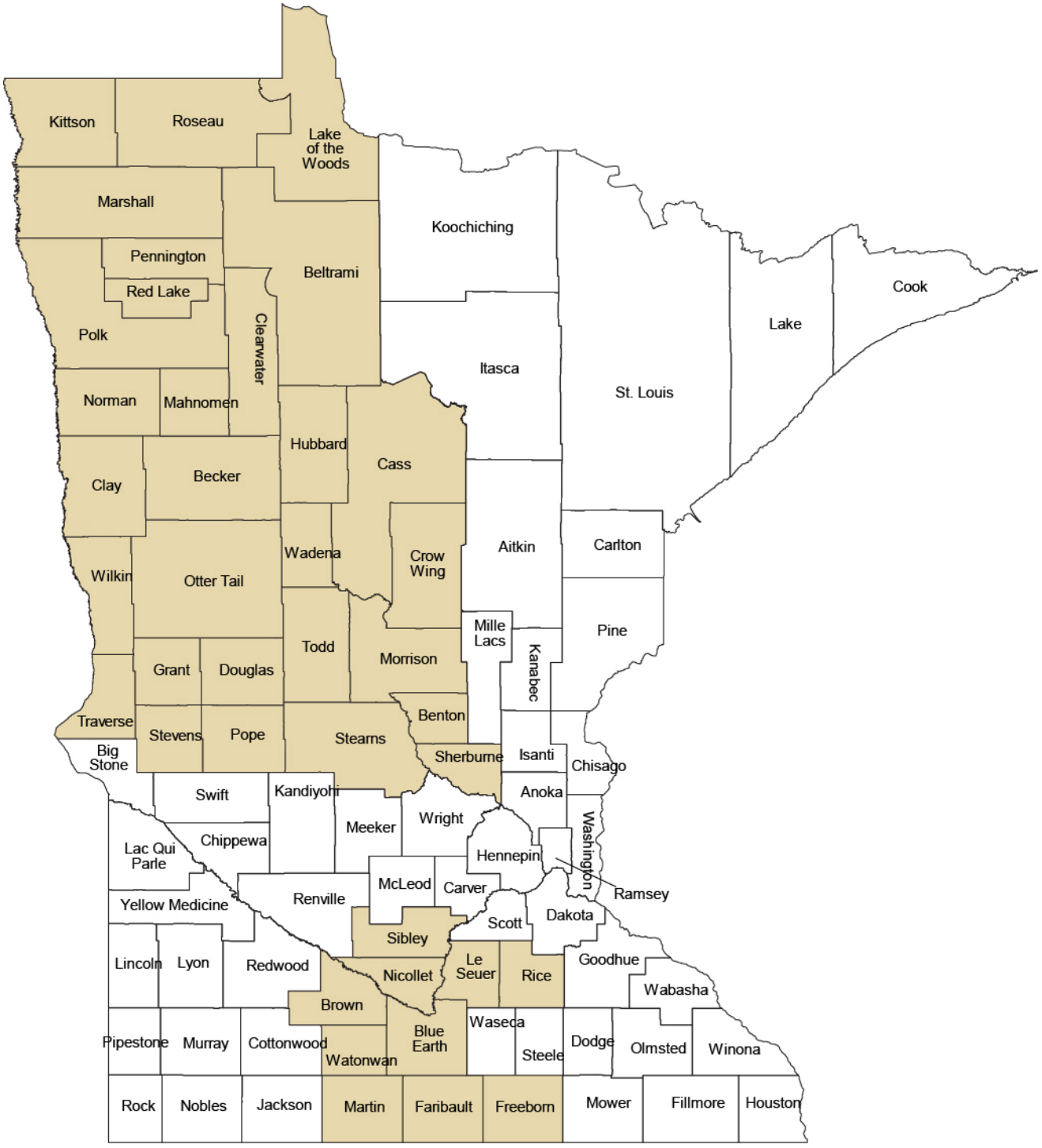
Key informants in greater Minnesota discussed reasons for the provider shortage in their area. They endorsed (n=11) the idea that working in more rural areas is less lucrative and generally pays less than working in the same field in the metro area. They also noted that there is a general shortage of mental health professionals affecting all parts of the state.

> *I guess it would fall into the funding part. You would have to make the opportunity attractive. What I mean by that is you would have to be willing to pay people sufficiently to want them to come here and stay here. There is not much here in this county to draw people.*
>
> *Low wages compared to other counties and private providers.*

These findings echo a report written for the Department of Human Services, in which mental health services were rarely identified as meeting or exceeding the need (Wilder Research, 2015). Particularly, psychiatric prescribers, adult residential or inpatient mental health beds, and mental health services for Veterans were among the most needed mental health resources in Minnesota. In the study, many key informants identified a shortage of psychiatric prescribers, and an inability to retain or recruit prescribers as one of the primary gaps in services. This study also showed that there are greater service needs, including access to services, in large, rural geographies.

The U.S. Department of Health and Human Services has developed a health professional shortage area designation for counties and tribal nations across the country based on a national threshold using a combination of mental health capacity and need (U.S. Department of Health and Human Services, 2016). This designation, or lack of, demonstrates the community's formal capacity to serve individuals with mental health needs. Currently, 39 Minnesota counties and two tribes are designated mental health professional shortage areas, all of which are in greater Minnesota (Figure 27).

27. Mental health professional shortage areas in Minnesota



Risk and protective factors

The literature about risk and protective factors for mental health disorders and suicidal behaviors is expansive. In this portion of the report, we focus on the risk and protective factors that have been identified for Veterans, including factors measured in the survey administered for this study, as well as factors that may be addressed through services.

Demographic characteristics

Gender

Minnesota Veteran survey results

The Minnesota Veteran survey found that Veteran women were significantly more likely than Veteran men to report a diagnosis of anxiety disorder or panic disorder (50% versus 29%; $p<.001$), major depression (50% versus 26%; $p<.001$), and PTSD (38% versus 26%; $p<.05$; Appendix Figure A111). Women were also more likely to report suicidal ideation than men (47% versus 33%; $p<.01$) and a previous suicide attempt (16% versus 7%; $p<.05$). However, women reporting suicidal ideation were also more likely to report seeking help for suicidal behaviors (59% versus 40%; $p<.01$).

Women were more likely to screen positive in the survey for anxiety and more likely to have a diagnosis if they did. Women and men were similarly likely to screen positive for depression symptoms, but women who screened positive were significantly more likely to also have a diagnosis (Figure 28). This may indicate that women are more likely to seek treatment for their depression and anxiety symptoms. Conversely, women were more likely to screen positive for PTSD symptoms compared to men; however, they were about equally as likely to have a diagnosis if they screened positive. Women and men were equally likely to screen clinically significant for a substance use disorder and to have a diagnosis.

28. Survey responses on standardized screening tools, by gender

	Percent of men survey respondents (N=718-746)	Percent of women survey respondents (N=118-130)
Depression subscale		
Percent of respondents that screened positive for depression	25% (N=742)	32% (N=130)
Of those who screened positive for depression, percent reporting a diagnosis of major depression	65%* (N=178)	84%* (N=38)
Anxiety subscale		
Percent of respondents that screened positive for anxiety	25%** (N=744)	38%** (N=130)
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	63%** (N=175)	87%** (N=45)
PTSD scale		
Percent of respondents that screened positive for PTSD	31% (N=746)	40% (N=130)
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	64% (N=222)	65% (N=49)
Alcohol or drug abuse scale		
Percent of respondents that screened clinically significant for alcohol or drug abuse	30% (N=745)	23% (N=130)
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	48% (N=217)	41% (N=27)
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	13% (N=202)	12% (N=25)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05 and **p < .01

Additional data from existing sources

Similarly, among the Minnesota Veterans surveyed in the BRFSS, depression diagnoses were significantly more common among women (23%) than men (13%). In addition, women (18%) were significantly more likely than men (10%) to score as having at least a mild mental health disorder on a standardized screening tool (Centers for Disease Control, 2013). In another national study, Veteran women were 70 percent more likely to have a serious psychological disorder, but men were twice as likely to have a substance use disorder (Golub, Vazan, Bennett, & Liberty, 2013). In the College Student Health Survey, Veteran women in college were significantly more likely to have a depression diagnosis in the past year (13%), compared to Veteran men (8%) (Boynton Health Service, 2013).

In the U.S. overall, women are more likely to make suicide attempts, but men die by suicide four times as often as women (Nock, 2008). This pattern is reflected in VA patients, for whom the suicide rate tends to be higher for men (around 40% from 2010 to 2014) than for women (around 15% from 2010 to 2014) (U.S. Department of Veterans Affairs, 2016). Also, Minnesota death records show that nearly all Veteran deaths ruled as suicide were men (95%) (Minnesota Department of Health, 2016).

Race

Minnesota Veteran survey results

In the Minnesota Veteran survey, respondents of color comprised a small proportion of respondents, thus an analysis of each race individually was not possible. For this section, we grouped respondents into white Veterans and Veterans of color. Respondents of color were more likely than white respondents to report any of the diagnoses listed, and they were significantly more likely to report a diagnosis of PTSD, personality disorder, drug abuse disorder, schizophrenia, or another paranoid or delusional disorder (Figure 29).

29. Survey respondent behavioral health diagnoses, by race

	White survey respondents (N=732-759)	Survey respondents of color (N=75-79)
Anxiety disorder or panic disorder	32%	42%
Major depression	29%	39%
Post-Traumatic Stress Disorder (PTSD)	27%*	39%*
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	11%***	26%***
Alcohol abuse disorder	17%	21%
A concussion or traumatic brain injury	11%	16%
Drug abuse disorder	4%*	11%*
Manic episodes or manic depression, bipolar disorder	6%	9%
Paranoid or delusional disorder, other than schizophrenia	2%**	8%**
Schizophrenia	1%***	7%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001.

Veterans of color were significantly more likely than white Veterans to screen positive for current PTSD (46% versus 32%; p<.05), depression (36% versus 25%; p<.05), and anxiety (44% versus 25%; p<.001) symptoms. Veterans of color were also more likely to report experiencing psychological distress (62%) than white Veterans (47%; p<.05), including severe psychological distress (20% versus 11%).

Compared to white Veterans, Veterans of color were similarly likely to report suicidal ideation (37% versus 35%). However, Veterans of color were significantly more likely (p<.01) to have current suicidal ideation (11% versus 4%).

Additional data from existing sources

According to Minnesota death certificates, nearly all Veteran suicides were among white Veterans (95%) (Minnesota Department of Health, 2016).

Age

In the Minnesota Veteran survey, younger respondents were more likely to report suicidal ideation than older respondents (45% for those age 18-34, 43% for those age 35-54, 37% age 55-64, and 23% 65+; p<.001). In addition, younger respondents were significantly more likely than older respondents to have been diagnosed with anxiety, PTSD, depression, and a severe personality disorder (Figure 30).

30. Survey respondent behavioral health diagnosis, by age

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Age 18-34 (N=126-131)	Age 35-54 (N=233-247)	Age 55-64 (N=166-178)	Age 65+ (N=283-297)
Anxiety disorder or panic disorder	44%***	47%***	26%***	20%***
Post-Traumatic Stress Disorder (PTSD)	40%***	37%***	20%***	21%***
Major depression	30%***	41%***	32%***	20%***
Alcohol abuse disorder	20%	18%	18%	15%
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	14%*	16%*	12%*	7%*
Drug abuse disorder	7%	3%	7%	3%
Manic episodes or manic depression, bipolar disorder	6%	8%	9%	4%
Paranoid or delusional disorder, other than schizophrenia	2%	2%	4%	2%
Schizophrenia	1%	2%	2%	1%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001. Each age group was compared individually to every other age group.

As for current symptomology, younger Veterans were significantly more likely than older Veterans to screen positive for current PTSD symptoms, psychological distress, depression, and anxiety (Figure 31). Overall, the age groups were equally likely to have a corresponding diagnosis if they screened positive.

31. Survey responses on standardized screening tools, by age

	Age 18-34	Age 35-54	Age 55-64	Age 65+
Depression subscale				
Percent of respondents that screened positive for depression	31%*** (N=131)	37%*** (N=255)	29%*** (N=186)	14%*** (N=302)
Of those who screened positive for depression, percent reporting a diagnosis of major depression	59% (N=39)	75% (N=91)	70% (N=50)	63% (N=40)
Anxiety subscale				
Percent of respondents that screened positive for anxiety	36%*** (N=131)	37%*** (N=255)	28%*** (N=187)	13%*** (N=303)
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	68% (N=47)	77% (N=91)	60% (N=47)	61% (N=38)
PTSD scale				
Percent of respondents that screened positive for PTSD	52%*** (N=131)	40%*** (N=255)	30%*** (N=187)	20%*** (N=305)
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	60% (N=67)	70% (N=99)	54% (N=48)	69% (N=59)
Alcohol or drug abuse scale				
Percent of respondents that screened clinically significant for alcohol or drug abuse	36% (N=131)	32% (N=255)	26% (N=187)	27% (N=304)
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	47% (N=47)	51% (N=77)	51% (N=45)	44% (N=78)
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	20% (N=45)	12% (N=69)	21% (N=42)	7% (N=73)
Any psychological distress	64%*** (N=131)	62%*** (N=255)	50%*** (N=187)	30%*** (N=306)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001. Each age group was compared individually to every other age group.

When asked about their mental well-being, younger Veterans were significantly more likely to say they are getting better or it depends on the day. Older Veterans were significantly more likely to report their mental well-being is staying the same (Figure 32).

32. Survey respondent changes in mental well-being, by age

Thinking about your mental well-being right now, overall, would you say you are…	Age 18-34 (N=131)	Age 35-54 (N=255)	Age 55-64 (N=185)	Age 65+ (N=300)
Getting better	34%***	20%***	17%***	17%***
Getting worse	3%***	8%***	3%***	1%***
Staying the same	26%***	38%***	45%***	62%***
Depends on the day	32%***	31%***	31%***	17%***
I'm not sure	5%***	4%***	3%***	3%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p <.001. Each age group was compared individually to every other age group.

Additional data from existing sources

While the younger Veterans may have been more likely to have mental health diagnoses or symptoms in the survey, existing data shows that older Veterans are more likely to die by suicide. National VA data shows that about 65 percent of all Veterans who died by suicide were age 50 and older (U.S. Department of Veterans Affairs, 2016). Similarly, according to Minnesota death records, the majority of deaths by suicide have been for Veterans age 55 or over consistently from 2013 through 2015 (Figure 33) (Minnesota Department of Health, 2016). However, the proportion of deaths by suicide for Veterans age 18 through 34 has increased over time.

33. Minnesota death record Veteran death by suicide, by age

	2013 (N=104)	2014 (N=103)	2015 (N=102)
Age 18-34	14%	13%	22%
Age 35-54	27%	26%	24%
Age 55-64	15%	21%	22%
Age 65+	43%	40%	33%

Combat status

Minnesota Veteran survey respondents who reported having served in a combat or war zone were significantly more likely than respondents that had not served in a combat or war zone to have a diagnosis of PTSD, anxiety, or alcohol abuse disorder (Figure 34). They were also significantly more likely to report having a disability or chronic medical condition that interferes with their daily life (65% for combat Veterans versus 50% for non-combat Veterans; p<.001).

34. Survey respondent behavioral health diagnosis, by combat status

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Combat (N=457-480)	Non-Combat (N=378-396)
Post-Traumatic Stress Disorder (PTSD)	40%***	14%***
Anxiety disorder or panic disorder	37%**	27%**
Major depression	31%	27%
Alcohol abuse disorder	21%**	13%**
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	13%	11%
Manic episodes or manic depression, bipolar disorder	6%	7%
Drug abuse disorder	4%	4%
Paranoid or delusional disorder, other than schizophrenia	3%	2%
Schizophrenia	1%	2%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001.

Combat Veteran respondents were more likely than non-combat Veteran respondents to screen positive for PTSD, depression, anxiety, and alcohol/drug abuse (Figure 35). Combat Veterans also were more likely to have a diagnosis of PTSD if they screened positive for PTSD. Combat Veteran respondents were also more likely to have some level of psychological distress (55% versus 40%; p<.001).

35. Survey responses on standardized screening tools, by combat status

	Combat (N=485-490)	Non-Combat (N=403-407)
PTSD Scale		
Percent of respondents that screened positive for active PTSD	42%***	21%***
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	73%***	45%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001.

35. Survey responses on standardized screening tools, by combat status (continued)

	Combat (N=485-490)	Non-Combat (N=403-407)
Depression subscale		
Percent of respondents that screened positive for depression	30%**	22%**
Of those who screened positive for depression, percent reporting a diagnosis of major depression	66%	71%
Anxiety subscale		
Percent of respondents that screened positive for anxiety	30%*	23%*
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	71%	66%
CAGE Alcohol and Drug Abuse Scale		
Screened as clinically significant for alcohol/drug abuse	35%***	22%***
Of those who screened clinically significant for alcohol/drug abuse, percent reporting an alcohol abuse disorder diagnosis	48%	48%
Of those who screened clinically significant for alcohol/drug abuse, percent reporting a drug abuse disorder diagnosis	11%	18%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001.

Geography

Minnesota Veteran survey results

Minnesota Veteran survey respondents in greater Minnesota were significantly more likely than Twin Cities metro area respondents to report a diagnosis of depression (34% versus 27%; p<.05), PTSD (33% versus 24%; p<.01), or an alcohol abuse disorder (22% versus 13%; p<.01). In addition, although Veterans in greater Minnesota and the Twin Cities metro area were similarly likely to screen positive in the survey for symptoms of depression, anxiety, PTSD, and alcohol or drug abuse, those in greater Minnesota who screened positive for PTSD or alcohol abuse were significantly more likely to have an associated diagnosis (Figure 36).

36. Survey responses on standardized screening tools, by geography

	Greater MN survey respondents	Twin Cities metro survey respondents
Depression subscale		
Percent of respondents that screened positive for depression	29% (N=384)	24% (N=483)
Of those who screened positive for depression, percent reporting a diagnosis of major depression	69% (N=107)	68% (N=111)
Anxiety subscale		
Percent of respondents that screened positive for anxiety	28% (N=384)	26% (N=483)
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	67% (N=117)	70% (N=117)
PTSD scale		
Percent of respondents that screened positive for PTSD	34% (N=386)	31% (N=484)
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	74%** (N=125)	57%** (N=144)
Alcohol or drug abuse scale		
Percent of respondents that screened clinically significant for alcohol or drug abuse	31% (N=383)	28% (N=485)
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder*	57%* (N=112)	40%* (N=129)
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	11% (N=104)	16% (N=120)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001.

Additional data from existing sources

Nationally, Veterans farther from a VA facility were at significantly greater risk for suicidal ideation (Maguen, et al., 2015). Rural VA patients tended to have higher suicide rates than urban patients, and rural residence is a suicide risk factor, even controlling for access to mental health services (McCarthy, et al., 2012). Based on Minnesota death records, about half of Veteran suicides were in greater Minnesota, which is consistent with the proportion of Veterans living in greater Minnesota (Minnesota Department of Health, 2016).

College students

In the 2013 College Student Health Survey, 19 percent of Veterans enrolled in 29 colleges across Minnesota reported a mental health diagnosis in the past year, and 43 percent reported a lifetime diagnosis (Boynton Health Service, 2013). This is higher than that rate of diagnosis among civilian students (16% past year and 36% lifetime). In addition, 15 percent of Veteran college students reported taking medication for depression at the time of the survey.

Homelessness

According to a triennial study of people experiencing homelessness in Minnesota, approximately 6 percent of homeless adults in 2015 met the Minnesota definition for Veteran (Wilder Research, 2016). The majority (64%) of homeless Veterans in Minnesota had a mental health diagnosis and/or received treatment for a mental health issue in the past 2 years, which is comparable to the overall homeless population in Minnesota (60%). The most common mental health diagnoses homeless Veterans reported include anxiety or panic disorder (35%), PTSD (33%), and major depression (31%). In addition, 35 percent reported they needed to see someone about a mental health concern at the time of the survey.

Nearly one-third of homeless Veterans in Minnesota (31%) had a chemical dependency diagnosis in the past 2 years, which is higher than the overall homeless population in Minnesota (21%). Homeless Veterans were more likely to have a diagnosed alcohol abuse disorder (27%) than the overall homeless population (16%), though they were similarly likely to have a diagnosed drug abuse disorder (16% versus 14%). In addition, homeless Veterans were more likely than the overall homeless population to report being treated in an outpatient alcohol or drug treatment program (46% versus 33%) and to identify as an alcoholic or chemically dependent (37% versus 26%). Finally, homeless Veterans were more likely to report both a mental health and chemical health diagnosis (27%), compared to the overall homeless population (18%).

Social supports

Minnesota Veteran survey results

The Minnesota Veteran survey found that social connectedness is a strong protective factor for behavioral health. Survey respondents that either reported a strong sense of belonging in their community or reported receiving the social support they need were significantly less likely to report behavioral health diagnoses and symptoms based on standardized screening tools (Figure 37).

37. Survey respondent behavioral health diagnoses and symptoms, by sense of belonging and by social support

	Sense of belonging to local community		Frequency of receiving needed social and emotional support	
	Strong (N=503-515)	Weak (N=318-342)	Always/Usually (N=469-485)	Sometimes/ Rarely/Never (N=352-369)
Behavioral health diagnoses				
Schizophrenia	1%	3%	1%	2%
Paranoid or delusional disorder, other than schizophrenia	1%**	5%**	1%*	4%
Manic episodes or manic depression, bipolar disorder	3%***	12%***	4%**	9%**
Major depression	17%***	50%***	19%***	44%***
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	5%***	23%***	6%***	19%***
Alcohol abuse disorder	12%***	26%***	12%***	23%***
Drug abuse disorder	3%**	7%**	4%*	5%*
Post-Traumatic Stress Disorder (PTSD)	19%***	43%***	21%***	37%***
A concussion or traumatic brain injury	8%	16%	9%*	14%*
Anxiety disorder or panic disorder	22%***	49%***	25%***	43%***
Screening tools				
Percent of respondents that screened positive for depression	12%***	48%***	12%***	41%***
Percent of respondents that screened				
Positive for anxiety	14%***	46%***	13%***	44%***
Positive for PTSD	18%***	55%***	18%***	49%***
Clinically significant for alcohol or drug abuse	23%***	39%***	24%***	34%***

Note. Significance tests were conducted using chi-square tests. Differences between strong and weak community connectedness and differences between reported levels of social support are significant at *p < .05, **p <.01, and ***p < .001.

Additional data from existing sources

Previous studies have also found that social supports can be a strong protective factor for Veteran mental health. In particular, a lack of social support tends to be associated with increased PTSD symptoms (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; James, Van Kampen, Miller, & Engdahl, 2013), increased depressive symptoms (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; James, Van Kampen, Miller, & Engdahl, 2013), and increased suicidal ideation or attempts (Montross Thomas, et al., 2014).

Also, social connectedness has been found to reduce the severity of traumatic stress and depressive symptoms (Pietrzak, Harpaz-Rotem, & Southwick, 2011; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009), as well as the risk of suicide (Fanning & Pietrzak, 2013; Lemaire & Graham, 2011; Montross Thomas, et al., 2014; Nock, et al., 2013; Smith, et al., 2016) in Veterans. Protective social supports can include connections with one's family, friends, and former unit. In particular, unit cohesion has been shown to buffer against the development of PTSD and other psychiatric symptoms, and may decrease the risk of suicidal behaviors (Nock, et al., 2013).

