



National Rural Health Association: Rural Veterans and Their Families Policy Paper

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Introduction

Veterans and their families are an untapped rural, community asset that have the potential to be a driver of improving health, holistically, and economy in their communities. Yet, the current policies, challenges, supports, and systems specific to improving the lives of veterans and their families often work against one another or lack consideration of how they could work in concert for a common goal. This paper takes a unique focus looking through the lens of a healthy community to begin to understand several community-based assets that veterans may interact with, what is being done in those arenas, and how they play out in rural areas. The authors willingly choose to highlight the community-based systems above and beyond the health care systems that may or may not be available to veterans in rural areas. Also minimizing the focus on the Veterans Administration's (VA) traditional role in the care of veterans.

It is well understood that where you live matters. Moreover, healthy communities, rural or urban, have the components of focusing collaborative work around equity (i.e., lack of disparities), primary prevention of disease, social determinants of health and policy and environmental changes (Health Research in Action 2013). Healthy communities engage in processes that promote overarching health, while they may involve individual behavioral change, the majority of their efforts are focused on systems and upstream factors that support individuals. Furthermore, these components create a system that can be intervened in. Veterans have a unique experience within a system and by nature of their military status create barriers and opportunities to support the development of healthy communities. By understanding the rural system(s) that veterans interact with, we can make recommendations for policy changes and investments in community asset building through various lenses. The following paper provides an overview of systems approaches highlighting the importance of community engagement, community building, and advocacy in a systems approach. It then highlights four components of the system that rural veterans experience, understanding that this is not a full representation. However, these areas provide opportunities for policy recommendations. The four components are:

1. Public-Private Partnerships
2. Bolstering Faith-based Solutions
3. Leveraging Media and the Stories of Veterans, and
4. Financing & Economic Security for Rural Veterans.

Systems Approaches to Healthy Communities

Communities are complex ecological systems. Interventions, such as policy changes, can be treated as events in systems that impact the social networks, relationships, activities, and resources (Hawe, Shiell, & Riley, 2009). Currently, systems-level approaches to health and community engagement are seen as powerful, flexible mechanisms for creating the necessary environment for health to thrive. Systems approaches require understanding the dynamic interrelations between parts within the system (Diez Roux, 2011). Understanding the unique



experience of veterans as they navigate and interact with these systems is a necessary step in ensuring policies to support veterans are inclusive and accessible to them. Additionally, using models that support principles of community engagement, community building, and advocacy may better provide sustainable changes to support rural veterans and their families.

Community Engagement, Community Building, & Advocacy

Community engagement requires a level of support that enables individuals, organizations, and networks to come together around a common purpose. It is seen as a promising practice for improving health on both the individual level and community level (Syme, 2004). It is well established that community engagement increases the acceptability and sustainability of programs that aim to address health inequalities and inequities (Assai, Siddiqi, & Watts, 2006; Taylor-Ide & Taylor, 2002; Wallerstein & Bernstein, 1994). This aligns well with community organizing, and therefore community building, principles. However, the two, engagement and organizing have distinct differences. Engagement focuses more on awareness and civic duty, whereas organizing has a social justice core.

Through the development and refinement of community organizing practice a new "orientation" to community organizing, community building, has gained favor (Minkler, 2012). Community building is the practice of conducting community organizing practices through the lens of building individual, organizational, and community-level characteristics or capacities. This approach values the community's strengths and assets and attempts to build these. Similar too is community-based participatory research (CBPR), which uses these principles to partner with communities and/or groups (such as veterans) to effectively conduct research (Israel, Schulz, Parker, & Becker, 2001). Often the outcome of this research is effective advocacy efforts resulting in policy change (Cacari-Stone, Wallerstein, Garcia, & Minkler, 2014; Farrer, Marinetti, Cavaco, & Kuipers Costongs, 2015). These broad functions, community engagement, community building, and advocacy place exceptional focus on the importance of civic engagement and multi-disciplinary groups coming together to improve public health. It is important to understand the different orientations and how they support various groups, such as veterans. The following four vignettes explore some of the work being done in these areas with a particular focus on rural veterans.