Health

Concussion or traumatic brain injury

Minnesota Veteran survey results

Survey respondents with a concussion or TBI diagnosis were significantly more likely to report suicidal ideation than those without that diagnosis (56% versus 31%; $p<.001$). In addition, respondents with a concussion or TBI diagnosis were significantly more likely to have a diagnosis of anxiety, PTSD, depression, a severe personality disorder, bipolar disorder, and schizophrenia (Figure 38).

38. Survey respondent mental and chemical health diagnoses, by concussion/TBI status

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Concussion/TBI diagnosis (N=83-92)	No concussion/TBI diagnosis (N=744-745)
Anxiety disorder or panic disorder	62%***	26%***
Post-Traumatic Stress Disorder (PTSD)	62%***	21%***
Major depression	48%***	24%***
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	30%***	9%***
Alcohol abuse disorder	22%	14%
Manic episodes or manic depression, bipolar disorder	12%*	5%*
Drug abuse disorder	5%	3%
Schizophrenia	4%*	1%*
Paranoid or delusional disorder, other than schizophrenia	2%	2%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001.

Respondents with a concussion or TBI diagnosis were significantly more likely than those without a diagnosis were to screen positive in the survey for depression, anxiety, and active PTSD (Figure 39). They were also more likely to screen positive for psychological distress (77% for those with a diagnosis, 43% for those without; p<.001).

39. Survey responses on standardized screening tools, by concussion/TBI status

	Has a concussion or TBI diagnosis	Does not have a concussion or TBI diagnosis
Depression subscale		
Percent of respondents that screened positive for depression	55%*** (N=93)	21%*** (N=734)
Of those who screened positive for depression, percent reporting a diagnosis of major depression	72% (N=50)	64% (N=154)
Anxiety subscale		
Percent of respondents that screened positive for anxiety	52%*** (N=92)	22%*** (N=737)
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	81%* (N=47)	62%* (N=161)
PTSD scale		
Percent of respondents that screened positive for PTSD	60%*** (N=93)	28%*** (N=742)
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	87%*** (N=55)	56%*** (N=205)

39. Survey responses on standardized screening tools, by concussion/TBI status (continued)

	Has a concussion or TBI diagnosis	Does not have a concussion or TBI diagnosis
Alcohol or drug abuse scale		
Percent of respondents that screened clinically significant for alcohol or drug abuse	37% (N=93)	27% (N=735)
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	48% (N=31)	43% (N=198)
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	14% (N=29)	11% (N=195)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

Survey respondents with a concussion or TBI diagnosis were significantly less likely to feel they received the social and emotional support they needed (46% report always or usually receiving the support they need versus 59% always or usually without a concussion or TBI, p<.05). Additionally, they were significantly less likely to feel a strong sense of belonging to their local community (45% versus 63% for those without a concussion or TBI, p<.01).

Additional data from existing sources

Previous studies have also found that traumatic brain injury is associated with increased risk for depression and PTSD (Hoge, et al., 2008; Schneiderman, Braver, & Kang, 2008), as well as suicidal behaviors (Simpson & Tate, 2002; Simpson & Tate, 2007). Based on Simpson and Tate's (2007) meta-analysis, individuals experiencing a concussion have three times the risk of suicide, and individuals with severe traumatic brain injury (TBI) have four times the risk, compared to the general population. This risk is further increased to seven times higher than the general population if the brain injury is accompanied by substance use. Overall, this study found that approximately 21-22 percent of people with a traumatic brain injury have clinically significant suicidal ideation.

Disability status

Minnesota Veteran survey results

Respondents to the Minnesota Veteran survey were asked whether they had a disability or chronic medical condition that interferes with their daily life. Respondents who reported having a disability were significantly more likely to report any mental or chemical health diagnosis listed (Figure 40). Respondents with a disability were also at significantly increased risk of suicidal ideation (44% for respondents with a disability versus 23% for those without a disability; p<.001).

40. Survey respondent mental and chemical health diagnoses, by disability status

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Disability (N=471-504)	No disability (N=362-369
Schizophrenia	2%*	<1%*
Paranoid or delusional disorder, other than schizophrenia	4%**	1%**
Manic episodes or manic depression, bipolar disorder	9%***	3%***
Major depression	42%***	12%***
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	19%***	3%***
Alcohol abuse disorder	23%***	9%***
Drug abuse disorder	6%*	3%*
Post-Traumatic Stress Disorder (PTSD)	41%***	10%***
A concussion or traumatic brain injury	16%	5%
Anxiety disorder or panic disorder	44%***	17%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001.

Respondents with a disability were significantly more likely than respondents without a disability to screen positive for depression, anxiety, and PTSD, as well as clinically significant for alcohol or drug abuse (Figure 41).

41. Survey responses on standardized screening tools, by disability status

	Disability	No disability
Depression subscale		
Percent of respondents that screened positive for depression	38%*** (N=520)	9%*** (N=375)
Of those who screened positive for depression, percent reporting a diagnosis of major depression	71%* (N=189)	50%* (N=34)
Anxiety subscale		
Percent of respondents that screened positive for anxiety	39%*** (N=518)	10%*** (N=377)
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	73%* (N=190)	51%* (N=37)
PTSD scale		
Percent of respondents that screened positive for PTSD	47%*** (N=525)	12%*** (N=378)
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	71%*** (N=234)	29%*** (N=45)
Alcohol or drug abuse scale		
Percent of respondents that screened clinically significant for alcohol or drug abuse	33%** (N=518)	23%** (N=375)
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol disorder	56%*** (N=165)	32%*** (N=84)
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol disorder	16% (N=152)	9% (N=80)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001.

Respondents with a disability were significantly more likely to have experienced sexual assault (22% for those with a disability versus 15% for those who did not report a disability; p<.01). Respondents with a disability were also significantly less likely to feel they get the social and emotional support they need (48%) and have a strong sense of belonging to their local community (50%) than respondents without a disability (70% and 74%, respectively; p<.001).

Additional data from existing sources

Chronic pain and physical illness have been associated with suicidal behaviors in the research literature as well (Braden & Sullivan, 2008; Fanning & Pietrzak, 2013; Scott, et al., 2010). In a study of older male Veterans, physical health difficulties was one of the strongest predictors of suicidal ideation, accounting for a two-fold increase in risk (Fanning & Pietrzak, 2013).

Sexual assault

Minnesota Veteran survey results

Nineteen percent of Minnesota Veteran survey respondents reported experiencing sexual assault in their lives. Of those who experienced sexual assault, over half were assaulted before their military service (58%), over half were assaulted during their military service (54%), and 13 percent were assaulted after their service. This indicates that a considerable number of respondents had multiple sexual assault experiences.

Similar to the findings from literature, survey respondents who experienced sexual assault, compared to those who had not, were significantly more likely to report nearly all behavioral health diagnoses asked about in the survey and were more likely to screen positive in the survey for symptoms of anxiety, depression, PTSD, and alcohol or drug abuse (Figure 42).

Survey respondents who experienced sexual assault were significantly more likely to report thoughts of suicide (61% versus 29%; p<.001) and suicide attempts (25% versus 5%; p<.001). They were also more likely to seek help for those behaviors (59% versus 37%; p<.001).

42. Survey respondent behavioral health diagnoses and symptoms, by sexual assault experience

Behavioral health diagnoses	Survey respondents who experienced sexual assault (N=145)	Survey respondents who have not experienced sexual assault (N=677-678)
Schizophrenia	3%	1%
Paranoid or delusional disorder, other than schizophrenia	5%	2%
Manic episodes or manic depression, bipolar disorder	13%***	5%***
Major depression	57%***	23%***
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	22%***	10%***
Alcohol abuse disorder	28%***	15%***
Drug abuse disorder	12%***	3%***
Post-Traumatic Stress Disorder (PTSD)	49%***	24%***
Anxiety disorder or panic disorder	58%***	27%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001.

42. Survey respondent behavioral health diagnoses and symptoms, by sexual assault experience (continued)

	Survey respondents who experienced sexual assault (N=145)	Survey respondents who have not experienced sexual assault (N=677-678)
Depression screening		
Percent of respondents that screened positive for depression	42%***	23%***
Of those who screened positive for depression, percent reporting a diagnosis of major depression	84%** (N=67)	62%** (N=155)
Anxiety screening		
Percent of respondents that screened positive for anxiety	46%***	22%***
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	86% (N=72)	61% (N=152)
PTSD screening		
Percent of respondents that screened positive for PTSD	48%***	29%***
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	71% (N=77)	62% (N=201)
Alcohol or drug abuse screening		
Percent of respondents that screened clinically significant for alcohol or drug abuse	38%**	27%**
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	55% (N=60)	46% (N=190)
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	26%** (N=53)	10%** (N=179)

Additional data from existing sources

Nationally, approximately 1 in 4 women and 1 in 100 men screened by the VA reported experiencing military sexual trauma (MST), which is defined in Federal law as "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training" (Title 38 U.S. Code 1720D). A study of recent Veterans found that 41 percent of women and 4 percent of men experienced MST (Barth, et al., 2016).

In addition, in an independent study of active duty service members, 15 percent of women and 2 percent of men said they experienced a sexual assault since joining the military, and 85 percent of those experiencing sexual assault reported the assailant was another member of the military (Morral, 2016). Of those who experienced a sexual assault in the past year, 62 percent of women and 40 percent of men told someone about the event, and

22 percent of women and 8 percent of men officially reported the event, which may indicate that rates of MST, especially among men, may be under-reported. While the proportion of women experiencing MST is higher, the total number of men in the military is much greater, so the number of men experiencing MST is likely greater than the number of women.

In addition, Veteran women in college were more likely to experience sexual assault (37%) than civilian women in college (28%) (Boynton Health Service, 2013). Nearly half of Veteran college students who have been sexually assaulted reported experiencing depression (47%), which is more than double the rate of depression among Veteran college students who did not experience sexual assault (21%).

Sexual assault by gender

While Minnesota Veteran survey respondents who identified as women were significantly more likely than men to experience sexual assault (62% compared to 11%; $p<.001$), the number of women and men who have experienced sexual assault were roughly equal. In total, 84 men and 79 women reported having experienced sexual assault.

Men and women who had experienced sexual assault had similar rates of diagnosis for mental health disorders, however men were significantly more likely than women to have a diagnosis of alcohol abuse disorder (34% compared to 17%) and drug abuse disorder (17% compared to 5%). In fact, when compared, women reported similar rates of diagnosis for alcohol and drug abuse disorders to respondents that had not experienced sexual assault.

When asked when they had been sexually assaulted, the majority of men (75%) reported they had experienced sexual assault prior to their military service (Figure 43). Twenty-seven percent of men experienced sexual assault during their service. Slightly less than half of women (44%) reported having experienced sexual assault prior to their military service. Eighty percent of women experienced sexual assault during their service. Men who had experienced sexual assault were less likely to seek help for their sexual assault experience than women (31% versus 54%; $p<.01$).

43. Of survey respondents who experienced sexual assault, timing of sexual assault experience by gender

When did you have these experiences?	Has experienced sexual assault Men (N=84)	Has experienced sexual assault Women (N=78)
Before your service	75%***	44%***
During your service	27%***	80%***
After your service	10%	15%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p <.001. Columns total more than 100 percent because respondents could select more than one response.

Of those respondents who have experienced sexual assault, women and men screened positive for anxiety and depression at similar rates. However, women were significantly more likely than men to have a diagnosis for either if they did screen positive (Figure 44). Men were significantly more likely than women to screen positive for alcohol/drug abuse (48% compared to 25%).

44. Survey responses on standardized screening tools, by sexual assault experience and gender

	Has experienced sexual assault Men	Has experienced sexual assault Women
PTSD scale		
Percent of respondents that screened positive for active PTSD	46% (N=84)	49% (N=79)
Of those that screened positive for active PTSD, percent reporting a diagnosis of PTSD	67% (N=39)	76% (N=39)
Depression subscale		
Percent of respondents that screened positive for depression	42% (N=83)	42% (N=79)
Of those who screened positive for depression, percent reporting a diagnosis of major depression	74%* (N=35)	93%* (N=33)
Anxiety subscale		
Percent of respondents that screened positive for anxiety	43% (N=84)	49% (N=79)
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	77%* (N=36)	94%* (N=39)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001

44. Survey responses on standardized screening tools, by sexual assault experience and gender (continued)

	Has experienced sexual assault Men	Has experienced sexual assault Women
CAGE Alcohol and Drug Abuse Scale		
Screened clinically significant for alcohol/drug abuse	48%** (N=83)	25%** (N=79)
Of those who screened clinically significant for alcohol/drug abuse, percent reporting an alcohol abuse disorder diagnosis	56% (N=39)	41% (N=17)
Of those who screened clinically significant for alcohol/drug abuse, percent reporting a drug abuse disorder diagnosis	29% (N=35)	20% (N=15)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p < .05, **p < .01, and ***p < .001

Recommendations

Wilder Research identified the following recommendations based on the primary and secondary data included in this report. It is important to consider that these service needs for Veterans exist within the context of a broader behavioral health system that is struggling to meet the needs of Minnesotans, overall.

- **Collaborate with efforts to address statewide provider shortages.** As identified in the key informant interviews and previous studies, there is a shortage of behavioral health services, especially psychiatry and crisis services and services in rural areas. This shortage is attributed to barriers such as difficulty recruiting and retaining qualified providers, especially in rural areas where they may not be paid as well. These issues cannot be addressed by MDVA alone. However, MDVA could enhance collaborations with other efforts to address these concerns. For instance, in 2016, Governor Dayton convened a task force dedicated to addressing capacity challenges within Minnesota's mental health system. The recommendations of this task force will likely impact the Veterans described in this study as well.

- **Increase mental health and chemical health services for Veterans in rural areas.** Key informants in greater Minnesota noted an overall lack of mental and behavioral health services in their area. In particular, they said that same-day and crisis services for Veterans are needed, as well as more chemical health services. In addition, a more comprehensive transportation system for Veterans is needed, particularly for Veterans in crisis and Veterans with physical disabilities. Existing data demonstrates that a number of services exist across Minnesota, ranging from county or Veteran crisis lines to community-based services to residential treatment services. However, many of these services operate at or near capacity, and many areas still do not have services available locally. In fact, data from the Minnesota Department of Human Services (Wilder Research, 2015) and the U.S. Department of Health and Human Services (2016) have identified a shortage of mental health providers in greater Minnesota.

- **Train community specific service providers on issues related to serving Veterans.** Given the lack of Veteran-specific services, particularly in rural areas, and some Veterans' preference to seek services outside of Veteran-specific organizations, it is important that mental health and behavioral health providers serving the community are trained to identify and address conditions and concerns common to Veterans.

- **Increase awareness of available services and eligibility requirements.** Survey respondents most often cited not having a VA diagnosis as a barrier to obtaining services. There is a need to increase awareness of when a formal VA diagnosis is necessary, and what services may be available without a formal diagnosis.

- **Reduce stigma surrounding behavioral health services.** In addition to needing a VA diagnosis, the next most common barriers to survey respondents accessing services were being worried about how they will be seen, being worried about the effect on current or future employment, and not thinking the services will help. Similarly, the top barriers key informants identified included concerns over effect on employment, concerns over how the Veteran will be seen by others, concerns over effect on future military service, and not believing that services will help. Therefore, there is a need to address these concerns and reduce the stigma surrounding accessing behavioral health services.

- **Enhance support services to accommodate dual-diagnosis.** In the Minnesota Veteran survey, nearly half (46%) had either a mental health or chemical health diagnosis, and 16 percent had both a mental and chemical health diagnosis. Of those with a mental health diagnosis, nearly half (46%) also had a chemical health diagnosis, and of those with a chemical health diagnosis, most (89%) also had a mental health diagnosis. Therefore, many Veterans receiving services for mental health and especially chemical health needs, are likely to also present co-occurring concerns.

- **Increase access to Veteran social supports.** Previous studies have clearly documented the ways in which social supports and community connectedness can protect Veterans from experiencing PTSD and depression symptoms, as well as suicidal ideation and behaviors (e.g., Pietrzak, Harpaz-Rotem, & Southwick, 2011; Nock et al., 2013). Similarly, the Veteran survey conducted for this study found that a strong sense of community belonging and consistent social supports protect Veterans from mental and chemical health diagnoses and symptoms. Specific recommendations for increasing access to Veteran social supports are:

  - **Increase and improve efforts to prepare families and friends to support Veterans.** Many studies have identified that protective social supports often focus on family and friends (Nock et al., 2013). When survey respondents were asked what supports are missing they most often mentioned forms of social support including family, friends, spousal, and community support.

- **Increase opportunities for Veterans to obtain informal, individual support from peers.** Key informants endorsed the need for more peer-to-peer services for Veterans. They noted that Veterans are experts in their own experiences and know how to support each other. In addition, 26 percent of survey respondents reported a preference for peer-to-peer support. Nock and colleagues (2013) identified that connections to former military units can be a particularly effective buffer for PTSD and other psychiatric symptoms. The majority of survey respondents preferred to receive support in an individual one-on-one format. Training and certification are currently available in Minnesota for individuals interested in providing mental and/or chemical health peer support services.

- **Provide population-specific behavioral health services for Veterans.** This study identified several groups of Veterans at an increased risk for behavioral health issues. In particular, women Veterans, Veterans of color, younger Veterans, and Veterans with a disability or chronic medical condition, including traumatic brain injury, tended to report more behavioral health diagnoses and symptoms. Most key informants said services for specific-sub groups of Veterans are not available in their area. Some described a need for services tailored to women Veterans, Veterans who have served in the same conflict or era, and Veterans with traumatic brain injury.

- **Provide services related to sexual assault for both men and women.** In the survey of Veterans conducted for this study, there is a great deal of evidence that Veterans experiencing sexual assault have a greater risk for experiencing mental and chemical health symptoms and diagnoses, including suicidal ideation or behaviors. While the proportion of Veterans reporting sexual assault is greater for women, the number of men reporting sexual assault is higher (given the much larger number of men in the military), so specialized services for both men and women experiencing sexual assault are essential. Men having experienced sexual assault are more likely to need chemical dependency services and are less likely to seek help, so services need to be able to address this. It is also important to note that many Veterans had a sexual assault experience prior to serving in the military, so supports must address sexual violence that occurred prior to, as well as during, active service. Key informants also discussed the need for services specifically for Veterans who have experienced sexual assault, including separate services for men and women. It should be noted that the majority of key informants identified that there are services available for Veterans who have experienced sexual assault, and the VA has programs specifically focused on military sexual trauma, but these programs may not be as accessible or appropriate to address all of the service needs in this area, including the needs of male victims.

References

Barth, S. K., Kimerling, R. E., Pavao, J., McCutheon, S. J., Batten, S. V., Dursa, E., Peterson, M.R., & Schneiderman, A. I. (2016). Military sexual trauma among recent veterans: Correlates of sexual assault and sexual harassment. *American Journal of Preventive Medicine, 50*(1), 77-86.

Boynton Health Service. (2013). *College Student Health Survey report: Health and health-related behaviors: Minnesota postsecondary student veterans.* Minneapolis, MN.

Braden, J. B., & Sullivan, M. D. (2008). Suicidal thoughts and behavior among adults with self-reported pain conditions in the National Comorbidity Survey replication. *Journal of Pain, 9*(12), 1106-1115.

Cavanagh, J. T., Carson, A. J., Sharpe, M., & Lawrie, S. M. (2003). Psychological autopsy studies of suicide: A systematic review. *Psychological Medicine, 33*(3), 395-405.

Centers for Disease Control. (2013). Behavioral Risk Factor Surveillance System (BRFSS) [Dataset]. Retrieved from https://www.cdc.gov/brfss/annual_data/annual_2013.html

Corson, K., Denneson, L. M., Bair, M. J., Helmer, D. A., Goulet, J. L., & Dobscha, S. K. (2013). Prevalence and correlates of suicidal ideation among Operation Enduring Freedom and Operation Iraqi Freedom veterans. *Journal of Affective Disorders, 149*(1-3), 291-298.

Cox, K. S., Mouilso, E. R., Venners, M. R., Defever, M. E., Duvivier, L., Rauch, S. A., . . . Tuerk, P. W. (2016). Reducing suicidal ideation through evidence-based treatment for posttraumatic stress disorder. *Journal of Psychiatric Research, 80*, 59-63. doi:10.1016/j.jpsychires.2016.05.011

Ewing, J. (1984). Detecting alcoholism: The CAGE questionnaire. *JAMA, 252*(14), 1905-7.

Fanning, J. R., & Pietrzak, R. H. (2013). Suicidality among older male veterans in the United States: Results from the National Health and Resilience in Veterans study. *Journal of Psychiatric Research, 47*(11), 1766-1775.

Golub, A., Vazan, P., Bennett, A. S., & Liberty, H. J. (2013). Unmet need for treatment of substance use disorders and serious pyschological distress among veterans: A nationwide analysis using the NSDUH. *Military Medicine, 178*(1), 107-114.

Harris, E. C., & Barraclough, B. (1997). Suicide as an outcome for mental disorders. A meta-analysis. *British Journal of Psychiatry, 170*(3), 205-228.

Hoge, C. W., McGurk, D., Thomas, J. L., Cox, A. L., Engel, C. C., & Castro, C. A. (2008). Mild traumatic brain injury in U.S. soldiers returing from Iraq. *New England Journal of Medicine, 358*(5), 453-463. doi:10.1056/NEJMoa072972

James, L. M., Van Kampen, E., Miller, R. D., & Engdahl, B. E. (2013). Risk and protective factors associated with symptoms of post-traumatic stress, depression, and alcohol misuse in OEF/OIF Veterans. *Military Medicine, 178*(2), 159-165. doi:10.7205/MILMED-D-12-00282

Kroenke, K., Spitzer, R., Williams, J., & Lowe, B. (2009). An ultra-brief screening scale for anxiety and depression: The PHQ-4. *Psychosomatics, 50*(6), 613-21.

Lemaire, C. M., & Graham, D. P. (2011). Factors associated with suicidal ideation in OEF/OIF veterans. *Journal of Affective Disorders, 130*(1), 231-238.

Maguen, S., Madden, E., Cohen, B. E., Bertenthal, D., Neylan, T. C., & Seal, K. H. (2015). Suicide risk in Iraq and Afghanistan veterans with mental health problems in VA care. *Journal of Psychiatric Research, 68*, 120-124.

McCarthy, J. F., Blow, F. C., Ignacio, R. V., Ilgen, M. A., Austin, K. L., & Valenstein, M. (2012). Suicide among patients in the Veterans Affairs Health System: Rural–urban differences in rates, risks, and methods. . *American Journal of Public Health, 102*(S1), S111-S117.

Miller, M., & Hemenway, D. (2008). Guns and suicide in the United States. *New England Journal of Medicine, 359*(10), 989-991.

Minneapolis VA Health Care System. (n.d.). Inpatient psychiatry [website]. Retrieved from https://www.va.gov/directory/guide/state.asp?STATE=MN&dnum=ALL

Minneapolis VA Health Care System. (n.d.). Mental health services [website]. Retrieved from http://www.minneapolis.va.gov/services/Mental_Health_Services.asp

Minnesota Department of Health. (2016). *Death certificate data* [Dataset]. St. Paul, MN.

Minnesota Department of Human Services. (2016). *Anoka Metro Regional Treatment Center 2015 Utilization Data*. St. Paul, MN.

Minnesota Department of Human Services. (2016). *Mental and chemical health licensure data* [Dataset]. St. Paul, MN.

Minnesota Department of Veterans Affairs. (2016). *2015 Annual Report.* St. Paul, MN.

Minnesota Hospital Association. (2015). *Mental and behavioral health: Options and opportunities for Minnesota.* St. Paul, MN.

Minnesota Office of the Legislative Auditor. (2016). *Mental health services in county jails: Evaluation report.* Program Evaluation Division, St. Paul, MN.

Montross Thomas, L. P., Palinkas, L. A., Meier, E. A., Iglewicz, A., Kirkland, T., & Zisook, S. (2014). Yearning to be heard: What veterans teach us about suicide risk and effective interventions. *Crisis, 35*(3), 161-167. doi:10.1027/0227-5910/a000247

Morral, A. R., Gore, K. L., Schell, T. L., Bicksler, B., Farris, C., Dastidar, M. G., Jaycox, L. H., Kilpatrick, D., Kistler, S., Street, A., Tanielian, T., & Williams, K. M. (2016). Sexual assault and sexual harassment in the U.S. military: Volume 2. Estimates for Department of Defense Service Members from the 2014 RAND Military Workplace Study. (A. R. Morral, K. L. Gore, & T. L. Schell, Eds.) Santa Monica, CA: RAND Corporation.

Nock, M. K. (2008). Actions speak louder than words: An elaborated theoretical model of the social functions of self-injury and other harmful behaviors. *Applied and Preventive Psychology, 12*(4), 159-168.

Nock, M. K., Deming, C. A., Fullerton, C. S., Gilman, S. E., Goldenberg, M., Kessler, R. C., . . . Ursano, R. J. (2013). Suicide among soldiers: A review of psychosocial risk and protective factors. *Psychiatry, 76*(2), 97-125. doi:10.1521/psyc.2013.76.2.97

Nock, M. K., Hwang, I., Sampson, N., & Kessler, R. C. (2010). Mental disorders, comorbidity, and suicidal behaviors: Results from the National Comorbidity Survey Replication. *Molecular Psychiatry, 15*(8), 868-876.

Nock, M. K., I, H., Sampson, N., Kessler, R. C., Angermeyer, M., Beautrais, A., . . . Williams, D. R. (2009). Cross-national analysis of the associations among mental disorders and suicidal behavior: Findings from the WHO World Mental Health Surveys. *PLOS Medicine, 6*(8). doi:10.1371/journal.pmed.1000123

Pietrzak, R. H., Harpaz-Rotem, I., & Southwick, S. M. (2011). Cognitive-behavioral coping strategies associated with combat-related PTSD in treatment-seeking OEF-OIF Veterans. *Psychiatry Research, 189*(2), 251-258.

Pietrzak, R. H., Johnson, D. C., Goldstein, M. B., Malley, J. C., & Southwick, S. M. (2009). Psychological resilience and postdeployment social support protect against traumatic stress and depressive symptoms in soldiers returning from Operations Enduring Freedom and Iraqi Freedom. *Depression and Anxiety, 26*(8), 745-51.

Prins, A., Ouimette, P., Kimerling, R., Cameron, R., Hugelshofer, D., Shaw-Hegwer, J., . . . Sheikh, J. (2003). The primary care PTSD screen (PC-PTSD): development and operating characteristics. *Primary Care Psychiatry, 9*(1), 9-14. doi: 10.1185/135525703125002360

Rudd, M. D., Berman, A. L., Joiner, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., . . . Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior, 36*(3), 255-262. doi: 10.1521/suli.2006.36.3.255

Schneiderman, A. I., Braver, E. R., & Kang, H. K. (2008). Understanding sequelae of injury mechanisms and mild traumatic brain injury incurred during the conflicts in Iraq and Afghanistan: Persistent postconcussive symptoms and post-traumatic stress disorder. *American Journal of Epidemiology, 167*(12), 1446-1452. doi:10.1093/aje/kwn068

Scott, K. M., Hwang, I., Chiu, W. T., Kessler, R. C., Sampson, N. A., Angermeyer, M., . . . Nock, M. K. (2010). Chronic physical conditions and their association with first onset of suicidal behavior in the world mental health surveys. *72*(7), 712-719. doi:10.1097/PSY.0b013e3181e3333d

Simpson, G., & Tate, R. (2002). Suicidality after traumatic brain injury: Demographic, injury and clinical correlates. *Psychological Medicine, 32*(4), 687-697.

Simpson, G., & Tate, R. (2007). Suicidality in people surviving a traumatic brain injury: Prevalence, risk factors and implications for clinical management. *Brain Injury, 21*(13-14), 1335-1351.

Smith, N. B., Mota, N., Tsai, J., Monteith, L., Harpaz-Rotem, I., Southwick, S. M., & Pietrzak, R. H. (2016). Nature and determinants of suicidal ideation among U.S. Veterans: Results from the national health and resilience in veterans study. *Journal of Affective Disorders, 197*, 66-73. doi:10.1016/j.jad.2016.02.069

St. Cloud VA Health Care System. (n.d.). Mental health [website]. Retrieved from http://www.stcloud.va.gov/services/mentalhealth.asp

St. Cloud VA Health Care System. (n.d.).Locations [website]. Retrieved from https://www.va.gov/directory/guide/facility.asp?id=127

U.S. Department of Health and Human Services HRSA Data Warehouse. (2016). *Health Professional Shortage Area (HPSA) Find*. Retrieved from https://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx

U.S. Department of Veterans Affairs. (2012). *Guide to VA mental health services for veterans and families.* Washington, DC.

U.S. Department of Veterans Affairs. (2016). *Suicide among Veterans and other Americans: 2001-2014*. Washington, DC.

Wilder Research. (2015). *Department of Human Services gaps analysis study: Statewide report.* St. Paul, MN.

Wilder Research. (2016). 2015 statewide homeless study data [Dataset]. St. Paul, MN.

Appendix

Key informant interview respondent characteristics

Clients served

A1. Clients served by key informants' organizations

Clients (N=43)	%
Veterans meeting Minnesota state definition	100%
Current or former service members not meeting Minnesota state definition	95%
Civilians[a]	81%

Note. Total for who was served exceeds 100 percent because respondents were asked to select all that apply.

[a] Some organizations only served spouses and dependent children of Veterans, while others served the public in general.

Role in organization

A2. Key informants' role in their organization

Clients (N=43)	N
Connect to local services and resources	22
Facilitate access to local, state, and federal benefits and entitlements	21
Outreach	15
Participate in community initiatives and groups	8
Provide mental health or behavioral health services	5

Descriptions of roles:

- **Connect to local services and resources** (n=22). Most key informants also connect Veterans to programming, resources, and opportunities available through local, state, and national organizations. Common examples included helping Veterans access mental health services, legal advocacy, emergency financial assistance, and transportation.
- **Facilitate access to local, state, and federal benefits and entitlements** (n=21). Key informants described educating Veterans on the local, state, and national benefits available to them, as well as assisting them with the following: identifying the most appropriate resources to meet their needs, acquiring evidence of their eligibility, completing paperwork, and advocating for their rights as needed.

- **Outreach** (n=15). Many of the key informants interviewed conducted some form of outreach as part of their work. In some cases, the goal was to locate and work with Veterans who were unable or unlikely to come in for the services. In other cases, the outreach was to build awareness about Veterans experiences and available resources. These education efforts targeted various audiences including Veterans, houses of worship, human service organizations, and the public at large.
- **Participate in community initiatives and groups** (n=8). Several key informants described working on coalitions and committees in order to advocate for and advance Veterans well-being. Examples included participating in efforts to address homelessness, attending post-secondary student groups, and serving as a liaison to government committees. A few key informants also noted volunteering in local programming for Veterans.
- **Provide mental health or behavioral health services** (n=5). Several key informants provided direct mental or behavioral health services to Veterans. These included both inpatient and outpatient programming, as well as individual, couple, family, and group formats.

Geographic area of expertise

Respondents were asked what geographic area they felt comfortable discussing relative to mental health and behavioral health related services and gaps. Of the 43 interviews completed, 65 percent focused on an area in greater Minnesota, 33 percent on the Twin Cities metro area (including Hennepin, Ramsey, Anoka, Washington, Dakota, Scott, and Carver counties), and 2 percent on the entire state of Minnesota (see Figure A3). More specifically, key informants were interviewed from each of the seven regions of the state, as defined by the Minnesota Housing Finance Agency Continuum of Care regions.

A3. Key Informants

Geographic area (N=43)	%
Twin Cities metro	33%
Greater Minnesota	65%
Statewide	2%
Region (N=43)	
Central	14%
Hennepin/Ramsey/Suburban Metro	33%
Northeast/St. Louis	7%
Northwest	9%
Southeast	14%
Southwest	9%
Statewide	2%

DHS licenses: residential treatment

A4. Department of Human Services residential treatment licenses by region

	Twin Cities metro	Central	Northeast	Northwest	Southeast	Southwest	West Central
Residential Crisis Stabilization Services							
Number of facilities	7	2	2	1	4	3	1
Number of beds	289	11	20	15	49	25	9
Intensive Residential Treatment Services (IRTS)							
Number of facilities	20	3	3	1	6	3	2
Number of beds	264	42	42	15	76	36	19
Substance use disorder residential treatment							
Number of facilities, total	50	15	15	5	13	4	9
Number of beds, total	1,453	742	274	149	422	148	189
Number of facilities, dual-diagnosis	30	7	5	1	8	3	3
Number of beds, dual-diagnosis	1,094	574	92	24	233	127	58

DHS licenses: community based treatment

A5. Department of Human Services community based treatment licenses by region

	Twin Cities metro	Central	Northeast	Northwest	Southeast	Southwest	West Central
Assertive Community Treatment (ACT) teams	14	3	4	0	2	3	0
Adult Rehabilitative Mental Health Services (ARMHS)	132	72	32	20	61	42	31
Dialectical Behavior Therapy (DBT)	26	5	5	0	5	3	2
Mental health centers or clinics	38	5	5	3	7	5	2

Survey respondents' perceptions of what is most helpful

A6. What was most helpful? (N=323)

	%
Individual counseling	33%
VA based services	32%
Medication	13%
Private/civilian/local services	10%
Group counseling	6%
Nothing	5%
Faith-based services	4%
Peer-to-peer support	3%
Veterans Center	3%
Outpatient treatment	3%
Veterans Recovery House/ Residential Rehabilitation Treatment Program/Saint Cloud Rehab	3%
Talking with other Veterans with similar experiences	2%
Friend/Family/Community supports	2%
Nonprofit services	2%
Unspecified mental health services	2%
NA	2%
Other	2%
Both mental and chemical health	1%
Everything	1%
Inpatient treatment	1%
Service or companion animal; psychiatric service dogs (psd)	1%
Financial supports (GI Bill, VA Home Loan, Retirement benefits)	1%
Dialectical Behavioral Therapy (DBT)	1%
Sexual health/sexual assault	1%
Marriage or family counseling	1%
Eagle's Healing Nest	1%
Physical health services	1%
County services	1%
State services	1%
University-based services; school-based services	1%

A6. What was most helpful? (N=323) (continued)

	%
Supportive housing	<0.01%
Crisis line	<0.01%
Vet Court	<0.01%
Received diagnosis from medical provider	<0.01%
Meditation, yoga, naturopath, chiropractor, etc.	<0.01%
Acceptance and Commitment Therapy (ACT)	<0.01%
Bio-feedback/Neuro-feedback	<0.01%
Cognitive Behavioral Therapy (CBT)	<0.01%
Cognitive Behavioral Social Skills Training (CBSST)	<0.01%
Cognitive Processing Therapy (CPT)	<0.01%
Deep Immersion Therapy	<0.01%
Eye Movement Desensitization and Reprocessing (EMDR)	<0.01%
Pain psychologist	<0.01%
Psychiatry Partial Hospital Program (PPH)	<0.01%
MAC-V	<0.01%
Minnesota Veterans Home – Hastings	<0.01%
VA Inpatient Psychiatry (1K)	<0.01%
MN Adult and Teen Challenge	<0.01%
Prison-based services	<0.01%
Non-VA services (general)	<0.01%
Both inpatient and outpatient	<0.01%
VFW	<0.01%
360 Veterans Association	<0.01%
Unspecified chemical health services	<0.01%

Survey respondents perceptions of what is least helpful

A7. What was least helpful? (N=260)

	%
VA-based services/ Federal services	19%
Individual counseling	11%
General positive response	7%
N/A	7%
Nothing	5%
Medication	5%
Private/civilian/local services	5%
Group counseling/ support groups	4%
County services	4%
State services	2%
Nothing helped	3%
Acceptance and commitment therapy	2%
Self-treatment/ignoring the issue	2%
Have not used any other services	2%
Social supports	2%
Group home	2%
Online/Call Services	1%
Medical care/primary care (pain clinic, physical therapy, weight loss)	1%
Nonprofit services	1%
Marriage or family counseling	1%
Prolonged Exposure Therapy (PE therapy)	1%
Peer-to-peer support	1%
Medication with no therapy/Medication alone	1%
Inpatient Treatment	<0.01%
Dialectical Behavioral Therapy (DBT)	<0.01%
Cognitive Behavioral Therapy (CBT)	<0.01%
Grief Counseling	<0.01%
Cognitive Processing Therapy (CPT)	<0.01%
Faith-based services	<0.01%
Care coordination	<0.01%
Prison-based services	<0.01%
Services specifically for Veterans	<0.01%

A7. What was least helpful? (N=260) (continued)

	%
Unspecified mental health services	<0.01%
Outpatient	<0.01%
If provided 'least' helpful' response, why?	
Service did not care about individual issues/treatment not personalized	9%
Provider not good with Veterans' issues/doesn't understand	7%
Services don't help/Not getting to root of problem	7%
Long wait times/need more frequency	4%
Side effects	3%
Bad rapport with provider	3%
Services made condition/symptoms worse	2%
Staff too busy/things felt rushed	2%
Could not afford services/service not covered by insurance	2%
Service not good quality	2%
Too much red tape/Too much bureaucracy	2%
Don't want to talk about it/haven't talked about it	2%
Lack of trust	2%
Staff turnover	1%
Services closed on weekends/scheduling difficult/limit to number of sessions	1%
Needed service not available through provider	1%
No staff accountability	1%
Service too far away	1%
Could not figure out what was wrong/told me nothing was wrong	1%
Could not get diagnosis to get proper services	1%
Blame	1%
Service not well organized	<0.01%
Not eligible for service	<0.01%
Not enough staff	<0.01%
Feel stigmatized for seeking help	<0.01%
Needed to be staff led (as opposed to peer led)	<0.01%
Felt Detached	<0.01%

Survey respondents' missing supports

A8. What supports are missing? (N=367)

	%
Nothing	16%
Family support	7%
Financial support	5%
Community support	4%
Improved healthcare benefits	4%
Friends' support	4%
Employment services	4%
Don't know	4%
Spouse support	3%
Physical health services	3%
General negative comment about services	3%
General emotional support	3%
More individual counseling	2%
Expressed difficulty navigating the system	2%
Lack of trust	2%
Services closer to home	2%
More caring/understanding providers	2%
Shared a bad experience they had with the VA	2%
Support groups	2%
Lack of awareness of services	2%
Generally missing support	2%
Other	2%
Supportive housing	1%
Military culture discourages seeking help	1%
Long wait times	1%
VA support missing	1%
Peer-to-peer group support	1%
Same day/ crisis services	1%
Follow-up care	1%
Disability services	1%
Providers with shared experiences	1%
Legal support	1%

A8. What supports are missing? (N=367) (continued)

	%
Currently waiting on feedback from a provider/VA	1%
Services only open during standard business hours	1%
Expressed general apathy	1%
Concerned about privacy	1%
Education services	1%
Lack of understanding from civilian population	1%
No continuity of care for rural Veterans	1%
Not wanting to go from rural to city for care	1%
No appointments available	1%
Difficult scheduling appointments	1%
In-home care	1%
Female specific services/Male specific services	1%
PTSD services	1%
Ketamine treatment	1%
Services for non-combat Veterans	1%
Services for “non-severe” cases/Lower priority	1%
Companion animal for emotional stability	1%
Medical marijuana	1%
Grief counseling	1%
Inpatient treatment	1%
Non-VA care services	1%
Pain management help	1%
Time with their unit	1%
Nonsensical response	1%
Spiritual/house of worship/chaplain	<0.01%
Vocational rehab	<0.01%
Insufficient transportation	<0.01%
Slow to fill prescription	<0.01%
Feel vets do not need help/Part of job	<0.01%
Services for whole family	<0.01%
More frequent appointments	<0.01%
TBI treatment	<0.01%
Providers in shortage-general	<0.01%

A8. What supports are missing? (N=367) (continued)

	%
Providers who understand Veteran issues	<0.01%
Provider without VA restrictions	<0.01%
More consistent providers	<0.01%

Survey respondent tables

Tables by age

A9. Demographics by age

	Age 18-34	Age 35-54	Age 55-64	Age 65+
Race/ethnicity	**(N=131)**	**(N=251)**	**(N=187)**	**(N=305)**
White/Caucasian	82%***	88%***	90%***	96%***
Veterans of color	18%***	12%***	10%***	4%***
Age	**(N=131)**	**(N=255)**	**(N=187)**	**(N=307)**
18 to 34 years	100%	0%	0%	0%
35 to 54 years	0%	100%	0%	0%
55 to 64 years	0%	0%	100%	0%
65 to 74 years	0%	0%	0%	87%
75 years and over	0%	0%	0%	13%
Gender	**(N=131)**	**(N=253)**	**(N=186)**	**(N=307)**
Men	74%***	81%***	80%***	96%***
Women	25%***	19%***	20%***	4%***
Other	1%***	<1%***	0%***	<1%***

Note. Respondents were asked separately about race and Hispanic ethnicity. Those who report Hispanic ethnicity are not included in the racial categories for data in this table.

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A10. Region by age

Region	Age 18-34 (N=130)	Age 35-54 (N=251)	Age 55-64 (N=184)	Age 65+ (N=302)
Central	15%	18%	10%	19%
Northeast	2%	6%	4%	5%
Northwest	3%	4%	4%	2%
Southeast	8%	11%	14%	17%
Southwest	2%	6%	3%	3%
Twin Cities Metro Area	64%	51%	62%	52%
West Central	5%	3%	4%	1%

A11. National Guard or Reserve Component status by age

National Guard component	Age 18-34 (N=131)	Age 35-54 (N=251)	Age 55-64 (N=183)	Age 65+ (N=303)
Never served on active duty as a member of the National Guard/Reserve Component	62%	69%	73%	85%
Yes, served on active duty while in the National Guard/Reserves, still serving	10%	3%	0%	<1%
Yes, served on active duty while in the National Guard/Reserves, have separated/ retired	28%	28%	27%	15%

A12. Branch of military by age

Branch	Age 18-34 (N=131)	Age 35-54 (N=254)	Age 55-64 (N=186)	Age 65+ (N=306)
Army	59%	54%	42%	54%
Navy	12%	20%	27%	25%
Air Force	12%	18%	28%	18%
Marine Corps	18%	11%	7%	7%
Coast Guard	0%	1%	1%	<1%
Other	0%	<1%	0%	<1%

A13. Service era by age

Service Era	Age 18-34 (N=131)	Age 35-54 (N=255)	Age 55-64 (N=187)	Age 65+ (N=307)
September 2001 or later	100%	47%	22%	4%
August 1990 to August 2001 (includes Persian Gulf War)	4%	66%	34%	7%
May 1975 to July 1990	0%	44%	73%	10%
Vietnam era (August 1964 to April 1975)	0%	<1%	39%	87%
February 1955 to July 1964%	0%	0%	0%	15%
Korean War (July 1950 to January 1955)	0%	0%	0%	3%
January 1947 to June 1950	0%	0%	0%	0%
World War II (December 1941 to December 1946)	0%	0%	0%	1%
November 1941 or earlier	0%	0%	1%	<1%

A14. Served in a combat/war zone by age

	Age 18-34 (N=130)	Age 35-54 (N=254)	Age 55-64 (N=184)	Age 65+ (N=307)
Served in a combat/war zone	70%	58%	30%	61%

A15. Discharge status by age

Character of discharge	Age 18-34 (N=131)	Age 35-54 (N=255)	Age 55-64 (N=187)	Age 65+ (N=307)
Honorable discharge	93%	93%	95%	98%
General (under honorable conditions)	7%	7%	5%	2%

A16. Time in active duty by age

Time in active duty	Age 18-34 (N=129)	Age 35-54 (N=254)	Age 55-64 (N=185)	Age 65+ (N=298)
Less than 2 years	9%	8%	5%	7%
2-3 years	16%	16%	23%	48%
4-5 years	47%	28%	22%	26%
6-10 years	25%	19%	14%	7%
11-15 years	35	9%	8%	2%
16+ years	1%	21%	29%	10%

A16. Time in active duty by age (continued)

Time in active duty	Age 18-34 (N=129)	Age 35-54 (N=254)	Age 55-64 (N=185)	Age 65+ (N=298)
Mean	4.8 years	8.5 years	10.9 years	5.9 years
Median	4 years	5 years	6 years	3 years
Range	0 to 16 years	0 to 30 years	0 to 42 years	0 to 46 years

A17. Veteran mental health diagnosis by age

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Age 18-34 (N=126-131)	Age 35-54 (N=233-247)	Age 55-64 (N=166-178)	Age 65+ (N=283-297)
Anxiety disorder or panic disorder	44%***	47%***	26%***	20%***
Post-Traumatic Stress Disorder (PTSD)	40%***	37%***	20%***	21%***
Major depression	30%***	41%***	32%***	20%***
Alcohol abuse disorder	20%	18%	18%	15%
A concussion or traumatic brain injury	19%***	17%***	8%***	6%***
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	14%*	16%*	12%*	7%*
Drug abuse disorder	7%	3%	7%	3%
Manic episodes or manic depression, bipolar disorder	6%	8%	9%	4%
Paranoid or delusional disorder, other than schizophrenia	2%	2%	4%	2%
Schizophrenia	1%	2%	2%	1%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A18. Disability by age

	Age 18-34 (N=131)	Age 35-54 (N=254)	Age 55-64 (N=187)	Age 65+ (N=305)
Has a disability	53%	64%	60%	54%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A19. Survey responses on standardized screening tools, by age

	Age 18-34 (N=131)	Age 35-54 (N=255)	Age 55-64 (N=186-187)	Age 65+ (N=302-305)
Depression subscale				
Percent of respondents that screened positive for depression	31%***	37%***	29%***	14%***
Of those who screened positive for depression, percent reporting a diagnosis of major depression	59%	75%	70%	63%
Anxiety subscale				
Percent of respondents that screened positive for anxiety	36%***	37%***	28%***	13%***
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	68%	77%	60%	61%
PTSD scale				
Percent of respondents that screened positive for PTSD	52%***	40%***	30%***	20%***
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	60%	70%	54%	69%
Alcohol or drug abuse scale				
Percent of respondents that screened clinically significant for alcohol or drug abuse	36%	32%	26%	27%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	47%	51%	51%	44%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	20%	12%	21%	7%
Any psychological distress	**64%*** **	**62%*** **	**50%*** **	**30%*** **