Public-Private Partnerships

Public-private partnerships are an opportunity to improve care and access to care for veterans and their families (Pedersen et al., 2015). Public-private partnerships (PPP) is an umbrella term for all types of public-private cooperation, including formal or informal efforts (Reynaers, 2013). In some instances, PPPs have become a popular tool for guiding rural development (Bjarstig & Sandstrom, 2017) Additionally there have been efforts from several systems supporting veterans to engage in public-private partnerships. Specifically, the Veterans Administration (VA) using guidance from The Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163, Section 506) has invested in a Rural Coordination Pilot looking to increase coordination of services for care that embed veterans in community-based organizations. Since 2012, the Federal Office of Rural Health Policy (FORHP) in partnership with the National Rural Health Association & Grantmakers in Health have convened a Public-Private Collaborations in Rural Health Meeting to lay the foundation for successful PPPs. Notably absent from the most



recent meeting agenda was representation of the Veterans Administration Office of Rural Health.

Public-private partnerships provide an opportunity to invest in some of the more long-term efforts needed to support rural veterans and their families. There is tremendous guidance that has come from rural philanthropy and implementation for health improvement that should be considered when designing or investigating the feasibility of PPPs for veterans. Specifically, there is the need to take an asset-based approach when considering working with rural communities (Meit et al., 2018).

Bolstering Faith-based Solutions

Faith-based organizations (FBO) are often community resources that veterans utilize for counseling and readjustment to civilian life after military service (Werber, Derose, Rudnick, Harrell, & Naranjo, 2015). Much of the work done by FBO explore how military service, especially for deployed military service members, has created a spiritual or moral wound that is not being addressed by traditional clinical approaches (Werber et al., 2015). The VA has a VA Center for Faith-Based and Neighborhood Partnerships that helps train chaplains and spiritual leaders of FBO to specifically work with veterans (Werber et al., 2015). Approximately 2 in 5 veterans that return home with a mental health issue live in a rural area and often prefer clergy for mental health due to their familiarity with the local clergy members (Sullivan et al., 2014). The Department of Veterans Affairs South Central Veterans Integrated Service Network began a program called the Mental Health-Clergy Partnership Program that targeted and trained rural clergy and involved community members in interventions (Sullivan et al., 2014).

The VA began the Mental Illness Research Education and Clinical Center (MIRECC), which utilizes the community-based participatory model, to connect clergy and first responders with veterans' issues to provide greater access to mental health resources, especially in rural areas (Grove 2015). Access to mental health is an issue that many rural veterans face after returning from combat or leaving the military and transitioning to civilian life and community partnerships, such as with FBOs, are often able to bridge this gap (Kirchner, Farmer, Shue, Blevins, & Sullivan, 2011). Although many rural areas have community-based outpatient clinics, many veterans do not seek their physical or mental health care through the VA (Kirchner et al., 2011). The Military Family Research Institute's program, Reaching Rural Veterans is a collaborative program with faith-based food pantries located in rural areas in Kentucky and Indiana to assist with food, shelter, and employment needs (Military Family Research Institute, 2018). Research has shown that in many instances of working with veterans who have experienced trauma, whether in military service or exacerbated by military service, acknowledging and encompassing spirituality within treatment services has benefits in successful treatment (Englund, 2017). Within the student veteran population, pastoral care is often used for successful primary or supplemental care for mental health needs (Kopacz & Karras, 2015).

Although there have been successful outcomes with the partnership with FBO in working with veterans with mental health issues, there is also conflict, debate, and mistrust when combining mental health treatment with spirituality (or the lack of acknowledging the veteran's spirituality) (Sullivan et al., 2013). Often mental health providers do not take spirituality into account when providing services, while clergy often do not agree with modern non-religious mental health counseling; both can be detrimental to the treatment of veterans, especially rural veterans that



often do not have extensive resources (Sullivan et al., 2013). There are opportunities to collaborate clinical treatment and spiritual based organizations to best serve veterans, especially in rural areas (Sullivan et al., 2013; Derose, Haas, & Werber, 2016). Engaging FBOs can also work to reduce the number of veteran suicides and increase successful reintegration into civilian life (Matthieu, Gardiner, Ziegemeier, & Buxton, 2014; Werber et al., 2015).