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A20. When Veteran experienced PTSD by age

When did you have these experiences?	Age 18-34 (N=88)	Age 35-54 (N=153)	Age 55-64 (N=102)	Age 65+ (N=109)
Before your service	7%	5%	9%	5%
During your service	68%	54%	55%	29%
After your service	88%	84%	80%	92%

A21. Sought help because of PTSD by age

	Age 18-34 (N=88)	Age 35-54 (N=153)	Age 55-64 (N=102)	Age 65+ (N=109)
Sought help because of experiences	72%	75%	63%	66%

A22. Suicidal ideation by age

	Age 18-34 (N=131)	Age 35-54 (N=254)	Age 55-64 (N=185)	Age 65+ (N=300)
Have you ever thought of killing yourself?	45%***	43%***	37%***	23%***
Do you currently have these thoughts?	12% (5% of total)	13% (5% of total)	16% (6% of total)	10% (2% of total)
Have you ever attempted suicide?	20% (9% of total)	30% (13% of total)	26% (10% of total)	21% (5% of total)
Have you ever sought help because you were suicidal?	41% (18% of total)	44% (19% of total)	54% (20% of total)	38% (9% of total)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A23. Sexual assault by age

Sexual assault	Age 18-34 (N=131)	Age35-54 (N=254)	Age 55-64 (N=186)	Age 65+ (N=305)
Have you ever been touched sexually against your will/without your consent or ever been pressured to engage in sexual acts against your will/without your consent?	24%*** (N=32)	26%*** (N=66)	22%*** (N=39)	10%*** (N=30)
Before your service?	66%**	55%**	41%**	83%**
During your service?	63%*	58%*	62%*	27%*
After your service?	19%	12%	8%	13%
Have you ever sought help because of your experiences?	31%	52%	51%	27%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A24. Social support by age

How often would you say you get the social and emotional support you need?	Age 18-34 (N=130)	Age 35-54 (N=255)	Age 55-64 (N=186)	Age 65+ (N=304)
Always/Usually	60%***	46%***	51%***	68%***
Sometimes/Rarely/Never	40%***	54%***	49%***	32%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A25. Sense of belonging by age

How would you describe your sense of belonging to your local community?	Age 18-34 (N=131)	Age 35-54 (N=255)	Age 55-64 (N=186)	Age 65+ (N=306)
Very/somewhat strong	53%***	50%***	54%	76%***
Very/somewhat weak	47%***	50%***	46%	24%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A26. Wellbeing by age

Thinking about your mental wellbeing right now, overall, would you say you are…	Age 18-34 (N=131)	Age 35-54 (N=255)	Age 55-64 (N=185)	Age 65+ (N=300)
Getting better	34%***	20%***	17%***	17%***
Getting worse	3%***	8%***	3%***	1%***
Staying the same	26%***	38%***	45%***	62%***
Depends on the day	32%***	31%***	31%***	17%***
I'm not sure	5%***	4%***	3%***	3%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A27. Services received and attempted to obtain by age

	Age 18-34 (N=127-131)	Age 35-54 (N=253-255)	Age 55-64 (N=185-187)	Age 65+ (N=299-305)
Received services since exiting the military	54%***	58%***	43%***	28%***
Received services in the past two years	53%***	50%***	37%***	20%***
Feel they have the support they need	75%***	69%***	71%***	88%***
Attempted and been unable to obtain services	20%***	14%***	11%***	4%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A28. Mental health services received by age

Mental health	Age 18-34 (N=70)	Age 35-54 (N=127)	Age 55-64 (N=70)	Age 65+ (N=62)
Individual counseling (outpatient)	93%	92%	84%	89%
Group counseling (outpatient)	29%	21%	20%	24%
Peer to peer support	31%	19%	19%	19%
Inpatient counseling or treatment	19%	17%	19%	13%
Crisis line	10%	13%	16%	5%
Recovery services	9%	9%	7%	5%
Supportive housing	4%	8%	10%	2%
Faith-based support services	19%	18%	13%	10%
Other	7%**	7%**	23%**	21%**
NONE	3%	4%	3%	3%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A29. Chemical health services received by age

Chemical health	Age 18-34 (N=70)	Age 35-54 (N=127)	Age 55-64 (N=70)	Age 65+ (N=62)
Individual counseling (outpatient)	19%**	12%**	11%**	0%**
Group counseling (outpatient)	11%	9%	6%	0%
Peer to peer support	9%	9%	7%	10%
Inpatient counseling or treatment	16%**	6%**	4%**	2%**
Crisis line	3%	5%	1%	2%
Recovery services	9%	9%	7%	3%
Supportive housing	3%	6%	3%	2%
Faith-based support services	7%	3%	1%	2%
Other	3%	2%	1%	2%
NONE	74%	79%	86%	89%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A30. Service origin by age

Service origin	Age 18-34 (N=70)	Age 35-54 (N=127)	Age 55-64 (N=70)	Age 65+ (N=62)
Federal service	73%	75%	64%	74%
State service	23%	19%	20%	13%
County service	21%	17%	21%	10%
Local government service	9%	9%	4%	5%
Private service	37%	36%	46%	35%
Non-profit service	14%	25%	14%	16%
NONE	0%*	3%*	1%*	8%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A31. Barriers by age

Barrier	Age 18-34 (N=78)	Age 35-54 (N=148)	Age 55-64 (N=106)	Age 65+ (N=128)
Was not eligible for services	5%	14%	13%	9%
Could not pay for services	28%***	12%***	20%***	6%***
Could not find transportation to get to services	10%**	26%**	2%**	<1%**
The service was not available in my area	13%*	14%*	8%*	4%*
The people who provide it don't speak my language/I could not get an interpreter	0%	0%	0%	<1%
The wait time was too long	22%***	20%***	14%***	4%***
Services were not good with Veteran-specific issues	21%**	16%**	11%**	6%**
I was worried about how I would be seen	35%**	33%**	30%**	16%**
I was worried about the effect on current or future employment	31%***	36%***	27%***	4%***
I was worried about the effect on my current or future military service	12%**	7%**	5%**	0%**
I was worried about my family finding out	18%	12%	13%	7%
Cannot financially afford to take time off	27%***	26%***	9%***	2%***
I don't have a VA diagnosis	33%	33%	30%	37%
I don't think the services will help	17%	19%	19%	20%
Other	10%**	19%**	25%**	31%**
NONE	0%	0%	0%	<1%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A32. Preferred service format by age

Service format	Age 18-34 (N=123)	Age 35-54 (N=231)	Age 55-64 (N=161)	Age 65+ (N=229)
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social or practical help to each other)	37%**	29%**	23%**	21%**
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	24%	28%	21%	22%
Individual (one-on-one services with a professional care provider)	18%***	74%***	72%***	52%***
Online (services provided online)	18%	20%	19%	16%
Text (services provided through text)	10%**	11%**	8%**	3%**
Informal support (such as support from family, friends, etc.)	25%	34%	32%	36%
Other	4%	7%	9%	11%
NONE	0%	0%	0%	0%

Tables by combat status

A33. Demographics by combat status

	Combat	Non-Combat
Gender	**(N=481)**	**(N=)**
Men	91%***	78%***
Women	9%***	22%***
Other	<1%***	<1%***
Race/ethnicity	**(N=478)**	**(N=393)**
White/Caucasian	90%	90%
Veterans of color	10%	10%
Age	**(N=481)**	**(N=394)**
18 to 34 years	19%	10%
35 to 54 years	31%	27%
55 to 64 years	11%	33%
65 to 74 years	37%	23%
75 years and over	2%	7%

Note. Respondents were asked separately about race and Hispanic ethnicity. Those who report Hispanic ethnicity are not included in the racial categories for data in this table.
Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A34. Region by combat status

Region	Combat (N=475)	Non-Combat (N=392)
Central	18%	15%
Northeast	5%	5%
Northwest	4%	3%
Southeast	14%	12%
Southwest	3%	4%
Twin Cities Metro Area	52%	60%
West Central	3%	2%

A35. National Guard or Reserve Component by combat status

National Guard component	Combat (N=493)	Non-Combat (N=408)
Never served on active duty as a member of the National Guard/Reserve Component	70%	80%
Yes, served on active duty while in the National Guard/Reserves and I am still serving in the National Guard/Reserves	4%	<1%
Yes, served on active duty while in the National Guard/Reserves and have separated/ retired from the National Guard/Reserves	26%	19%

A36. Branch of military by combat status

Branch	Combat (N=497)	Non-Combat (N=412)
Army	60%	44%
Navy	20%	26%
Air Force	13%	25%
Marine Corps	11%	8%
Coast Guard	<1%	1%
Other	<1%	<1%

A37. Service era by combat status

Service Era	Combat (N=500)	Non-Combat (N=413)
September 2001 or later	45%	21%
August 1990 to August 2001 (includes Persian Gulf War)	31%	26%
May 1975 to July 1990	24%	41%
Vietnam era (August 1964 to April 1975)	41%	37%
February 1955 to July 1964	3%	9%
Korean War (July 1950 to January 1955)	<1%	2%
January 1947 to June 1950	0%	0%
World War II (December 1941 to December 1946)	<1%	<1%
November 1941 or earlier	<1%	<1%

A38. Time in active duty by combat status

Time in active duty	Combat (N=493)	Non-Combat (N=405)
Less than 2 years	7%	8%
2-3 years	27%	31%
4-5 years	27%	30%
6-10 years	14%	14%
11-15 years	6%	5%
16+ years	19%	12%
Mean	8.3 years	6.7 years
Median	4 years	4 years
Range	0 to 46 years	0 to 42 years

A39. Character of discharge by combat status

	Combat (N=500)	Non-Combat (N=413)
Honorable discharge	96%	93%
General (under honorable conditions)	4%	7%

A40. Veteran mental health diagnosis by combat status

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Combat (N=457)	Non-Combat (N=379)
Schizophrenia	1%	2%
Paranoid or delusional disorder, other than schizophrenia	3%	2%
Manic episodes or manic depression, bipolar disorder	6%	7%
Major depression	31%	27%
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	13%	11%
Alcohol abuse disorder	21%**	13%**
Drug abuse disorder	4%	4%
Post-Traumatic Stress Disorder (PTSD)	40%***	14%***
A concussion or traumatic brain injury	13%	9%
Anxiety disorder or panic disorder	37%**	27%**

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A41. Disability by combat status

	Combat (N=494)	Non-Combat (N=408)
Has a disability	65%***	50%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A42. Survey responses on standardized screening tools, by combat status

Depression subscale	Combat (N=485-489)	Non-Combat (N=403-407)
Percent of respondents that screened positive for depression	30%**	22%**
Of those who screened positive for depression, percent reporting a diagnosis of major depression	66%	71%
Anxiety subscale		
Percent of respondents that screened positive for anxiety	30%*	23%*
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	71%	66%
PTSD scale		
Percent of respondents that screened positive for PTSD	42%***	21%***
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	73%***	45%***
Alcohol or drug abuse scale		
Percent of respondents that screened clinically significant for alcohol or drug abuse	35%***	22%***
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	48%	48%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	11%	18%
Any psychological distress	**55%*** **	**40%*** **

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A43. When Veteran experienced PTSD by combat status

When did you have these experiences?	Combat (N=294)	Non-Combat (N=166)
Before your service	5%	8%
During your service	49%	54%
After your service	90%	80%

A44. Sought help because of PTSD by combat status

	Combat (N=294)	Non-Combat (N=166)
Sought help because of their symptoms	71%	64%

A45. Suicidal ideation by combat status

	Combat (N=481)	Non-Combat (N=401)
Have you ever thought of killing yourself?	38%	32%
Do you currently have these thoughts?	13% (5% of total)	14% (4% of total)
Have you ever attempted suicide?	21%* (8% of total)	32%* (10% of total)
Have you ever sought help because you were suicidal?	39% (14% of total)	50% (15% of total)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A46. Sexual assault by combat status

Sexual assault	Combat (N=485)	Non-Combat (N=404)
Have you ever been touched sexually against your will/without your consent or ever been pressured to engage in sexual acts against your will/without your consent?	15%*** (N=73)	24%*** (N=97)
Before your service?	63%	54%
During your service?	55%	54%
After your service?	12%	14%
Have you ever sought help because of your experiences?	36%	47%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A47. Social support by combat status

How often would you say you get the social and emotional support you need?	Combat (N=485-486)	Non-Combat (N=401)
Always/Usually	56%	58%
Sometimes/Rarely/Never	44%	42%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A48. Sense of belonging by combat status

How would you describe your sense of belonging to your local community?	Combat (N=486)	Non-Combat (N=402)
Very/somewhat strong	56%*	65%*
Somewhat/very weak	44%*	35%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A49. Wellbeing by combat status

Thinking about your mental wellbeing right now, overall, would you say you are…	Combat (N=485)	Non-Combat (N=395)
Staying the same	42%	50%
Depends on the day	29%	23%
Getting better	21%	19%
Getting worse	4%	4%
I'm not sure	3%	4%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A50. Services received by combat status

	Combat (N=476-485)	Non-Combat (N=396-401)
Received services since exiting the military	48%*	39%*
Received services in the past two years	42%***	31%***
Feel they have the support they need	77%	77%
Attempted and been unable to obtain services	12%	9%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A51. Mental health services received by combat status

Mental health	Combat (N=206)	Non-Combat (N=125)
Individual counseling (outpatient)	94%***	82%***
Group counseling (outpatient)	25%	18%
Peer to peer support	25%	16%
Inpatient counseling or treatment	18%	14%
Crisis line	10%	13%
Recovery services	8%	8%
Supportive housing	4%	10%
Faith-based support services	16%	15%
Other	12%	14%
NONE	2%	5%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A52. Chemical health services received by combat status

Chemical health	Combat (N=206)	Non-Combat (N=125)
Individual counseling (outpatient)	11%	10%
Group counseling (outpatient)	9%	5%
Peer to peer support	9%	9%
Inpatient counseling or treatment	5%	9%
Crisis line	4%	2%
Recovery services	7%	8%
Supportive housing	3%	5%
Faith-based support services	4%	2%
Other	2%	2%
NONE	81%	82%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A53. Service origin by combat status

Service origin	Combat (N=206)	Non-Combat (N=125)
Federal service	77%*	65%*
State service	17%	22%
County service	17%	18%
Local government service	9%	5%
Private service	37%	39%
Non-profit service	21%	15%
NONE	2%	6%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A54. Barriers by combat status

Barrier	Combat (N=259)	Non-Combat (N=202)
Was not eligible for services	5%***	17%***
Could not pay for services	17%	22%
Could not find transportation to get to services	5%	3%
The service was not available in my area	12%*	6%*
The people who provide it don't speak my language/I could not get an interpreter	<1%	0%
The wait time was too long	16%	12%
Services were not good with Veteran-specific issues	18%***	6%***
I was worried about how I would be seen	32%*	23%*
I was worried about the effect on current or future employment	24%	24%
I was worried about the effect on my current or future military service	7%	3%
I was worried about my family finding out	13%	11%
Cannot financially afford to take time off	16%	15%
I don't have a VA diagnosis	33%	35%
I don't think the services will help	21%	17%
Other	20%	23%
NONE	<1%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A55. Preferred service format by combat status

Service format	Combat (N=417)	Non-Combat (N=327)
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social or practical help to each other)	29%	22%
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	26%	21%
Individual (one-on-one services with a professional care provider)	66%	71%
Online (services provided online)	19%	17%
Text (services provided through text)	8%	8%
Informal support (such as support from family, friends, etc.)	34%	31%
Other	8%	8%
NONE	<1%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

Tables by concussion/TBI diagnosis

A56. Demographics by concussion/TBI diagnosis

	Concussion/TBI Diagnosis	No Concussion/TBI Diagnosis
Race/ethnicity	**(N=91)**	**(N=716)**
White/Caucasian	87%	91%
Veterans of color	23%	9%
Age	**(N=92)**	**(N=721)**
18 to 34 years	26%	14%
35 to 54 years	42%	27%
55 to 64 years	14%	21%
65 to 74 years	15%	32%
75 years and over	2%	5%
Gender	**(N=92)**	**(N=722)**
Men	84%	86%
Women	15%	14%
Other	1%	<1%

Note. Respondents were asked separately about race and Hispanic ethnicity. Those who report Hispanic ethnicity are not included in the racial categories for data in this table.

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A57. Region by concussion/TBI diagnosis

Region	Concussion/TBI Diagnosis (N=91)	No Concussion/TBI Diagnosis (N=713)
Central	20%	16%
Northeast	3%	5%
Northwest	9%	2%
Southeast	9%	14%
Southwest	4%	4%
Twin Cities Metro Area	53%	56%
West Central	2%	3%

A58. National Guard or Reserves Component by concussion/TBI diagnosis

National Guard component	Concussion/TBI Diagnosis (N=94)	No Concussion/TBI Diagnosis (N=733)
Never served on active duty as a member of the National Guard/Reserve Component	63%	75%
Yes, served on active duty while in the National Guard/Reserves and I am still serving in the National Guard/Reserves	6%	2%
Yes, served on active duty while in the National Guard/Reserves and have separated/ retired from the National Guard/Reserves	31%	23%

A59. Branch of military by concussion/TBI diagnosis

Branch	Concussion/TBI Diagnosis (N=94)	No Concussion/TBI Diagnosis (N=742)
Army	64%	52%
Navy	16%	23%
Air Force	17%	19%
Marine Corps	10%	10%
Coast Guard	0%	1%
Other	1%	<1%

A60. Service era by concussion/TBI diagnosis

Service Era	Concussion/TBI Diagnosis (N=94)	No Concussion/TBI Diagnosis (N=746)
September 2001 or later	51%	33%
August 1990 to August 2001 (includes Persian Gulf War)	29%	30%
May 1975 to July 1990	31%	32%
Vietnam era (August 1964 to April 1975)	18%	41%
February 1955 to July 1964%	1%	6%
Korean War (July 1950 to January 1955)	0%	1%
January 1947 to June 1950	0%	0%
World War II (December 1941 to December 1946)	1%	<1%
November 1941 or earlier	0%	<1%

A61. Served in combat/war zone by concussion/TBI diagnosis

	Concussion/TBI Diagnosis (N=93)	No Concussion/TBI Diagnosis (N=743)
Served in a combat/war zone	62%	54%

A62. Discharge status by concussion/TBI diagnosis

Character of discharge	Concussion/TBI Diagnosis (N=94)	No Concussion/TBI Diagnosis (N=746)
Honorable discharge	90%	96%
General (under honorable conditions)	10%	4%

A63. Time in active duty by concussion/TBI diagnosis

Time in active duty	Concussion/TBI Diagnosis (N=91)	No Concussion/TBI Diagnosis (N=736)
Less than 2 years	7%	7%
2-3 years	24%	29%
4-5 years	19%	30%
6-10 years	26%	12%
11-15 years	12%	5%
16+ years	12%	17%
Mean	7.7 years	7.6 years
Median	6 years	4 years
Range	1 to 37 years	0 to 46 years

A64. Veteran mental health diagnosis by concussion/TBI diagnosis

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Concussion/TBI Diagnosis (N=83-92)	No Concussion/TBI Diagnosis (N=744-745)
Schizophrenia	4%*	1%*
Paranoid or delusional disorder, other than schizophrenia	2%	2%
Manic episodes or manic depression, bipolar disorder	12%*	5%*
Major depression	48%***	24%***
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	30%***	9%***
Alcohol abuse disorder	22%	14%
Drug abuse disorder	5%	3%
Post-Traumatic Stress Disorder (PTSD)	62%***	21%***
A concussion or traumatic brain injury	100%	0%
Anxiety disorder or panic disorder	62%***	26%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A65. Disability by concussion/TBI diagnosis

	Concussion/TBI Diagnosis (N=93)	No Concussion/TBI Diagnosis (N=742)
Has a disability	81%***	54%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A66. Survey responses on standardized screening tools, by concussion/TBI diagnosis

	Concussion/TBI Diagnosis (N=92-93)	No Concussion/TBI Diagnosis (N=734-742)
Depression subscale		
Percent of respondents that screened positive for depression	55%***	21%***
Of those who screened positive for depression, percent reporting a diagnosis of major depression	72%	64%
Anxiety subscale		
Percent of respondents that screened positive for anxiety	52%***	22%***
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	81%*	62%*
PTSD scale		
Percent of respondents that screened positive for PTSD	60%***	28%***
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	87%***	56%***
Alcohol or drug abuse scale		
Percent of respondents that screened clinically significant for alcohol or drug abuse	37%	27%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	48%	43%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	14%	11%
Any psychological distress	77%***	43%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A67. When Veteran experienced PTSD by concussion/TBI diagnosis

When did you have these experiences?	Concussion/TBI Diagnosis (N=74)	No Concussion/TBI Diagnosis (N=333)
Before your service	9%	6%
During your service	62%	49%
After your service	86%	86%

A68. Sought help because of PTSD by concussion/TBI diagnosis

	Concussion/TBI Diagnosis (N=74)	No Concussion/TBI Diagnosis (N=333)
Sought help because of their experience	81%	63%

A69. Suicidal ideation by concussion/TBI diagnosis

	Concussion/TBI Diagnosis (N=93)	No Concussion/TBI Diagnosis (N=725)
Have you ever thought of killing yourself?	56%***	31%***
Do you currently have these thoughts?	15% (9% of total)	12% (3% of total)
Have you ever attempted suicide?	31% (17% of total)	23% (7% of total)
Have you ever sought help because you were suicidal?	54% (30% of total)	40% (12% of total)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A70. Sexual assault by concussion/TBI diagnosis

Sexual assault	Concussion/TBI Diagnosis (N=93)	No Concussion/TBI Diagnosis (N=730)
Have you ever been touched sexually against your will/without your consent or ever been pressured to engage in sexual acts against your will/without your consent?	25% (N=23)	17% (N=122)
Before your service?	52%	64%
During your service?	74%*	48%*
After your service?	22%	10%
Have you ever sought help because of your experiences?	43%	41%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A71. Social support by Concussion/TBI diagnosis

How often would you say you get the social and emotional support you need?	Concussion/TBI Diagnosis (N=93)	No Concussion/TBI Diagnosis (N=728)
Always/Usually	46%*	59%*
Sometimes/Rarely/Never	54%*	41%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A72. Sense of belonging by concussion/TBI diagnosis

How would you describe your sense of belonging to your local community?	Concussion/TBI Diagnosis (N=93)	No Concussion/TBI Diagnosis (N=731)
Very/somewhat strong	45%**	63%**
Very/somewhat weak	55%**	37%**

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A73. Wellbeing by concussion/TBI diagnosis

Thinking about your mental wellbeing right now, overall, would you say you are…	Concussion/TBI Diagnosis (N=93)	No Concussion/TBI Diagnosis (N=723)
Getting better	20%*	20%*
Getting worse	9%*	3%*
Staying the same	37%*	49%*
Depends on the day	30%*	25%*
I'm not sure	4%*	3%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A74. Services received by Concussion/TBI diagnosis

	Concussion/TBI Diagnosis (N=90-93)	No Concussion/TBI Diagnosis (N=720-731)
Received services since exiting the military	73%***	37%***
Received services in the past two years	67%***	31%***
Feel they have the support they need	64%**	79%**
Attempted and been unable to obtain services	22%***	9%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A75. Mental health services received by concussion/TBI diagnosis

Mental health	Concussion/TBI Diagnosis (N=62)	No Concussion/TBI Diagnosis (N=225)
Individual counseling (outpatient)	94%	89%
Group counseling (outpatient)	35%*	20%*
Peer to peer support	32%	20%
Inpatient counseling or treatment	24%	16%
Crisis line	15%	11%
Recovery services	16%*	6%*
Supportive housing	10%	5%
Faith-based support services	19%	14%
Other	18%	11%
NONE	0%	4%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A76. Chemical health services received by concussion/TBI diagnosis

Chemical health	Concussion/TBI Diagnosis (N=62)	No Concussion/TBI Diagnosis (N=225)
Individual counseling (outpatient)	10%	12%
Group counseling (outpatient)	6%	8%
Peer to peer support	5%	9%
Inpatient counseling or treatment	8%	7%
Crisis line	3%	4%
Recovery services	6%	7%
Supportive housing	3%	4%
Faith-based support services	6%	3%
Other	0%	2%
NONE	82%	82%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A77. Service origin by concussion/TBI diagnosis

Service origin	Concussion/TBI Diagnosis (N=62)	No Concussion/TBI Diagnosis (N=225)
Federal service	73%	73%
State service	32%**	15%**
County service	27%	16%
Local government service	6%	8%
Private service	45%	38%
Non-profit service	24%	17%
NONE	0%	2%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A78. Barriers by concussion/TBI diagnosis

Barrier	Concussion/TBI Diagnosis (N=60)	No Concussion/TBI Diagnosis (N=364)
Was not eligible for services	12%	10%
Could not pay for services	27%	18%
Could not find transportation to get to services	8%	4%
The service was not available in my area	18%*	8%*
The people who provide it don't speak my language/I could not get an interpreter	0%	0%
The wait time was too long	23%	14%
Services were not good with Veteran-specific issues	15%	12%
I was worried about how I would be seen	28%	27%
I was worried about the effect on current or future employment	28%	23%
I was worried about the effect on my current or future military service	7%	4%
I was worried about my family finding out	7%	13%
Cannot financially afford to take time off	22%	15%
I don't have a VA diagnosis	25%	36%
I don't think the services will help	18%	19%
Other	20%	23%
NONE	0%	<1%

Note. Significance tests were conducted using chi-square tests.Differences are significant at *p <.05, **p < .01, and ***p < .001.

A79. Preferred service format by concussion/TBI diagnosis

Service format	Concussion/TBI Diagnosis (N=83)	No Concussion/TBI Diagnosis (N=602)
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social or practical help to each other)	29%	26%
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	35%*	22%*
Individual (one-on-one services with a professional care provider)	75%	66%
Online (services provided online)	23%	18%
Text (services provided through text)	16%**	7%**
Informal support (such as support from family, friends, etc.)	33%	33%
Other	10%	8%
NONE	0%	<1%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

Tables by disability status

A80. Demographics by disability status

	Disability (N=508-509)	No disability (N=365-370)
Gender		
Men	85%	84%
Women	14%	16%
Other	<1%	<1%
Race/ethnicity		
White/Caucasian	89%*	93%*
Veterans of color	11%*	7%*
Age		
18 to 34 years	14%	17%
35 to 54 years	32%	35%
55 to 64 years	22%	20%
65 to 74 years	28%	33%
75 years and over	4%	5%

Note. Respondents were asked separately about race and Hispanic ethnicity. Those who report Hispanic ethnicity are not included in the racial categories for data in this table.
Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A81. Region by disability status

Region	Disability (N=501)	No disability (N=368)
Central	18%	14%
Northeast	5%	4%
Northwest	4%	2%
Southeast	13%	14%
Southwest	4%	3%
Twin Cities Metro Area	52%	61%
West Central	4%	1%

A82. National Guard or Reserve Component status by disability status

National Guard component	Disability (N=519)	No disability (N=375)
Never served on active duty as a member of the National Guard/Reserve Component	73%	76%
Yes, served on active duty while in the National Guard/Reserves and I am still serving in the National Guard/Reserves	2%	3%
Yes, served on active duty while in the National Guard/Reserves and have separated/ retired from the National Guard/Reserves	25%	21%

A83. Branch of military by disability status

Branch	Disability (N=525)	No disability (N=378)
Army	54%	50%
Navy	21%	24%
Air Force	17%	21%
Marine Corps	11%	9%
Coast Guard	<1%	1%
Other	<1%	0%

A84. Service era by disability status

Service Era	Disability (N=527)	No disability (N=380)
September 2001 or later	36%	32%
August 1990 to August 2001 (includes Persian Gulf War)	31%	27%
May 1975 to July 1990	35%	28%
Vietnam era (August 1964 to April 1975)	38%	41%
February 1955 to July 1964	5%	7%
Korean War (July 1950 to January 1955)	1%	2%
January 1947 to June 1950	0%	0%
World War II (December 1941 to December 1946)	<1%	<1%
November 1941 or earlier	<1%	<1%

A85. Time in active duty by disability status

Time in active duty	Disability (N=523)	No disability (N=369)
Less than 2 years	6%	8%
2-3 years	28%	28%
4-5 years	25%	33%
6-10 years	14%	15%
11+ years	27%	16%
Mean	8.4 years	6.6 years
Median	4 years	4 years
Range	0 to 43 years	0 to 46 years

A86. Served in a combat/warzone by disability status

	Disability (N=524)	No disability (N=378)
Served in a combat/war zone	61%	46%

A87. Character of discharge by disability status

	Disability (N=527)	No disability (N=380)
Honorable discharge	94%	97%
General (under honorable conditions)	6%	3%

A88. Veteran mental health diagnosis by disability status

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Disability (N=471-504)	No disability (N=362-369
Schizophrenia	2%*	<1%*
Paranoid or delusional disorder, other than schizophrenia	4%**	1%**
Manic episodes or manic depression, bipolar disorder	9%***	3%***
Major depression	42%***	12%***
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	19%***	3%***
Alcohol abuse disorder	23%***	9%***
Drug abuse disorder	6%*	3%*
Post-Traumatic Stress Disorder (PTSD)	41%***	10%***
A concussion or traumatic brain injury	16%	5%
Anxiety disorder or panic disorder	44%***	17%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A89. Survey responses on standardized screening tools, by disability status

	Disability (N=496-522)	No disability (N=364-377)
Depression subscale		
Percent of respondents that screened positive for depression	38%***	9%***
Of those who screened positive for depression, percent reporting a diagnosis of major depression	71%*	50%*
Anxiety subscale		
Percent of respondents that screened positive for anxiety	39%***	10%***
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	73%*	51%*
PTSD scale		
Percent of respondents that screened positive for PTSD	47%***	12%***
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	71%***	29%***
Alcohol or drug abuse scale		
Percent of respondents that screened clinically significant for alcohol or drug abuse	33%**	23%**
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	56%***	32%***
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	16%	9%
Any psychological distress	65%***	25%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A90. When Veteran experienced PTSD by disability status

When did you have these experiences?	Disability (N=342-343)	No disability (N=119)
Before your service	6%	8%
During your service	54%	42%
After your service	85%	89%
Sought help because of your experience(s)	78%	41%

A91. Sought help because of PTSD by disability status

	Disability (N=342)	No disability (N=119)
Sought help because of their experiences	78%	41%

A92. Sexual assault by disability status

Sexual assault	Disability (N=516)	No disability (N=374)
Have you ever been touched sexually against your will/without your consent or ever been pressured to engage in sexual acts against your will/without your consent?	22%** (N=114)	15%** (N=54)
Before your service?	55%	65%
During your service?	58%	46%
After your service?	15%	9%
Have you ever sought help because of your experiences?	47%	32%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A93. Suicidal ideation by disability status

	Disability (N=511)	No disability (N=374)
Have you ever thought of killing yourself?	44%***	23%***
Do you currently have these thoughts?	15% (6% of total)	8% (2% of total)
Have you ever attempted suicide?	28% (12% of total)	20% (5% of total)
Have you ever sought help because you were suicidal?	48%* (21% of total)	33%* (8% of total)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A94. Social support by disability status

How often would you say you get the social and emotional support you need?	Disability (N=518)	No disability (N=370)
Always/Usually	48%***	69%***
Sometimes/Rarely/Never	52%***	31%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A95. Sense of belonging by disability status

How would you describe your sense of belonging to your local community?	Disability (N=518)	No disability (N=372)
Very/somewhat strong	50%***	74%***
Very/Somewhat weak	50%***	26%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A96. Wellbeing by disability status

Thinking about your mental wellbeing right now, overall, would you say you are…	Disability (N=517)	No disability (N=365)
Staying the same	40%***	55%***
Depends on the day	33%***	18%***
Getting better	17%***	26%***
Getting worse	6%***	<1%***
I'm not sure	5%***	1%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A97. Services received by disability status

	Disability (N=506-516)	No disability (N=364-372)
Received services since exiting the military	57%***	26%***
Received services in the past two years	51%***	19%***
Feel they have the support they need	70%***	87%***
Attempted and been unable to obtain services	15%***	4%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A98. Mental health services received by disability status

Mental health	Disability (N=262)	No disability (N=71)
Individual counseling (outpatient)**	92%**	80%**
Group counseling (outpatient)	24%	18%
Peer to peer support	24%	14%
Inpatient counseling or treatment	19%	10%
Crisis line	13%	6%
Recovery services*	10%*	1%*
Supportive housing	8%	1%
Faith-based support services	16%	13%
Other	14%	11%
NONE*	2%*	9%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A99. Chemical health services received by disability status

Chemical health	Disability (N=262)	No disability (N=71)
Individual counseling (outpatient)	10%	13%
Group counseling (outpatient)	7%	10%
Peer to peer support	8%	11%
Inpatient counseling or treatment	7%	7%
Crisis line	4%	0%
Recovery services	8%	7%
Supportive housing	4%	3%
Faith-based support services	3%	3%
Other	2%	4%
NONE	81%	83%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A100. Service origin by disability status

Service origin	Disability (N=262)	No disability (N=309)
Federal service	81%***	41%***
State service	20%	16%
County service	19%	11%
Local government service	7%	9%
Private service	37%	42%
Non-profit service	22%*	9%*
NONE	2%**	10%**

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A101. Barriers by disability status

Barrier	Disability (N=304)	No disability (N=157)
Was not eligible for services	10%	12%
Could not pay for services	18%	21%
Could not find transportation to get to services	6%	2%
The service was not available in my area	13%**	3%**
The people who provide it don't speak my language/I could not get an interpreter	<1%	0%
The wait time was too long	18%***	7%***
Services were not good with Veteran-specific issues	16%***	5%***
I was worried about how I would be seen	32%*	20%*
I was worried about the effect on current or future employment	27%	19%
I was worried about the effect on my current or future military service	5%	6%
I was worried about my family finding out	12%	13%
Cannot financially afford to take time off	16%	15%
I don't have a VA diagnosis	29%**	43%**
I don't think the services will help	23%***	11%***
Other	22%	22%
NONE	0%	1%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A102. Preferred service format by disability status

Service format	Disability (N=466)	No disability (N=281)
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social or practical help to each other)	26%	26%
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	24%	23%
Individual (one-on-one services with a professional care provider)	70%	65%
Online (services provided online)	19%	17%
Text (services provided through text)	8%	6%
Informal support (such as support from family, friends, etc.)	34%	32%
Other	8%	8%
NONE	<1%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

Tables by gender

A103. Demographics by gender

	Men	Women
Race/ethnicity	**(N=741)**	**(N=129)**
White/Caucasian	91%	86%
Veterans of color	9%	14%
Age	**(N=744)**	**(N=130)**
18 to 34 years	13%	25%
35 to 54 years	27%	37%
55 to 64 years	20%	29%
65 to 74 years	35%	6%
75 years and over	5%	3%

Note. Respondents were asked separately about race and Hispanic ethnicity. Those who report Hispanic ethnicity are not included in the racial categories for data in this table.

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A104. Region by gender

Region	Men (N=738)	Women (N=128)
Central	16%	18%
Northeast	5%	2%
Northwest	3%	2%
Southeast	12%	16%
Southwest	4%	4%
Twin Cities Metro Area	56%	55%
West Central	3%	2%

A105. National Guard or Reserve Component by gender

National Guard component	Men (N=740)	Women (N=126)
Never served on active duty as a member of the National Guard/Reserve Component	76%	66%
Yes, served on active duty while in the National Guard/Reserves and I am still serving in the National Guard/Reserves	2%	6%
Yes, served on active duty while in the National Guard/Reserves and have separated/ retired from the National Guard/Reserves	23%	29%

A106. Branch of military by gender

Branch	Men (N=744)	Women (N=130)
Army	52%	56%
Navy	23%	18%
Air Force	19%	23%
Marine Corps	11%	5%
Coast Guard	1%	1%
Other	<1%	0%

A107. Service era by gender

Service Era	Men (N=748)	Women (N=130)
September 2001 or later	33%	45%
August 1990 to August 2001 (includes Persian Gulf War)	27%	44%
May 1975 to July 1990	30%	39%
Vietnam era (August 1964 to April 1975)	43%	16%
February 1955 to July 1964	6%	3%
Korean War (July 1950 to January 1955)	2%	0%
January 1947 to June 1950	0%	0%
World War II (December 1941 to December 1946)	<1%	0%
November 1941 or earlier	<1%	0%

A108. Served in combat/war zone by gender

	Men (N=745)	Women (N=128)
Did you ever serve in a combat/war zone?	59%	34%

A109. Discharge status by gender

Character of discharge	Men (N=748)	Women (N=130)
Honorable discharge	95%	96%
General (under honorable conditions)	5%	4%

A110. Time in active duty by gender

Time in active duty	Men (N=735)	Women (N=128)
Less than 2 years	6%	11%
2-3 years	30%	21%
4-5 years	29%	27%
6-10 years	14%	20%
11-15 years	5%	7%
16+ years	16%	15%
Mean	7.6 years	7.3 years
Median	4 years	4 years
Range	0 to 46 years	0 to 39 years

A111. Veteran mental health diagnosis by gender

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Men (N=696-718)	Women (N=114-124)
Schizophrenia	1%	1%
Paranoid or delusional disorder, other than schizophrenia	3%	1%
Manic episodes or manic depression, bipolar disorder	6%	10%
Major depression	26%***	50%***
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	11%	14%
Alcohol abuse disorder	18%	13%
Drug abuse disorder	5%	3%
Post-Traumatic Stress Disorder (PTSD)	26%*	38%*
A concussion or traumatic brain injury	11%	12%
Anxiety disorder or panic disorder	29%***	50%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A112. Disability by gender

	Men (N=745)	Women (N=130)
Has a disability	58%	55%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A113. Survey responses on standardized screening tools, by gender

Depression subscale	Men (N=718-747)	Women (N=118-130)
Percent of respondents that screened positive for depression	25%	32%
Of those who screened positive for depression, percent reporting a diagnosis of major depression	65%*	84%*
Anxiety subscale		
Percent of respondents that screened positive for anxiety	25%**	38%**
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	63%**	87%**
PTSD scale		
Percent of respondents that screened positive for PTSD	31%	40%
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	64%	65%
Alcohol or drug abuse scale		
Percent of respondents that screened clinically significant for alcohol or drug abuse	30%	23%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	48%	41%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	13%	12%
Any psychological distress	**46%****	**62%****

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A114. When Veteran experienced PTSD by gender

When did you have these experiences?	Men (N=370)	Women (N=80)
Before your service	5%	11%
During your service	48%	61%
After your service	86%	88%

A115. Sought help because of PTSD by gender

	Men (N=369)	Women (N=80)
Sought help because of their experience	**67%**	**78%**

A116. Suicidal ideation by gender

	Men (N=748)	Women (N=130)
Have you ever thought of killing yourself?	33%**	47%**
Do you currently have these thoughts?	14% (4% of total)	10% (5% of total)
Have you ever attempted suicide?	21%* (7% of total)	35%* (16% of total)
Have you ever sought help because you were suicidal?	40%** (13% of total)	59%** (28% of total)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A117. Sexual assault by gender

Sexual assault	Men (N=746)	Women (N=128)
Have you ever been touched sexually against your will/without your consent or ever been pressured to engage in sexual acts against your will/without your consent?	11%*** (N=84)	62%*** (N=79)
Before your service?	75%***	44%***
During your service?	27%***	79%***
After your service?	10%	15%
Have you ever sought help because of your experiences?	31%**	54%**

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A118. Social support by gender

How often would you say you get the social and emotional support you need?	Men (N=743)	Women (N=130)
Always/Usually	58%	50%
Sometimes/Rarely/Never	42%	50%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A119. Sense of belonging by gender

How would you describe your sense of belonging to your local community?*	Men (N=747)	Women (N=129)
Very/somewhat strong	62%*	51%*
Very/Somewhat weak	38%*	49%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A120. Wellbeing by gender

Thinking about your mental wellbeing right now, overall, would you say you are…	Men (N=740)	Women (N=129)
Getting better	19%***	29%***
Getting worse	4%***	5%***
Staying the same	49%***	29%***
Depends on the day	25%***	34%***
I'm not sure	4%***	2%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A121. Services received by gender

	Men (N=737-746)	Women (N=128-130)
Received services since exiting the military	40%***	62%***
Received services in the past two years	34%***	55%***
Feel they have the support they need	79%**	66%**
Attempted and been unable to obtain services	9%**	18%**

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A122. Mental health services received by gender

Mental health	Men (N=254)	Women (N=71)
Individual counseling (outpatient)	89%	92%
Group counseling (outpatient)	24%	18%
Peer to peer support	22%	20%
Inpatient counseling or treatment	19%*	8%*
Crisis line	9%	17%
Recovery services	9%	4%
Supportive housing	7%	3%
Faith-based support services	15%	18%
Other	14%	8%
NONE	4%	3%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A123. Chemical health services received by gender

Chemical health	Men (N=254)	Women (N=71)
Individual counseling (outpatient)	13%	6%
Group counseling (outpatient)	7%	7%
Peer to peer support	9%	6%
Inpatient counseling or treatment	7%	6%
Crisis line	4%	1%
Recovery services	8%	6%
Supportive housing	4%	3%
Faith-based support services	4%	3%
Other	2%	1%
NONE	80%	85%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A124. Service origin by gender

Service origin	Men (N=254)	Women (N=71)
Federal service	75%*	62%*
State service	20%	15%
County service	18%	14%
Local government service	8%	3%
Private service	37%	45%
Non-profit service	20%	15%
NONE	2%	6%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A125. Barriers by gender

Barrier	Men (N=383)	Women (N=75)
Was not eligible for services	9%	15%
Could not pay for services	17%*	29%*
Could not find transportation to get to services	3%*	9%*
The service was not available in my area	7%**	20%**
The people who provide it don't speak my language/I could not get an interpreter	<1%	0%
The wait time was too long	12%**	27%**
Services were not good with Veteran-specific issues	12%	15%
I was worried about how I would be seen	27%	31%
I was worried about the effect on current or future employment	23%	31%
I was worried about the effect on my current or future military service*	4%*	11%*
I was worried about my family finding out	11%	16%
Cannot financially afford to take time off	13%**	28%**
I don't have a VA diagnosis	36%*	23%*
I don't think the services will help	19%	17%
Other	23%	19%
NONE	<1%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A126. Preferred service format by gender

Service format	Men (N=622)	Women (N=120)
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social or practical help to each other)	25%	29%
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	23%	28%
Individual (one-on-one services with a professional care provider)	67%	76%
Online (services provided online)	18%	20%
Text (services provided through text)	7%*	13%*
Informal support (such as support from family, friends, etc.)	33%	32%
Other	9%	3%
NONE	0%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

Tables by length of service

A127. Demographics by length of service

	Less than 2 years	2-3 years	4-5 years	6-10 years	11+ years
Gender	**(N=61)**	**(N=246)**	**(N=249)**	**(N=126)**	**(N=184)**
Men	77%	89%	86%	79%	85%
Women	23%	11%	14%	21%	15%
Other	0%	0%	1%	0%	<1%
Race/ethnicity	**(N=61)**	**(N=245)**	**(N=246)**	**(N=125)**	**(N=185)**
White/Caucasian	87%	90%	89%	91%	93%
Veterans of color	13%	10%	11%	9%	7%
Age	**(N=62)**	**(N=246)**	**(N=249)**	**(N=125)**	**(N=184)**
18 to 34 years	19%	8%	24%	26%	3%
35 to 54 years	31%	16%	29%	38%	41%
55 to 64 years	15%	17%	16%	20%	38%
65 to 74 years	29%	51%	29%	15%	15%
75 years and over	7%	7%	2%	1%	4%

Note. Respondents were asked separately about race and Hispanic ethnicity. Those who report Hispanic ethnicity are not included in the racial categories for data in this table.
Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A128. Region by length of service

Region	Less than 2 years (N=61)	2-3 years (N=245)	4-5 years (N=246)	6-10 years (N=125)	11+ years (N=180)
Central	11%	16%	16%	19%	16%
Northeast	8%	4%	4%	5%	6%
Northwest	2%	2%	2%	4%	6%
Southeast	20%	16%	9%	10%	14%
Southwest	5%	4%	2%	5%	5%
Twin Cities Metro Area	54%	58%	63%	57%	46%
West Central	0%	1%	3%	0%	7%

A129. National Guard and Reserve Component status by length of service

National Guard component	Less than 2 years (N=64)	2-3 years (N=255)	4-5 years (N=253)	6-10 years (N=126)	11+ years (N=191)
Never served on active duty as a member of the National Guard/Reserve Component	41%	85%	90%	69%	52%
Yes, served on active duty while in the National Guard/Reserves and I am still serving in the National Guard/Reserves	2%	<1%	1%	6%	5%
Yes, served on active duty while in the National Guard/Reserves and have separated/ retired from the National Guard/Reserves	58%	14%	9%	25%	43%

A130. Branch of military by length of service

Branch	Less than 2 years (N=65)	2-3 years (N=260)	4-5 years (N=256)	6-10 years (N=125)	11+ years (N=193)
Army	71%	72%	25%	50%	58%
Navy	15%	13%	37%	22%	19%
Air Force	11%	10%	23%	20%	28%
Marine Corps	3%	6%	16%	10%	9%
Coast Guard	0%	0%	<1%	1%	2%
Other	0%	0%	0%	0%	1%
Service Era	**(N=65)**	**(N=261)**	**(N=256)**	**(N=127)**	**(N=194)**
September 2001 or later	38%	12%	33%	43%	60%
August 1990 to August 2001 (includes Persian Gulf War)	17%	10%	18%	33%	72%
May 1975 to July 1990	14%	16%	23%	36%	68%
Vietnam era (August 1964 to April 1975)	26%	61%	39%	18%	28%
February 1955 to July 1964	6%	7%	5%	2%	5%
Korean War (July 1950 to January 1955)	0%	3%	<1%	0%	1%
January 1947 to June 1950	0%	0%	0%	0%	0%
World War II (December 1941 to December 1946)	0%	1%	0%	0%	0%
November 1941 or earlier	0%	<1%	<1%	0%	0%

A131. Served in a combat or war zone by length of service

	Less than 2 years (N=65)	2-3 years (N=261)	4-5 years (N=255)	6-10 years (N=126)	11+ years (N=191)
Served in a combat/war zone	52%	52%	52%	55%	64%