Leveraging Media and the Stories of Veterans

Fewer Americans are serving in the military although the appearance of military service members and veterans in the news, media, television shows, and movies continues to grow; and the media is often the only face of the military/veterans that society sees (Moore, 2018). The influence of the media on the general public can have a positive impact but also a negative impact, by creating stereotypes, on veterans within their community and in transitioning to civilian life (Moore, 2018; Hunter, 2017; Kleykamp & Hipes, 2015). Many media portrayals of the military and veterans creates a stereotype of violence; negative outcomes of PTSD, substance abuse, and depression; and suicide (Kleykamp & Hipes, 2015). There is also a stereotype that all veterans either fall into the category of hero or victims (Parrot, Albright, Dyche, & Steele, 2018), which can place undue stress and hardship on veterans (Kleykamp & Hipes, 2015). Most stories of veterans in the media have been high profile stories in which veterans are damaged and this has an impact on veterans and their families (Substance Abuse & Mental Health Services Administration, 2012).

Many veterans' groups have attempted to work with media outlets to help frame the narrative about veterans, especially when related to suicide, to help prevent negative stereotypes and prevent veteran suicides (Rhidenour, Barrett, & Blackburn, 2017). Previous research shows that the media coverage of military suicide, which has risen while civilian suicide has remained steady, can lead to higher suicide rates among the veteran population due to glorification of suicide and the veteran (Edwards-Stewart, Kinn, June, & Fullerton, 2011). The media continues to coverage PTSD of veterans and often portrays a violent and out of control person, this often affects veterans when they apply for employment and transition in their civilian community; this can be more difficult for rural veterans due to lack of extensive employment opportunities and close-knit communities (Kleykamp & Hipes, 2015; Armstrong & Olatunji, 2009). The coverage of veterans by the media can be seen as telling the veterans' stories, but often only the negative and stigmatizing version creates an overall generalization of all veterans (Rhidenour, 2015).

Financing & Economic Security for Rural Veterans

Approximately 5 million veterans live in what the U.S. Census bureau classified as a rural area (Holder, 2017). When compared to urban veterans from 2011-2015, rural veterans had a higher unemployment rate and the median income for urban veterans was approximately \$6,000 higher than rural veteran households (Holder, 2017). However, despite the difference in household income, more veterans live in poverty in urban settings than rural (Holder, 2017). When examining the age of veterans living below the poverty line, in both rural and urban settings, this group is younger veterans (Holder, 2017). The average household income of rural veterans and rural nonveterans is similar with rural veterans being slightly higher, however more rural nonveterans were living in poverty than rural veterans (Holder, 2017).

Veterans, on average, receive more education and skills training than nonveterans and can



provide more economic stability to rural areas once transitioned to civilian life (United States Department of Agriculture, 2013). The main issues to economic security to veterans living in rural areas is limited job opportunities, limitations due to physical and mental health from their military service, and a higher cost to accessing resources (U.S. Department of Agriculture, 2013). Women veterans, living in rural areas, often face challenges that affect their economic security that differ from urban; including limited employment and limited access to childcare (Szelwach, Steinkogler, Badger, & Muttukumar, 2011). Economic recessions that happen in rural areas, often occur due to the types of employment and affect rural veterans more negatively than urban veterans, which often magnifies other challenges of transitioning rural veterans (Szelwach, 2011).

American Indian and Alaska Natives veterans are a group that are particularly vulnerable and have over 5,000 living within the state of Alabama and over 130,000 in the VA's Southern region (Holiday, Bell, Klein, & Wells, 2006). This subpopulation has poor employment outcomes and are more likely to be living in poverty, which has a negative impact on overall quality of life measures (Noe et al., 2011).

Recommendations

1. Establish policies to invest in Community-based participatory research (CBPR) with rural veterans and their families
 - a. Establish public-private partnerships for CBPR
 - b. Use promising practices to support organizational capacity growth in rural institutions to support veterans
2. Potential funding sources to invest in Community-based participatory research projects include, but are not limited to:
 - a. National, State, Regional, and Local Foundations
 - b. State governments
 - c. Federal agencies, such as the Veterans Administration (VA), USDA, and/or Federal Office of Rural Health Policy (FORHP)



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