A132. Discharge status by length of service

Character of discharge	Less than 2 years (N=65)	2-3 years (N=261)	4-5 years (N=256)	6-10 years (N=127)	11+ years (N=194)
Honorable discharge	86%	93%	96%	95%	97%
General (under honorable conditions)	14%	7%	4%	5%	3%

A133. Veteran mental health diagnosis by length of service

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Less than 2 years (N=57)	2-3 years (N=239)	4-5 years (N=234)	6-10 years (N=113)	11+ years (N=184)
Schizophrenia	2%	1%	2%	3%	1%
Paranoid or delusional disorder, other than schizophrenia	4%	3%	2%	4%	1%
Manic episodes or manic depression, bipolar disorder	7%	6%	6%	12%	5%
Major depression	25%*	26%*	28%*	41%*	31%*
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	13%	13%	11%	19%	8%
Alcohol abuse disorder	16%	18%	16%	23%	15%
Drug abuse disorder	10%**	4%**	4%**	9%**	1%**
Post-Traumatic Stress Disorder (PTSD)	28%	28%	22%	34%	33%
A concussion or traumatic brain injury	10%	9%	7%	21%	12%
Anxiety disorder or panic disorder	28%*	29%*	32%*	46%*	31%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A134. Disability by length of service

	Less than 2 years (N=64)	2-3 years (N=254)	4-5 years (N=253)	6-10 years (N=127)	11+ years (N=194)
Has a disability	52%***	59%***	51%***	56%***	72%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A135. Survey responses on standardized screening tools, by length of service

Depression subscale	Less than 2 years (N=63-64)	2-3 years (N=251-254)	4-5 years (N=251-253)	6-10 years (N=125-126)	11+ years (N=190)
Percent of respondents that screened positive for depression***	27%	22%	26%	34%	28%
Of those who screened positive for depression, percent reporting a diagnosis of major depression	53%	73%	68%	73%	66%
Anxiety subscale					
Percent of respondents that screened positive for anxiety	25%	25%	27%	34%	25%
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	69%	63%	70%	76%	69%
PTSD scale					
Percent of respondents that screened positive for PTSD	31%	28%	31%	40%	36%
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	60%	73%	56%	61%	69%
Alcohol or drug abuse scale					
Percent of respondents that screened clinically significant for alcohol or drug abuse	29%	28%	29%	33%	30%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	59%	54%	46%	51%	37%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	36%*	13%*	14%*	18%*	4%*
Any psychological distress	**45%****	**43%****	**48%****	**61%****	**54%****

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A136. When Veteran experienced PTSD by length of service

When did you have these experiences?	Less than 2 years (N=31)	2-3 years (N=117)	4-5 years (N=114)	6-10 years (N=84)	11+ years (N=108)
Before your service	0%	5%	9%	8%	5%
During your service	29%	33%	53%	62%	67%
After your service	90%	89%	86%	86%	81%

A137. Sought help because of PTSD by length of service

	Less than 2 years (N=31)	2-3 years (N=117)	4-5 years (N=114)	6-10 years (N=84)	11+ years (N=108)
Have sought help because of their experiences	74%	72%	66%	69%	69%

A138. Suicidal ideation by length of service

	Less than 2 years (N=63)	2-3 years (N=248)	4-5 years (N=248)	6-10 years (N=126)	11+ years (N=187)
Have you ever thought of killing yourself?	35% (N=22)	33% (N=81)	35% (N=86)	40% (N=50)	36% (N=68)
Do you currently have these thoughts?	10% (3% of total)	14% (4% of total)	13% (4% of total)	20% (8% of total)	9% (3% of total)
Have you ever attempted suicide?	23% (8% of total)	23% (7% of total)	25% (8% of total)	28% (11% of total)	28% (10% of total)
Have you ever sought help because you were suicidal?	32% (11% of total)	43% (13% of total)	44% (15% of total)	54% (21% of total)	41% (14% of total)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A139. Sexual assault by length of service

Sexual assault	Less than 2 years (N=64)	2-3 years (N=249)	4-5 years (N=250)	6-10 years (N=126)	11+ years (N=189)
Have you ever been touched sexually against your will/without your consent or ever been pressured to engage in sexual acts against your will/without your consent?	22% (N=14)	18% (N=44)	19% (N=48)	22% (N=28)	17% (N=33)
Before your service?	57%	57%	67%	64%	39%
During your service?	57%	45%	52%	50%	76%
After your service?	29%	21%	8%	11%	6%
Have you ever sought help because of your experiences?	50%	36%	48%	36%	45%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A140. Social support by length of service

How often would you say you get the social and emotional support you need?	Less than 2 years (N=62)	2-3 years (N=249)	4-5 years (N=249)	6-10 years (N=126)	11+ years (N=190)
Always/Usually	52%	60%	58%	53%	55%
Sometimes/Rarely/Never	48%	40%	42%	47%	45%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A141. Sense of belonging by length of service

How would you describe your sense of belonging to your local community?	Less than 2 years (N=64)	2-3 years (N=249)	4-5 years (N=249)	6-10 years (N=126)	11+ years (N=190)
Very/somewhat strong	59%*	68%*	62%*	51%*	54%*
Very/somewhat weak	41%*	32%*	38%*	49%*	46%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A142. Wellbeing by length of service

Thinking about your mental wellbeing right now, overall, would you say you are…	Less than 2 years (N=61)	2-3 years (N=247)	4-5 years (N=247)	6-10 years (N=126)	11+ years (N=190)
Getting better	13%*	19%*	22%*	27%*	17%*
Getting worse	2%*	3%*	5%*	6%*	4%*
Staying the same	48%*	53%*	46%*	30%*	47%*
Depends on the day	34%*	22%*	24%*	32%*	29%*
I'm not sure	3%*	4%*	3%*	5%*	2%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A143. Services received by length of service

Since exiting the military, have you received any services for your mental or chemical health?	Less than 2 years (N=62-64)	2-3 years (N=243-248)	4-5 years (N=245-248)	6-10 years (N=126)	11+ years (N=184-190)
Received services since exiting the military	44%*	40%*	40%*	56%*	46%*
Received services in the past two years	32%*	31%*	39%*	48%*	41%*
Feel they have the support they need	81%	80%	78%	73%	71%
Attempted and been unable to obtain services	11%	7%	13%	13%	10%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A144. Mental health services received by length of service

Mental health	Less than 2 years (N=20)	2-3 years (N=77)	4-5 years (N=96)	6-10 years (N=60)	11+ years (N=77)
Individual counseling (outpatient)	100%	90%	88%	92%	90%
Group counseling (outpatient)	25%	29%	19%	23%	18%
Peer to peer support	20%	19%	22%	25%	22%
Inpatient counseling or treatment	10%	21%	15%	20%	16%
Crisis line	0%	12%	14%	15%	8%
Recovery services	10%	12%	7%	7%	6%
Supportive housing	10%*	14%*	6%*	2%*	3%*
Faith-based support services	20%	19%	16%	10%	14%
Other	15%	17%	13%	13%	10%
NONE	0%	3%	5%	2%	4%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A145. Chemical health services received by length of service

Chemical health	Less than 2 years (N=20)	2-3 years (N=77)	4-5 years (N=96)	6-10 years (N=60)	11+ years (N=77)
Individual counseling (outpatient)	20%	13%	14%	10%	4%
Group counseling (outpatient)	10%	9%	8%	3%	6%
Peer to peer support	20%	9%	11%	5%	5%
Inpatient counseling or treatment	10%	4%	8%	12%	3%
Crisis line	0%	3%	4%	3%	3%
Recovery services	25%*	6%*	7%*	7%*	5%*
Supportive housing	0%	5%	5%	3%	3%
Faith-based support services	5%	3%	5%	3%	1%
Other	5%	0%	3%	2%	3%
NONE	65%	83%	77%	82%	88%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A146. Service origin by length of service

Service origin	Less than 2 years (N=20)	2-3 years (N=77)	4-5 years (N=96)	6-10 years (N=60)	11+ years (N=77)
Federal service	70%	70%	64%	80%	78%
State service	40%**	26%**	11%**	23%**	12%**
County service	25%*	13%*	14%*	32%*	13%*
Local government service	5%	6%	8%	8%	6%
Private service	45%	35%	43%	32%	40%
Non-profit service	25%	19%	21%	22%	12%
NONE	0%	4%	3%	3%	4%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A147. Barriers by length of service

Barrier	Less than 2 years (N=32)	2-3 years (N=112)	4-5 years (N=125)	6-10 years (N=77)	11+ years (N=111)
Was not eligible for services	19%*	17%*	9%*	8%*	6%*
Could not pay for services	25%	16%	20%	29%	14%
Could not find transportation to get to services	9%	5%	5%	7%	<1%
The service was not available in my area	19%	10%	7%	12%	7%
The people who provide it don't speak my language/I could not get an interpreter	0%	<1%	0%	0%	0%
The wait time was too long	16%	8%	15%	14%	19%
Services were not good with Veteran-specific issues	13%	12%	8%	21%	13%
I was worried about how I would be seen	19%***	16%***	26%***	31%***	41%***
I was worried about the effect on current or future employment	31%*	14%*	23%*	25%*	32%*
I was worried about the effect on my current or future military service	6%***	0%***	2%***	7%***	13%***
I was worried about my family finding out	13%	14%	8%	12%	14%
Cannot financially afford to take time off	19%	11%	17%	21%	14%
I don't have a VA diagnosis	41%	32%	38%	36%	29%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A147. Barriers by length of service (continued)

Barrier	Less than 2 years (N=32)	2-3 years (N=112)	4-5 years (N=125)	6-10 years (N=77)	11+ years (N=111)
I don't think the services will help	22%	20%	18%	13%	23%
Other	31%	23%	19%	25%	17%
NONE	0%	0%	<1%	0%	0%

A148. Preferred service format by length of service

Service format	Less than 2 years (N=55)	2-3 years (N=197)	4-5 years (N=208)	6-10 years (N=117)	11+ years (N=161)
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social or practical help to each other)	24%	23%	26%	31%	29%
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	33%	21%	23%	25%	25%
Individual (one-on-one services with a professional care provider)	62%	62%	71%	74%	70%
Online (services provided online)	16%	19%	15%	22%	19%
Text (services provided through text)	7%	7%	7%	9%	9%
Informal support (such as support from family, friends, etc.)	29%	28%	33%	36%	37%
Other	9%	9%	7%	10%	7%
NONE	0%	<1%	0%	0%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A149. Demographics by race

	White respondents (N=789)	Respondents of color (N=84-85)
Gender		
Men	86%*	77%*
Women	14%*	21%*
Other	<1%*	1%*
Age		
18 to 34 years	14%	27%
35 to 54 years	28%	36%
55 to 64 years	21%	22%
65 to 74 years	32%	14%
75 years and over	5%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A150. Region by race

Region	White respondents (N=780)	Respondents of color (N=84)
Central	17%	14%
Northeast	5%	5%
Northwest	3%	5%
Southeast	14%	4%
Southwest	4%	2%
Twin Cities Metro Area	54%	70%
West Central	3%	0%

A151. National Guard and Reserve Component by race

National Guard component	White respondents (N=780)	Respondents of color (N=84)
Never served on active duty as a member of the National Guard/Reserve Component	74%	79%
Yes, served on active duty while in the National Guard/Reserves and I am still serving in the National Guard/Reserves	2%	5%
Yes, served on active duty while in the National Guard/Reserves and have separated/ retired from the National Guard/Reserves	24%	17%

A152. Branch of military by race

Branch	White respondents (N=787)	Respondents of color (N=85)
Army	52%	58%
Navy	23%	18%
Air Force	20%	9%
Marine Corps	10%	15%
Coast Guard	1%	0%
Other	<1%	1%

A153. Service era by race

Service Era	White respondents (N=791)	Respondents of color (N=85)
September 2001 or later	33%	48%
August 1990 to August 2001 (includes Persian Gulf War)	29%	27%
May 1975 to July 1990	32%	32%
Vietnam era (August 1964 to April 1975)	41%	22%
February 1955 to July 1964	6%	1%
Korean War (July 1950 to January 1955)	1%	0%
January 1947 to June 1950	0%	0%
World War II (December 1941 to December 1946)	<1%	0%
November 1941 or earlier	<1%	0%

A154. Time in active duty by race

Time in active duty	White respondents (N=778)	Respondents of color (N=84)
Less than 2 years	7%	10%
2-3 years	28%	30%
4-5 years	28%	32%
6-10 years	15%	13%
11+ years	22%	15%
Mean	7.7 years	6.4 years
Median	4 years	4 years
Range	0 to 46 years	0 to 43 years

A155. Served in combat or war zone by race

	White respondents (N=786)	Respondents of color (N=85)
Served in a combat/war zone	55%	55%

A156. Character of discharge by race

	White respondents (N=791)	Respondents of color (N=85)
Honorable discharge	96%	86%
General (under honorable conditions)	4%	14%

A157. Veteran mental health diagnosis by race

Have you ever been told by a doctor or nurse that you have any of the following conditions?	White respondents (N=732-759)	Respondents of color (N=75-79)
Schizophrenia	1%**	7%**
Paranoid or delusional disorder, other than schizophrenia	2%**	8%**
Manic episodes or manic depression, bipolar disorder	6%	9%
Major depression	29%	39%
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	11%	26%
Alcohol abuse disorder	17%	21%
Drug abuse disorder	4%*	11%*
Post-Traumatic Stress Disorder (PTSD)	27%*	39%*
A concussion or traumatic brain injury	11%	16%
Anxiety disorder or panic disorder	32%	42%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A158. Disability by race

	White respondents (N=788)	Respondents of color (N=85)
Has a disability	57%*	68%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A159. Survey responses on standardized screening tools, by race

	White respondents (N=753-790)	Respondents of color (N=84-85)
Depression subscale		
Percent of respondents that screened positive for depression	25%*	36%*
Of those who screened positive for depression, percent reporting a diagnosis of major depression	67%	64%
Anxiety subscale		
Percent of respondents that screened positive for anxiety	25%***	44%***
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	68%	69%
PTSD scale		
Percent of respondents that screened positive for PTSD	32%*	46%*
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	65%	58%
Alcohol or drug abuse scale		
Percent of respondents that screened clinically significant for alcohol or drug abuse	29%	35%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	48%	48%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	12%*	26%*
Any psychological distress	**47%***	**62%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A160. When Veteran experienced PTSD by race

When did you have these experiences?	White respondents (N=397)	Respondents of color (N=56)
Before your service	6%	4%
During your service	50%	54%
After your service	86%	82%

A161. Sought help because of PTSD by race

	White respondents (N=397)	Respondents of color (N=56)
Did you seek help because of your experiences?	69%	71%

A162. Sexual assault by race

Sexual assault	White respondents (N=788)	Respondents of color (N=85)
Have you ever been touched sexually against your will/without your consent or ever been pressured to engage in sexual acts against your will/without your consent?	19% (N=147)	22% (N=19)
Before your service?	61%*	37%*
During your service?	50%*	79%*
After your service?	12%	16%
Have you ever sought help because of your experiences?	40%	53%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A163. Suicidal ideation by race

	White respondents (N=781)	Respondents of color (N=85)
Have you ever thought of killing yourself?	35%	37%
Do you currently have these thoughts?	11%** (4% of total)	29%** (11% of total)
Have you ever attempted suicide?	24% (8% of total)	36% (13% of total)
Have you ever sought help because you were suicidal?	46% (16% of total)	29% (11% of total)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A164. Social support by race

How often would you say you get the social and emotional support you need?	White respondents (N=786)	Respondents of color (N=85)
Always/Usually	58%	52%
Sometimes/Rarely/Never	42%	48%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A165. Sense of belonging by race

How would you describe your sense of belonging to your local community?	White respondents (N=789)	Respondents of color (N=85)
Very/somewhat strong	61%	57%
Very/somewhat weak	39%	43%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A166. Wellbeing by race

Thinking about your mental wellbeing right now, overall, would you say you are…	White respondents (N=782)	Respondents of color (N=85)
Staying the same	47%**	28%**
Depends on the day	26%**	33%**
Getting better	20%**	27%**
Getting worse	4%**	5%**
I'm not sure	3%**	7%**

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A167. Services received by race

	White respondents (N=779-789)	Respondents of color (N=84-85)
Received services since exiting the military	43%**	55%**
Received services in the past two years	36%***	55%***
Feel they have the support they need	78%	69%
Attempted and been unable to obtain services	10%**	21%**

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A168. Mental health services received by race

Mental health	White respondents (N=282)	Respondents of color (N=85)
Individual counseling (outpatient)	89%	94%
Group counseling (outpatient)	22%	28%
Peer to peer support	20%*	34%*
Inpatient counseling or treatment	16%	17%
Crisis line	10%	15%
Recovery services	7%	13%
Supportive housing	5%**	17%**
Faith-based support services	14%	21%
Other	12%	17%
NONE	4%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A169. Chemical health services received by race

Chemical health	White respondents (N=282)	Respondents of color (N=85)
Individual counseling (outpatient)	9%*	21%*
Group counseling (outpatient)	6%	15%
Peer to peer support	8%	13%
Inpatient counseling or treatment	6%	9%
Crisis line	3%	4%
Recovery services	7%	11%
Supportive housing	4%	6%
Faith-based support services	4%	2%
Other	2%	4%
NONE	83%*	70%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A170. Service origin by race

Service origin	White respondents (N=282)	Respondents of color (N=47)
Federal service	70%	83%
State service	16%**	34%**
County service	16%	26%
Local government service	6%*	15%*
Private service	39%	36%
Non-profit service	17%	28%
NONE	4%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A171. Barriers by race

Barrier	White respondents (N=403)	Respondents of color (N=54)
Was not eligible for services	10%	13%
Could not pay for services	19%	22%
Could not find transportation to get to services	4%	9%
The service was not available in my area	9%	11%
The people who provide it don't speak my language/I could not get an interpreter	<1%	0%
The wait time was too long	14%	17%
Services were not good with Veteran-specific issues	12%	15%
I was worried about how I would be seen	28%	26%
I was worried about the effect on current or future employment	23%	30%
I was worried about the effect on my current or future military service	5%	6%
I was worried about my family finding out	11%	17%
Cannot financially afford to take time off	15%	19%
I don't have a VA diagnosis	34%	30%
I don't think the services will help	19%	17%
Other	22%	20%
NONE	<1%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A172. Preferred service format by race

Service format	White respondents (N=663)	Respondents of color (N=78)
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social or practical help to each other)	25%	35%
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	23%	28%
Individual (one-on-one services with a professional care provider)	68%	68%
Online (services provided online)	18%	14%
Text (services provided through text)	7%	10%
Informal support (such as support from family, friends, etc.)	34%**	19%**
Other	8%	12%
NONE	0%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A173. Demographics by region

	Greater MN (N=383-384)	Regions						
		Twin Cities Metro (N=481-485)	Central (N=141-143)	Northeast (N=42-43)	Northwest (N=29)	Southeast (N=112-114)	Southwest (N=33)	West Central (N=24)
Gender								
Men	85%	85%	84%	93%	86%	82%	85%	88%
Women	15%	15%	16%	7%	10%	18%	15%	13%
Other	<1%	<1%	0%	0%	3%	0%	0%	0%
Race/ethnicity								
White/Caucasian	93%***	88%***	91%*	91%*	86%*	97%*	94%*	100%*
Veterans of color	7%***	12%***	9%*	9%*	14%*	3%*	6%*	0%*
Age								
18 to 34 years	12%	17%	14%	7%	14%	10%	9%	25%
35 to 54 years	32%	27%	32%	38%	41%	24%	45%	33%
55 to 64 years	18%	24%	13%	19%	24%	22%	15%	29%
65 to 74 years	33%	29%	36%	33%	21%	39%	24%	13%
75 years and over	5%	4%	5%	2%	3%	6%	6%	0%

Note. Respondents were asked separately about race and Hispanic ethnicity. Those who report Hispanic ethnicity are not included in the racial categories for data in this table.

[a] Source. 2014 U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics.

A174. National Guard and Reserve component status by region

National Guard component	Greater MN (N=380)	Regions: Twin Cities Metro (N=480)	Central (N=139)	Northeast (N=43)	Northwest (N=29)	Southeast (N=113)	Southwest (N=33)	West Central (N=23)
Never served on active duty as a member of the National Guard/Reserve Component	74%	75%	74%	81%	83%	72%	67%	65%
Yes, served on active duty while in the National Guard/ Reserves and I am still serving in the National Guard/Reserves	2%	3%	2%	0%	3%	2%	6%	0%
Yes, served on active duty while in the National Guard/Reserves and have separated/ retired from the National Guard/ Reserves	24%	23%	24%	18%	14%	27%	27%	33%

A175. Branch of military by region

Branch	Greater MN (N=385)	Regions: Twin Cities Metro (N=483)	Central (N=143)	Northeast (N=43)	Northwest (N=29)	Southeast (N=113)	Southwest (N=33)	West Central (N=24)
Army	54%	51%	55%	44%	69%	58%	46%	38%
Navy	22%	22%	25%	23%	14%	20%	18%	25%
Air Force	19%	20%	17%	19%	14%	19%	24%	33%
Marine Corps	10%	11%	9%	14%	7%	8%	15%	8%
Coast Guard	1%	<1%	0%	2%	0%	1%	0%	4%
Other	1%	0%	0%	2%	3%	0%	0%	0%

A176. Service era by region

Service Era	Greater MN (N=386)	Regions						
		Twin Cities Metro (N=486)	Central (N=143)	Northeast (N=43)	Northwest (N=29)	Southeast (N=114)	Southwest (N=33)	West Central (N=24)
September 2001 or later	34%	35%	32%	37%	41%	27%	30%	63%
August 1990 to August 2001 (includes Persian Gulf War)	33%	26%	25%	44%	41%	31%	42%	50%
May 1975 to July 1990	32%	31%	28%	23%	48%	29%	36%	58%
Vietnam era (August 1964 to April 1975)	42%	37%	44%	47%	28%	48%	33%	21%
February 1955 to July 1964	6%	5%	6%	5%	3%	11%	0%	0%
Korean War (July 1950 to January 1955)	1%	1%	1%	0%	0%	0%	0%	0%
January 1947 to June 1950	0%	0%	0%	0%	0%	0%	0%	0%
World War II (December 1941 to December 1946)	<1%	<1%	0%	0%	0%	0%	3%	0%
November 1941 or earlier	<1%	<1%	1%	0%	0%	0%	0%	0%

A177. Time in active duty by region

Time in Active Duty	Greater MN (N=376)	Regions						
		Twin Cities Metro (N=481)	Central (N=137)	Northeast (N=43)	Northwest (N=28)	Southeast (N=112)	Southwest (N=33)	West Central (N=23)
Less than 2 years	7%	7%	5%	12%	4%	11%	9%	0%
2-3 years	28%	29%	28%	23%	22%	34%	27%	13%
4-5 years	25%	32%	28%	26%	21%	21%	18%	30%
6-10 years	14%	15%	18%	14%	18%	12%	18%	0%
11+ years	26%	17%	21%	26%	36%	27%	27%	57%
Mean	8.5 years	6.6 years	7.4 years	8.2 years	12.3 years	7.6 years	8.2 years	15.0 years
Median	4 years	4 years	4 years	4 years	6.0 years	4 years	5.0 years	15.0 years
Range	0 to 42 years	0 to 46 years	0 to 35 years	0 to 42 years	1 to 38 years	0 to 40 years	0 to 25 years	2 to 41 years

A178. Served in a combat or war zone by region

Did you ever serve in a combat or war zone?	Greater MN (N=385)	Regions						
		Twin Cities Metro (N=482)	Central (N=142)	Northeast (N=43)	Northwest (N=29)	Southeast (N=114)	Southwest (N=33)	West Central (N=24)
Yes	59%	51%	59%	58%	66%	60%	49%	67%
No	41%	49%	41%	42%	35%	40%	52%	33%

A179. Character of discharge by region

	Greater MN (N=386)	Regions						
		Twin Cities Metro (N=486)	Central (N=143)	Northeast (N=43)	Northwest (N=29)	Southeast (N=114)	Southwest (N=33)	West Central (N=24)
Honorable discharge	96%	95%	94%	98%	97%	97%	97%	96%
General (under honorable conditions)	4%	5%	6%	2%	3%	3%	3%	4%

A180. Veteran mental health diagnosis by region

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Greater MN (N=353-367)	Regions						
		Twin Cities Metro (N=449-469)	Central (N=130-137)	Northeast (N=38-42)	Northwest (N=25-27)	Southeast (N=105-108)	Southwest (N=32)	West Central (N=22)
Schizophrenia	1%	1%	2%	3%	0%	1%	3%	0%
Paranoid or delusional disorder, other than schizophrenia	3%	2%	2%	8%	8%	2%	3%	0%
Manic episodes or manic depression, bipolar disorder	8%	5%	9%	15%	13%	4%	6%	0%
Major depression	34%*	27%*	34%	35%	42%	29%	36%	42%
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	13%	11%	14%	15%	19%	8%	19%	14%
Alcohol abuse disorder	22%**	13%**	20%	20%	30%	22%	16%	27%
Drug abuse disorder	4%	5%	5%	0%	0%	4%	6%	5%
Post-Traumatic Stress Disorder (PTSD)	33%**	24%**	35%	30%	57%	27%	25%	39%
A concussion or traumatic brain injury	12%	11%	14%	8%	32%	8%	13%	9%
Anxiety disorder or panic disorder	35%	31%	37%	39%	41%	31%	30%	30%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A181. Disability by region

Has a disability	Greater MN (N=385)	Regions						
		Twin Cities Metro (N=484)	Central (N=143)	Northeast (N=42)	Northwest (N29)	Southeast (N=114)	Southwest (N=33)	West Central (N=24)
	63%**	54%**	63%	64%	69%	55%	64%	83%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A182. Survey responses on standardized screening tools, by region

	Greater MN (N=366-386)	Regions						
		Twin Cities Metro (N=483-485)	Central (N=141-143)	Northeast (N=42-43)	Northwest (N=29)	Southeast (N=113-114)	Southwest (N=33)	West Central (N=24)
Depression subscale								
Percent of respondents that screened positive for depression	29%	24%	28%	33%	48%	21%	27%	46%
Of those who screened positive for depression, percent reporting a diagnosis of major depression	69%	69%	84%	62%	77%	63%	56%	46%
Anxiety subscale								
Percent of respondents that screened positive for anxiety	28%	26%	31%	37%	28%	21%	27%	33%
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	67%	57%	60%	75%	36%	21%	50%	29%
PTSD scale								
Percent of respondents that screened positive for PTSD	34%*	31%*	35%	37%	52%	25%	36%	46%
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	74%***	57%***	77%	71%	93%	70%	55%	73%

A182. Survey responses on standardized screening tools, by region (continued)

		Regions						
	Greater MN (N=366-386)	Twin Cities Metro (N=483-485)	Central (N=141-143)	Northeast (N=42-43)	Northwest (N=29)	Southeast (N=113-114)	Southwest (N=33)	West Central (N=24)
Alcohol or drug abuse scale								
Percent of respondents that screened clinically significant for alcohol or drug abuse	31%	28%	28%	38%	52%	27%	70%	67%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	57%*	40%*	59%	44%	57%	64%	40%	5/7
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of drug abuse disorder	11%	16%	14%	0%	0%	12%	20%	1/7
Any psychological distress	53%*	45%*	52%*	60%*	65%*	44%*	51%*	67%*

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A183. When Veteran experienced PTSD by region

When did you have these experiences?	Greater MN (N=205)	Regions						
		Twin Cities Metro (N=242)	Central (N=74)	Northeast (N=21)	Northwest (N=19)	Southeast (N=54)	Southwest (N=19)	West Central (N=17)
Before your service	2%	10%	0%	0%	5%	4%	5%	6%
During your service	47%	54%	46%	36%	68%	41%	47%	59%
After your service	88%	84%	88%	96%	95%	93%	74%	77%

A184. Weather they sought help due to PTSD experiences by region

	Greater MN (N=205)	Regions						
		Twin Cities Metro (N=242)	Central (N=74)	Northeast (N=21)	Northwest (N=19)	Southeast (N=54)	Southwest (N=19)	West Central (N=17)
Sought help because of their experiences	70%	67%	66%	68%	79%	76%	79%	53%

A185. Sexual assault by region

Sexual assault	Greater MN (N=383)	Regions						
		Twin Cities Metro (N=484)	Central (N=143)	Northeast (N=43)	Northwest (N=29)	Southeast (N=20)	Southwest (N=32)	West Central (N=24)
Have you ever been touched sexually against your will/without your consent or ever been pressured to engage in sexual acts against your will/without your consent?	18% (N=69)	20% (N=94)	19% (N=27)	19% (N=8)	21% (N=6)	18% (N=20)	9% (N=3)	21% (N=5)
Before your service?	70%*	52%*	22%	5/8	4/6	65%	3/3	2/5
During your service?	45%	60%	59%	3/8	4/6	50%	0/3	3/5
After your service?	10%	15%	89%	1/8	0/6	10%	0/3	1/5
Have you ever sought help because of your experiences?	35%	48%	41%	3/8	3/6	30%	1/3	0/5

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A186. Suicidal ideation by region

	Greater MN (N=381)	Regions						
		Twin Cities Metro (N=483)	Central (N=141)	Northeast (N=41)	Northwest (N=29)	Southeast (N=113)	Southwest (N=33)	West Central (N=24)
Have you ever thought of killing yourself?	36%	35%	33%	37%	52%	31%	42%	46%
Do you currently have these thoughts?	10% (3% of total)	16% (5% of total)	7% (2% of total)	13% (5% of total)	29% (14% of total)	6% (2% of total)	0% (0% of total)	18% (8% of total)
Have you ever attempted suicide?	25% (9% of total)	25% (8% of total)	36% (11% of total)	7% (2% of total)	33% (17% of total)	20% (6% of total)	21% (9% of total)	18% (8% of total)
Have you ever sought help because you were suicidal?	45% (16% of total)	44% (15% of total)	48% (16% of total)	40% (15% of total)	40% (21% of total)	49% (15% of total)	43% (18% of total)	36% (17% of total)

A187. Social support by region

How often would you say you get the social and emotional support you need?	Greater MN (N=382)	Regions						
		Twin Cities Metro (N=485)	Central (N=139)	Northeast (N=43)	Northwest (N=29)	Southeast (N=114)	Southwest (N=33)	West Central (N=24)
Always/Usually	56%	57%	58%	51%	52%	55%	52%	67%
Sometimes/Rarely/Never	44%	43%	42%	49%	48%	45%	48%	33%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A188. Sense of belonging by region

How would you describe your sense of belonging to your local community?	Greater MN (N=385)	Regions						
		Twin Cities Metro (N=484)	Central (N=142)	Northeast (N=43)	Northwest (N=29)	Southeast (N=114)	Southwest (N=33)	West Central (N=24)
Very/somewhat strong	60%	61%	59%	47%	55%	67%	64%	50%
Very/Somewhat weak	41%	39%	41%	53%	45%	33%	36%	50%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A189. Wellbeing by region

Thinking about your mental wellbeing right now, overall, would you say you are…	Greater MN (N=380)	Regions						
		Twin Cities Metro (N=483)	Central (N=140)	Northeast (N=43)	Northwest (N=29)	Southeast (N=112)	Southwest (N=32)	West Central (N=24)
Staying the same	43%	48%	44%	44%	41%	41%	53%	42%
Depends on the day	30%	24%	28%	37%	38%	30%	25%	21%
Getting better	20%	21%	21%	12%	14%	24%	19%	21%
Getting worse	4%	4%	4%	5%	3%	3%	3%	4%
I'm not sure	3%	3%	3%	2%	3%	3%	0%	13%

A190. Services received by region

	Greater MN (N=385-386)	Regions						
		Twin Cities Metro (N=480-484)	Central (N=138-143)	Northeast (N=43)	Northwest (N=28-29)	Southeast (N=113-114)	Southwest (N=32-33)	West Central (N=24)
Received services since exiting the military	45%	42%	45%	47%	66%	38%	46%	50%
Received services in the past two years	39%*	36%*	42%	42%	48%	32%	33%	50%
Feel they have the support they need	78%	77%	82%	74%	59%	79%	72%	83%
Attempted and been unable to obtain services	12%	10%	9%	12%	29%	12%	12%	13%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A191. Mental health services received by region

Mental health	Greater MN (N=151)	Regions						
		Twin Cities Metro (N=172)	Central (N=60)	Northeast (N=18)	Northwest (N=14)	Southeast (N=36)	Southwest (N=11)	West Central (N=12)
Individual counseling (outpatient)	89%	92%	85%	83%	48%	94%	91%	83%
Group counseling (outpatient)	20%	24%	23%	11%	0%	28%	18%	17%
Peer to peer support	19%	17%	20%	6%	21%	22%	27%	8%
Inpatient counseling or treatment	17%	13%	20%	11%	29%	11%	9%	17%
Crisis line	9%	9%	7%	0%	7%	19%	9%	8%
Recovery services	7%	9%	5%	0%	14%	11%	0%	8%
Supportive housing	4%	8%	5%	0%	0%	6%	0%	8%
Faith-based support services	16%	15%	13%	0%	29%	19%	18%	25%
Other	14%	12%	12%	22%	21%	14%	0%	17%
NONE	4%	2%	7%	6%	0%	0%	0%	8%

A192. Chemical health services received by region

Chemical health	Greater MN (N=151)	Regions						
		Twin Cities Metro (N=172)	Central (N=60)	Northeast (N=18)	Northwest (N=14)	Southeast (N=36)	Southwest (N=11)	West Central (N=12)
Individual counseling (outpatient)	7%	15%	12%	6%	0%	0%	0%	25%
Group counseling (outpatient)	6%	9%	7%	6%	7%	0%	9%	17%
Peer to peer support	7%	11%	8%	0%	14%	6%	0%	8%
Inpatient counseling or treatment	7%	6%	8%	6%	14%	0%	0%	25%
Crisis line	4%	2%	0%	6%	14%	0%	9%	17%
Recovery services	5%	10%	3%	6%	21%	0%	0%	17%
Supportive housing	5%	4%	3%	6%	14%	0%	0%	17%
Faith-based support services	3%	4%	2%	6%	0%	0%	0%	17%
Other	2%	2%	2%	0%	0%	3%	0%	8%
NONE	85%	78%	83%	83%	79%	94%	91%	67%

A193. Service origin by region

Service origin	Greater MN (N=151)	Regions						
		Twin Cities Metro (N=172)	Central (N=60)	Northeast (N=18)	Northwest (N=14)	Southeast (N=36)	Southwest (N=11)	West Central (N=12)
Federal service	74%	72%	77%	72%	86%	64%	82%	67%
State service	18%	20%	20%	6%	21%	14%	36%	17%
County service	19%	16%	25%	11%	14%	8%	36%	25%
Local government service	7%	7%	7%	11%	7%	3%	9%	17%
Private service	33%	42%	32%	28%	21%	39%	18%	58%
Non-profit service	17%	22%	20%	6%	21%	14%	9%	25%
NONE	4%	2%	5%	0%	0%	8%	0%	0%

A194. Barriers by region

Barrier	Greater MN (N=202)	Regions						
		Twin Cities Metro (N=252)	Central (N=143)	Northeast (N=26)	Northwest (N=21)	Southeast (N=60)	Southwest (N=16)	West Central (N=11)
Was not eligible for services	7%	13%	1%	15%	10%	12%	0%	0%
Could not pay for services	17%	21%	4%	23%	14%	23%	25%	9%
Could not find transportation to get to services	6%	3%	5%	4%	5%	5%	6%	0%
The service was not available in my area	15%***	5%***	6%	27%	24%	12%	13%	9%
The people who provide it don't speak my language/I could not get an interpreter	<1%	0%	0%	4%	0%	0%	0%	0%
The wait time was too long	16%	13%	7%	8%	14%	18%	25%	27%
Services were not good with Veteran-specific issues	11%	14%	5%	4%	19%	13%	0%	27%
I was worried about how I would be seen	30%	26%	13%	27%	38%	25%	44%	55%
I was worried about the effect on current or future employment	24%	24%	10%	27%	33%	18%	19%	64%
I was worried about the effect on my current or future military service	5%	6%	3%	4%	5%	3%	0%	9%
I was worried about my family finding out	14%	10%	7%	12%	29%	7%	6%	46%
Cannot financially afford to take time off	17%	15%	6%	15%	29%	18%	13%	18%
I don't have a VA diagnosis	29%	38%	13%	27%	14%	40%	19%	27%
I don't think the services will help	19%	19%	12%	27%	10%	13%	19%	9%
Other	18%	24%	9%	15%	29%	13%	31%	9%
NONE	0%	<1%	0%	0%	0%	0%	0%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A195. Preferred service format by region

Service format	Greater MN (N=330)	Regions						
		Twin Cities Metro (N=406)	Central (N=143)	Northeast (N=40)	Northwest (N=25)	Southeast (N=95)	Southwest (N=28)	West Central (N=20)
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social or practical help to each other)	22%*	30%*	15%	28%	28%	22%	29%	15%
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	22%	25%	15%	28%	24%	22%	29%	25%
Individual (one-on-one services with a professional care provider)	67%	70%	57%	65%	88%	64%	61%	65%
Online (services provided online)	19%	18%	17%	18%	8%	22%	21%	15%
Text (services provided through text)	7%	8%	6%	10%	4%	6%	7%	10%
Informal support (such as support from family, friends, etc.)	32%	34%	24%	35%	36%	32%	32%	50%
Other	8%	8%	7%	5%	8%	5%	11%	15%
NONE	0%	0%	15%	0%	0%	0%	0%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

Tables by sense of belonging

A196. Demographics by sense of belonging

	Strong sense of belonging (Very/Somewhat) (N=528-532)	Weak sense of belonging (Very/Somewhat) (N=346-347)
Gender		
Men	87%*	82%*
Women	12%*	18%*
Other	<1%	<1%
Race/ethnicity		
White/Caucasian	91%	92%
Veterans of color	9%	89%
Age		
18 to 34 years	13%	18%
35 to 54 years	24%	37%
55 to 64 years	18%	25%
65 to 74 years	37%	20%
75 years and over	7%	1%

Note. Respondents were asked separately about race and Hispanic ethnicity. Those who report Hispanic ethnicity are not included in the racial categories for data in this table.
Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A197. Region by sense of belonging

Region	Strong sense of belonging (Very/Somewhat) (N=525)	Weak sense of belonging (Very/Somewhat) (N=344)
Central	16%	17%
Northeast	4%	7%
Northwest	3%	4%
Southeast	14%	11%
Southwest	4%	3%
Twin Cities Metro Area	56%	55%
West Central	2%	3%

A198. National Guard and Reserve Component status by sense of belonging

National Guard component	Strong sense of belonging (Very/Somewhat) (N=529)	Weak sense of belonging (Very/Somewhat) (N=352)
Never served on active duty as a member of the National Guard/Reserve Component	76%	71%
Yes, served on active duty while in the National Guard/Reserves and I am still serving in the National Guard/Reserves	3%	2%
Yes, served on active duty while in the National Guard/Reserves and have separated/ retired from the National Guard/Reserves	21%	27%

A199. Branch of military by sense of belonging

Branch	Strong sense of belonging (Very/Somewhat) (N=534)	Weak sense of belonging (Very/Somewhat) (N=355)
Army	53%	52%
Navy	23%	20%
Air Force	18%	20%
Marine Corps	9%	11%
Coast Guard	1%	1%
Other	<1%	0%

A200. Service era by sense of belonging

Service Era	Strong sense of belonging (Very/Somewhat) (N=538)	Weak sense of belonging (Very/Somewhat) (N=355)
September 2001 or later	29%	43%
August 1990 to August 2001 (includes Persian Gulf War)	25%	36%
May 1975 to July 1990	29%	37%
Vietnam era (August 1964 to April 1975)	46%	29%
February 1955 to July 1964	8%	2%
Korean War (July 1950 to January 1955)	2%	<1%
January 1947 to June 1950	0%	0%
World War II (December 1941 to December 1946)	1%	0%
November 1941 or earlier	<1%	0%

A201. Served in combat or war zone by sense of belonging

	Strong sense of belonging (Very/Somewhat) (N=536)	Weak sense of belonging (Very/Somewhat) (N=352)
Served in a combat/war zone	51%	60%

A202. Time in active duty by sense of belonging

Time in active duty	Strong sense of belonging (Very/Somewhat) (N=527)	Weak sense of belonging (Very/Somewhat) (N=351)
Less than 2 years	7%	7%
2-3 years	32%	23%
4-5 years	29%	27%
6-10 years	12%	17%
11+ years	20%	26%
Mean	7.3 years	8.1 years
Median	4 years	4 years
Range	0 to 46 years	0 to 40 years

A203. Veteran mental health diagnosis by sense of belonging

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Strong sense of belonging (Very/Somewhat) (N=503-515)	Weak sense of belonging (Very/Somewhat) (N=318-342)
Schizophrenia	1%	3%
Paranoid or delusional disorder, other than schizophrenia	1%**	5%**
Manic episodes or manic depression, bipolar disorder	3%***	12%***
Major depression	17%***	50%***
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	5%***	23%***
Alcohol abuse disorder	12%***	26%***
Drug abuse disorder	3%**	7%**
Post-Traumatic Stress Disorder (PTSD)	19%***	43%***
A concussion or traumatic brain injury	8%	16%
Anxiety disorder or panic disorder	22%***	49%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A204. Disability by sense of belonging

	Strong sense of belonging (Very/Somewhat) (N=536)	Weak sense of belonging (Very/Somewhat) (N=354)
Has a disability	49%***	73%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A205. Survey responses on standardized screening tools, by sense of belonging

	Strong sense of belonging (Very/Somewhat) (N=515-537)	Weak sense of belonging (Very/Somewhat) (N=327-355)
Depression subscale		
Percent of respondents that screened positive for depression	12%***	48%***
Of those who screened positive for depression, percent reporting a diagnosis of major depression	60%	71%
Anxiety subscale		
Percent of respondents that screened positive for anxiety	14%***	46%***
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	58%*	75%*
PTSD scale		
Percent of respondents that screened positive for PTSD	18%***	55%***
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	61%	67%
Alcohol or drug abuse scale		
Percent of respondents that screened clinically significant for alcohol or drug abuse	23%***	40%***
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	41%*	55%*
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	11%	16%
Any psychological distress	**30%*** **	**75%*** **

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A206. When Veteran had PTSD experience by sense of belonging

When did you have these experiences?	Strong sense of belonging (Very/Somewhat) (N=199)	Weak sense of belonging (Very/Somewhat) (N=260)
Before your service	6%	6%
During your service	45%	55%
After your service	88%	84%

A207. Sought help because of PTSD by sense of belonging

	Strong sense of belonging (Very/Somewhat) (N=198)	Weak sense of belonging (Very/Somewhat) (N=260)
Sought help because of PTSD experiences	65%	72%

A208. Sexual assault by sense of belonging

Sexual assault	Strong sense of belonging (Very/Somewhat) (N=536)	Weak sense of belonging (Very/Somewhat) (N=353)
Have you ever been touched sexually against your will/without your consent or ever been pressured to engage in sexual acts against your will/without your consent?	13%*** (N=71)	28%*** (N=98)
Before your service?	61%	56%
During your service?	48%	59%
After your service?	13%	13%
Have you ever sought help because of your experiences?	66%	48%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A209. Suicidal ideation by sense of belonging

	Strong sense of belonging (Very/Somewhat) (N=530)	Weak sense of belonging (Very/Somewhat) (N=354)
Have you ever thought of killing yourself?	22%***	55%***
Do you currently have these thoughts?	5% (1% of total)**	18% (10% of total)**
Have you ever attempted suicide?	19% (4% of total)	29% (16% of total)
Have you ever sought help because you were suicidal?	41% (9% of total)	45% (25% of total)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A210. Social support by sense of belonging

How often would you say you get the social and emotional support you need?	Strong sense of belonging (Very/Somewhat) (N=535)	Weak sense of belonging (Very/Somewhat) (N=354)
Always/Usually	76%***	28%***
Sometimes/Rarely/Never	24%***	72%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A211. Wellbeing by sense of belonging

Thinking about your mental wellbeing right now, overall, would you say you are…	Strong sense of belonging (Very/Somewhat) (N=529)	Weak sense of belonging (Very/Somewhat) (N=353)
Staying the same	54%***	35%***
Depends on the day	15%***	44%***
Getting better	28%***	10%***
Getting worse	2%***	7%***
I'm not sure	3%***	4%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A212. Services received by sense of belonging

	Strong sense of belonging (Very/Somewhat) (N=532-536)	Weak sense of belonging (Very/Somewhat) (N=344-353)
Received services since exiting the military	30%***	65%***
Received services in the past two years	25%***	57%***
Feel like they have the support they need	91%***	55%***
Attempted and been unable to obtain services	6%***	18%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A213. Mental health services received by sense of belonging

Mental health	Strong sense of belonging (Very/Somewhat) (N=133)	Weak sense of belonging (Very/Somewhat) (N=200)
Individual counseling (outpatient)	84%**	94%**
Group counseling (outpatient)	29%*	19%*
Peer to peer support	28%*	18%*
Inpatient counseling or treatment	12%	20%
Crisis line	8%	13%
Recovery services	8%	9%
Supportive housing	7%	7%
Faith-based support services	23%**	11%**
Other	14%	13%
NONE	5%	3%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A214. Chemical health services received by sense of belonging

Chemical health	Strong sense of belonging (Very/Somewhat) (N=133)	Weak sense of belonging (Very/Somewhat) (N=200)
Individual counseling (outpatient)	11%	11%
Group counseling (outpatient)	10%	6%
Peer to peer support	13%*	6%*
Inpatient counseling or treatment	8%	6%
Crisis line	2%	4%
Recovery services	10%	6%
Supportive housing	5%	4%
Faith-based support services	5%	2%
Other	3%	2%
NONE	82%	82%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A215. Service origin by sense of belonging

Service origin	Strong sense of belonging (Very/Somewhat) (N=133)	Weak sense of belonging (Very/Somewhat) (N=200)
Federal service	65%*	78%*
State service	20%	19%
County service	14%	20%
Local government service	6%	8%
Private service	45%*	34%*
Non-profit service	27%**	14%**
NONE	5%	2%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A216. Barriers by sense of belonging

Barrier	Strong sense of belonging (Very/Somewhat) (N=222)	Weak sense of belonging (Very/Somewhat) (N=241)
Was not eligible for services	9%	12%
Could not pay for services	14%**	25%**
Could not find transportation to get to services	3%	5%
The service was not available in my area	9%	10%
The people who provide it don't speak my language/I could not get an interpreter	0%	<1%
The wait time was too long	10%*	18%*
Services were not good with Veteran-specific issues	7%***	18%***
I was worried about how I would be seen	21%**	34%**
I was worried about the effect on current or future employment	17%**	30%**
I was worried about the effect on my current or future military service	5%	6%
I was worried about my family finding out	8%**	16%**
Cannot financially afford to take time off	8%***	22%***
I don't have a VA diagnosis	35%	33%
I don't think the services will help	14%**	24%**
Other	27%*	17%*
NONE	1%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A217. Preferred service format by sense of belonging

Service format	Strong sense of belonging (Very/Somewhat) (N=421)	Weak sense of belonging (Very/Somewhat) (N=328)
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social or practical help to each other)	23%*	30%*
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	22%	26%
Individual (one-on-one services with a professional care provider)	63%***	75%***
Online (services provided online)	14%**	24%**
Text (services provided through text)	6%*	10%*
Informal support (such as support from family, friends, etc.)	36%*	29%*
Other	8%	8%
NONE	<1%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A218. Demographics by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Race/ethnicity	**(N=84)**	**(N=78)**	**(N=167)**	**(N=706)**
White/Caucasian	88%	90%	89%	91%
Veterans of color	12%	10%	11%	9%
Age	**(N=84)**	**(N=79)**	**(N=168)**	**(N=708)**
18 to 34 years	14%***	24%***	19%	14%
35 to 54 years	35%***	43%***	39%	27%
55 to 64 years	20%***	28%***	24%	21%
65 to 74 years	30%***	3%***	16%	34%
75 years and over	1%***	3%***	2%	5%
Gender	**(N=84)**	**(N=79)**	**(N=165)**	**(N=712)**
Men	100%	0%	52%***	93%***
Women	0%	100%	48%***	7%***
Other	0%	0%	1%	0%

Note. Respondents were asked separately about race and Hispanic ethnicity. Those who report Hispanic ethnicity are not included in the racial categories for data in this table.

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A219. Region by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Region	**(N=83)**	**(N=77)**	**(N=164)**	**(N=703)**
Central	17%	17%	16%	17%
Northeast	7%	3%	5%	5%
Northwest	5%	3%	4%	3%
Southeast	8%	14%	12%	13%
Southwest	2%	1%	2%	4%
Twin Cities Metro Area	57%	60%	58%	55%
West Central	4%	3%	3%	3%

A220. National Guard and Reserves component status by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Region	**(N=83)**	**(N=78)**	**(N=168)**	**(N=714)**
Never served on active duty as a member of the National Guard/Reserve Component	77%	63%	71%	75%
Yes, served on active duty while in the National Guard/Reserves and I am still serving in the National Guard/Reserves	1%	4%	2%	2%
Yes, served on active duty while in the National Guard/Reserves and have separated/ retired from the National Guard/Reserves	22%	33%	27%	22%

A221. Branch of military by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Branch	**(N=84)**	**(N=79)**	**(N=170)**	**(N=719)**
Army	46%	58%	51%	52%
Navy	27%	20%	25%	22%
Air Force	17%	23%	19%	19%
Marine Corps	12%	3%	8%	11%
Coast Guard	0%	0%	0%	1%
Other	0%	0%	0%	<1%

A222. Service era by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Service Era	**(N=84**	**(N=79)**	**(N=170)**	**(N=723)**
September 2001 or later	30%	44%	36%	34%
August 1990 to August 2001 (includes Persian Gulf War)	27%	49%	39%	27%
May 1975 to July 1990	38%	42%	41%	30%
Vietnam era (August 1964 to April 1975)	39%	14%	27%	42%
February 1955 to July 1964%	4%	3%	3%	6%
Korean War (July 1950 to January 1955)	0%	0%	0%	2%
January 1947 to June 1950	0%	0%	0%	0%
World War II (December 1941 to December 1946)	0%	0%	0%	<1%
November 1941 or earlier	0%	0%	0%	<1%

A223. Served in a combat or war zone by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
	(N=84)	(N=79)	(N=170)	(N=719)
Did you ever serve in a combat/war zone?	50%	35%	43%	57%

A224. Discharge status by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Character of discharge	(N=84)	(N=79)	(N=170)	(N=723)
Honorable discharge	89%	94%	91%	96%
General (under honorable conditions)	11%	6%	9%	4%

A225. Time in active duty by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Time in active duty	(N=82)	(N=78)	(N=167)	(N=711)
Less than 2 years	5%	12%	8%	7%
2-3 years	32%	22%	26%	29%
4-5 years	32%	26%	29%	28%
6-10 years	18%	17%	17%	14%
11-15 years	4%	7%	6%	5%
16+ years	10%	18%	14%	17%
Mean	6.8 years	7.6 years	7.3 years	7.7 years
Median	4.0 years	4.0 years	4 years	4 years
Range	1 to 43 years	0 to 39 years	0 to 43 years	0 to 46 years

A226. Veteran mental health diagnosis by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Have you ever been told by a doctor or nurse that you have any of the following conditions?	**(N=74-81)**	**(N=65-75)**	**(N=145)**	**(N=677-678)**
Schizophrenia	4%	2%	3%	1%
Paranoid or delusional disorder, other than schizophrenia	8%	2%	5%	2%
Manic episodes or manic depression, bipolar disorder	16%	9%	13%**	5%**
Major depression	51%	63%	57%***	23%***
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	23%	20%	22%***	10%***
Alcohol abuse disorder	34%*	17%*	28%***	15%***
Drug abuse disorder	17%*	5%*	12%***	3%***
Post-Traumatic Stress Disorder (PTSD)	44%	54%	49%***	24%***
A concussion or traumatic brain injury	16%	17%	16%	10%
Anxiety disorder or panic disorder	50%	64%	58%***	27%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A227. Disability by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
	(N=83)	**(N=79)**	**(N=169)**	**(N=721)**
Has a disability	70%	66%	67%**	56%**

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A228. Survey responses on standardized screening tools, by sense of belonging

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Depression subscale	**(N=83-84)**	**(N=79)**	**(N=169-170)**	**(N=719-722)**
Percent of respondents that screened positive for depression	42%	42%	42%***	23%***
Of those who screened positive for depression, percent reporting a diagnosis of major depression	74%*	93%*	84%**	62%**
Anxiety subscale				
Percent of respondents that screened positive for anxiety	43%	49%	46%***	22%***
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	77%*	94%*	86%***	61%***
PTSD scale				
Percent of respondents that screened positive for PTSD	46%	49%	48%***	29%***
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	67%	76%	71%	62%
Alcohol or drug abuse scale				
Percent of respondents that screened clinically significant for alcohol or drug abuse	48%**	25%**	38%**	27%**
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	56%	41%	55%	46%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	29%	20%	26%**	10%**
Any psychological distress	**64%**	**72%**	**68%*** **	**44%*** **

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A229. When Veteran had PTSD experience by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
When did you have these experiences?	**(N=61)**	**(N=56)**	**(N=123)**	**(N=336)**
Before your service	13%	16%	15%	3%
During your service	56%	68%	62%	47%
After your service	79%	88%	83%	88%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A230. Whether Veteran sought help due to PTSD experience by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Have you ever sought help because of your experience(s)?	**(N=61)**	**(N=56)**	**(N=123)**	**(N=335)**
Yes	80%	80%	81%	65%
No	20%	20%	20%	36%

A231. Suicidal ideation by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
	(N=81)	(N=79)	(N=167)	(N=716)
Have you ever thought of killing yourself?	62%	56%	61%***	29%***
Do you currently have these thoughts?	15% (10% of total)	12% (6% of total)	13% (8% of total)	13% (4% of total)
Have you ever attempted suicide?	35% (22% of total)	47% (25% of total)	42%*** (25% of total)	17%*** (5% of total)
Have you ever sought help because you were suicidal?	56% (36% of total)	64% (35% of total)	59%*** (35% of total)	37%*** (11% of total)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A232. When Veteran experienced sexual assault

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
When did you have these experiences?	**(N=84)**	**(N=78)**	**(N=169)**	**(N=336)**
Before your service	75%***	44%***	58%	NA
During your service	27%***	80%***	54%	NA
After your service	10%	15%	13%	NA

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A233. When Veteran experienced sexual assault by gender

	Has experienced sexual assault	
	Men	Women
When did you have these experiences?	**(N=84)**	**(N=78)**
Before your service ONLY	65%	19%
During your service ONLY	19%	49%
After your service ONLY	4%	1%
Before AND During your service	6%	17%
Before AND After your service	4%	0%
During AND After your service	2%	6%
Before, During, and After your service	0%	8%

A234. Whether Veteran sought help due to sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Have you ever sought help because of your experience(s)?	**(N=84)**	**(N=78)**	**(N=169)**	**(N=336)**
Yes	31%**	54%**	42%	NA
No	69%**	46%**	58%	NA

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A235. Social support by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
How often would you say you get the social and emotional support you need?	**(N=83)**	**(N=79)**	**(N=169)**	**(N=717)**
Always/Usually	49%	47%	48%**	59%**
Sometimes/Rarely/Never	51%	53%	52%**	41%**

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A236. Sense of belonging by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
How would you describe your sense of belonging to your local community?	**(N=84)**	**(N=79)**	**(N=170)**	**(N=719)**
Very/somewhat strong	45%	39%	42%***	65%***
Very/somewhat weak	55%	61%	58%***	35%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A237. Wellbeing by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Thinking about your mental wellbeing right now, overall, would you say you are…	**(N=84)**	**(N=79)**	**(N=170)**	**(N=710)**
Getting better	26%	28%	26%***	19%***
Getting worse	8%	8%	8%***	3%***
Staying the same	31%	23%	27%***	50%***
Depends on the day	31%	38%	35%***	24%***
I'm not sure	4%	4%	4%***	3%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A238. Services received by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
	(N=83-84)	**(N=78-79)**	**(N=167-169)**	**(N=706-718)**
Received series since exiting the military	68%	73%	70%***	38%***
Received services in the past two years	57%	66%	62%***	32%***
Feel they have the support they need	69%	56%	62%***	80%***
Attempted and been unable to obtain services	19%	19%	20%***	8%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A239. Mental health services received by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Mental health	**(N=47)**	**(N=52)**	**(N=104)**	**(N=228)**
Individual counseling (outpatient)	92%	94%	92%	89%
Group counseling (outpatient)	32%	19%	25%	22%
Peer to peer support	30%	21%	25%	21%
Inpatient counseling or treatment	26%	12%	17%	17%
Crisis line	21%	17%	19%**	7%**
Recovery services	13%	4%	8%	8%
Supportive housing	17%**	2%**	9%	6%
Faith-based support services	19%	21%	20%	14%
Other	21%	10%	16%	12%
NONE	2%	2%	2%	4%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A240. Chemical health services received by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Chemical health	**(N=47)**	**(N=52)**	**(N=104)**	**(N=228)**
Individual counseling (outpatient)	19%*	6%*	12%	11%
Group counseling (outpatient)	11%	8%	9%	7%
Peer to peer support	13%	4%	9%	9%
Inpatient counseling or treatment	11%	6%	8%	6%
Crisis line	2%	2%	2%	4%
Recovery services	9%	4%	6%	8%
Supportive housing	6%	2%	4%	4%
Faith-based support services	6%	2%	4%	3%
Other	4%	0%	2%	2%
NONE	68%	85%	77%	83%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A241. Service origin by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Service origin	**(N=47)**	**(N=52)**	**(N=104)**	**(N=228)**
Federal service	72%	64%	67%	74%
State service	26%	17%	21%	18%
County service	26%	15%	20%	16%
Local government service	11%	4%	8%	7%
Private service	38%	48%	42%	36%
Non-profit service	30%	19%	24%	17%
NONE	2%	4%	4%	3%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A242. Barriers by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Barrier	**(N=54)**	**(N=52)**	**(N=109)**	**(N=370)**
Was not eligible for services	17%	15%	17%*	9%*
Could not pay for services	24%	29%	27%*	17%*
Could not find transportation to get to services	6%	14%	10%**	3%**
The service was not available in my area	9%*	27%*	17%**	7%**
The people who provide it don't speak my language/I could not get an interpreter	0%	0%	0%	<1%
The wait time was too long	13%	29%	20%	13%
Services were not good with Veteran-specific issues	13%	15%	15%	12%
I was worried about how I would be seen	30%	32%	32%	26%
I was worried about the effect on current or future employment	24%	35%	28%	23%
I was worried about the effect on my current or future military service	6%	12%	8%	5%
I was worried about my family finding out	11%	19%	15%	11%
Cannot financially afford to take time off	19%	35%	27%***	12%***
I don't have a VA diagnosis	32%	19%	27%	36%
I don't think the services will help	15%	21%	18%	19%
Other	24%	17%	20%	22%
NONE/No Answer Provided	0%	0%	0%	<1%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A243. Preferred service format by sexual assault experience

	Has experienced sexual assault			Not experienced sexual assault
	Men	Women	Total	
Service format	**(N=78)**	**(N=77)**	**(N=160)**	**(N=586)**
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social or practical help to each other)	28%	29%	29%	25%
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	33%*	30%*	31%*	22%*
Individual (one-on-one services with a professional care provider)	71%	75%	74%	67%
Online (services provided online)	14%	20%	17%	18%
Text (services provided through text)	5%	14%	9%	7%
Informal support (such as support from family, friends, etc.)	36%	32%	34%	32%
Other	15%	5%	10%	8%
NONE	0%	0%	0%	<1%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A244. Demographics by social support

	Always/Usually	Sometimes/Rarely/Never
Race/ethnicity	**(N=497)**	**(N=374)**
White/Caucasian	91%	89%
Veterans of color	9%	11%
Age	**(N=498)**	**(N=377)**
18 to 34 years	16%***	14%***
35 to 54 years	24%***	36%***
55 to 64 years	19%***	24%***
65 to 74 years	35%***	24%***
75 years and over	7%***	1%***
Gender	**(N=498)**	**(N=377)**
Men	87%	83%
Women	13%	17%
Other	<1%	0%

Note. Respondents were asked separately about race and Hispanic ethnicity. Those who report Hispanic ethnicity are not included in the racial categories for data in this table.
Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A245. Region by social support

Region	Always/Usually (N=491)	Sometimes/Rarely/Never (N=376)
Central	16%	15%
Northeast	4%	6%
Northwest	3%	4%
Southeast	13%	14%
Southwest	3%	4%
Twin Cities Metro Area	56%	55%
West Central	3%	2%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A246. National Guard and Reserves Component status by social support

National Guard component	Always/Usually (N=501)	Sometimes/Rarely/Never (N=378)
Never served on active duty as a member of the National Guard/Reserve Component	75%	74%
Yes, served on active duty while in the National Guard/Reserves and I am still serving in the National Guard/Reserves	3%	2%
Yes, served on active duty while in the National Guard/Reserves and have separated/retired from the National Guard/Reserves	23%	24%

A247. Branch of military by social support

Branch	Always/Usually (N=504)	Sometimes/Rarely/Never (N=383)
Army	51%	54%
Navy	23%	21%
Air Force	20%	18%
Marine Corps	9%	11%
Coast Guard	1%	1%
Other	<1%	<1%

A248. Service era by social support

Service era	Always/Usually (N=506)	Sometimes/Rarely/Never (N=385)
September 2001 or later	34%	34%
August 1990 to August 2001 (includes Persian Gulf War)	26%	34%
May 1975 to July 1990	28%	37%
Vietnam era (August 1964 to April 1975)	44%	33%
February 1955 to July 1964%	7%	3%
Korean War (July 1950 to January 1955)	2%	<1%
January 1947 to June 1950	0%	0%
World War II (December 1941 to December 1946)	1%	0%
November 1941 or earlier	<1%	0%

A249. Served in combat or war zone by social support

	Always/Usually (N=503)	Sometimes/Rarely/Never (N=383)
Served in a combat/war zone	54%	56%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A250. Discharge status by social support

Character of discharge	Always/Usually (N=506)	Sometimes/Rarely/Never (N=385)
Honorable discharge	96%	94%
General (under honorable conditions)	4%	6%

A251. Time in active duty by social support

Time in active duty	Always/Usually (N=496)	Sometimes/Rarely/Never (N=380)
Less than 2 years	6%	8%
2-3 years	30%	26%
4-5 years	29%	28%
6-10 years	13%	16%
11-15 years	4%	8%
16+ years	17%	15%
Mean	7.9 years	7.4 years
Median	4 years	4 years
Range	0 to 46 years	0 to 40 years

A252. Veteran mental health diagnosis by social support

Have you ever been told by a doctor or nurse that you have any of the following conditions?	Always/Usually (N=469-485)	Sometimes/Rarely/Never (N=352-369)
Schizophrenia	1%	2%
Paranoid or delusional disorder, other than schizophrenia	1%*	4%
Manic episodes or manic depression, bipolar disorder	4%**	9%**
Major depression	19%***	44%***
Anti-social personality, obsessive-compulsive personality, or any other severe personality disorder	6%***	19%***
Alcohol abuse disorder	12%***	23%***
Drug abuse disorder	4%*	5%*
Post-Traumatic Stress Disorder (PTSD)	21%***	37%***
A concussion or traumatic brain injury	9%*	14%*
Anxiety disorder or panic disorder	25%***	43%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A253. Disability by social support

	Always/usually (N=505)	Sometimes/Rarely/Never (N=383)
Has a disability	49%***	71%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A254. Survey responses on standardized screening tools, by social support

Depression subscale	Always/Usually (N=505-506)	Sometimes/Rarely/Never (N=380)
Percent of respondents that screened positive for depression	12%***	45%***
Of those who screened positive for depression, percent reporting a diagnosis of major depression	67%	68%
Anxiety subscale		
Percent of respondents that screened positive for anxiety	13%***	45%***
Of those who screened positive for anxiety, percent reporting a diagnosis of anxiety	67%	70%
PTSD scale		
Percent of respondents that screened positive for PTSD	18%***	51%***
Of those who screened positive for PTSD, percent reporting a diagnosis of PTSD	69%	63%
Alcohol or drug abuse scale		
Percent of respondents that screened clinically significant for alcohol or drug abuse	24%	36%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of an alcohol abuse disorder	42%	52%
Of those who screened clinically significant for alcohol or drug abuse, percent reporting a diagnosis of a drug abuse disorder	14%	12%
Any psychological distress	**31%*** **	**73%*** **

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A255. When Veteran experienced PTSD by social support

When did you have these experiences?	Always/Usually (N=178)	Sometimes/Rarely/Never (N=279-280)
Before your service	6%	6%
During your service	57%	48%
After your service	84%	88%
Have you ever sought help?	69%	68%

A256. Suicidal ideation by social support

	Always/Usually (N=504)	Sometimes/Rarely/Never (N=377)
Have you ever thought of killing yourself?	24%***	50%***
Do you currently have these thoughts?	7%** (2% of total)	12%** (5% of total)
Have you ever attempted suicide?	23% (6% of total)	25% (12% of total)
Have you ever sought help because you were suicidal?	47% (11% of total)	42% (19% of total)

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A257. Sexual assault by social support

Sexual assault	Always/Usually (N=505)	Sometimes/Rarely/Never (N=381)
Have you ever been touched sexually against your will/without your consent or ever been pressured to engage in sexual acts against your will/without your consent?	16%** (N=81)	23%** (N=88)
Before your service?	59%	57%
During your service?	49%	60%
After your service?	11%	15%
Have you ever sought help because of your experiences?	40%	58%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A258. Social support categories by social support

How often would you say you get the social and emotional support you need?	Always/usually (N=506)	Sometimes/Rarely/Never (N=385)
Always	32%	0%
Usually	68%	0%
Sometimes	0%	63%
Rarely	0%	28%
Never	0%	9%

A259. Sense of belonging by social support

How would you describe your sense of belonging to your local community?	Always/Usually (N=505)	Sometimes/Rarely/Never (N=384)
Very/somewhat strong	80%***	34%***
Very/somewhat weak	20%***	66%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A260. Wellbeing by social support

Thinking about your mental wellbeing right now, overall, would you say you are…	Always/Usually (N=498)	Sometimes/Rarely/Never (N=384)
Getting better	28%***	11%***
Getting worse	1%***	7%***
Staying the same	55%***	35%***
Depends on the day	14%***	42%***
I'm not sure	2%***	5%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A261. Services received by social support

	Always/Usually (N=499-504)	Sometimes/Rarely/Never (N=233-240)
Received services since exiting the military	35%***	56%***
Received services in the past two years	30%***	47%***
Feel they have the support they need	93%***	56%***
Attempted and been unable to obtain services	6%***	17%***

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A262. Mental health services received by social support

Mental health	Always/Usually (N=151)	Sometimes/Rarely/Never (N=204)
Individual counseling (outpatient)	87%	92%
Group counseling (outpatient)	26%	20%
Peer to peer support	25%	19%
Inpatient counseling or treatment	16%	18%
Crisis line	10%	12%
Recovery services	9%	8%
Supportive housing	7%	6%
Faith-based support services	19%**	13%**
Other	15%	12%
NONE	4%	2%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A263. Chemical health services received by social support

Chemical health	Always/Usually (N=151)	Sometimes/Rarely/Never (N=204)
Individual counseling (outpatient)	11%	11%
Group counseling (outpatient)	10%	5%
Peer to peer support	11%	7%
Inpatient counseling or treatment	8%	6%
Crisis line	3%	3%
Recovery services	10%	6%
Supportive housing	4%	4%
Faith-based support services	7%	1%
Other	3%	1%
NONE	80%	83%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A264. Service origin by social support

Service origin	Always/usually (N=151)	Sometimes/Rarely/Never (N=204)
Federal service	66%*	78%*
State service	17%	20%
County service	13%	21%
Local government service	5%	9%
Private service	44%	33%
Non-profit service	19%	19%
NONE	3%	3%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A265. Barriers by social support

Barrier	Always/Usually (N=199)	Sometimes/Rarely/Never (N=262)
Was not eligible for services	7%**	14%**
Could not pay for services	16%	22%
Could not find transportation to get to services	2%**	6%**
The service was not available in my area	5%**	13%**
The people who provide it don't speak my language/I could not get an interpreter	0%	<1%
The wait time was too long	8%**	19%**
Services were not good with Veteran-specific issues	9%**	15%**
I was worried about how I would be seen	22%*	32%*
I was worried about the effect on current or future employment	19%*	28%*
I was worried about the effect on my current or future military service	7%	5%
I was worried about my family finding out	6%**	16%**
Cannot financially afford to take time off	9%***	21%***
I don't have a VA diagnosis	35%	33%
I don't think the services will help	12%***	25%***
Other	26%	18%
NONE	0%	<1%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.

A266. Preferred service format by social support

Service format	Always/Usually (N=396)	Sometimes/Rarely/Never (N=243)
Peer-to-peer (trained or untrained supporters who provide knowledge, experience, emotional, social or practical help to each other)	24%	28%
Group (a group of people with common experiences or concerns who provide each other with encouragement, comfort, or advice)	22%	25%
Individual (one-on-one services with a professional care provider)	68%	69%
Online (services provided online)	14%***	23%***
Text (services provided through text)	6%	9%
Informal support (such as support from family, friends, etc.)	36%	29%
Other	7%**	10%
NONE	<1%	0%

Note. Significance tests were conducted using chi-square tests. Differences are significant at *p <.05, **p < .01, and ***p < .001.