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Combat Veteran Mental Health Care Advocacy

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COUN 6785: Social Change in Action:

Prevention, Consultation, and Advocacy

Social Change Portfolio

Combat Veteran Mental Health Care Advocacy

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OVERVIEW

Keywords: Combat Veterans, Mental Health, PTSD, Depression, Anxiety, Substance Abuse, Suicide, Unemployment, Social Ecological Model, Evidence-Based Prevention and Treatment

Goal: The goal of Combat Veteran Mental Health Care Advocacy is to promote, support and draw attention to critical combat veteran mental health issues, such as PTSD, depression and substance abuse, where the real and actual consequence may lead to suicide.

Significant Findings: Presently, there are about 18 million living veterans (Inoue et al., 2023; Vespa, 2020), of which approximately 7.7 million served between 1990 and the present; roughly 42 percent of the total (Vespa, 2020). Wounded Warrior Project (2022) reported that these combat veterans face significant mental health issues such as sleep deprivation, PTSD, anxiety, and depression. The primary consequence is suicide. Nearly 1 in 5 Wounded Warrior Project warriors have attempted suicide, 1 in 4 have entertained suicide thoughts. Research has indicated the combat veteran feels isolated, misunderstood and avoids confronting misguided and erroneous misconceptions people have about them and their invisible wounds.

Stategies: Utilize evidenced-based models strategic in the application of preventive measures and treatment interventions for treating combat veteran mental health issues and disorders; employ the military Psychological Health Research Continuum model and the Social Cognitive Theory model; use the ACA Advocacy Toolkit to promote advocacy actions; collaborate with the American Psychological Association, the American Psychiatric Association, and veterans groups and organizations on advocacy actions; and promote passage of the STRONG Veterans Act of 2022 (H.R.6411), the Honoring our PACT Act of 2021 (H.R.3967), and the Improving Access to Behavioral Health Integration Act (S.4306)

INTRODUCTION

The American Counseling Association (ACA) Code of Ethics (2014) Section A.7. Roles and Relationships at Individual, Group, Institutional, and Societal Levels, subsection A.7.a. Advocacy states that "When appropriate, counselors advocate at individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients" (p. 5). This section of the ACA Code of Ethics informs and encourages counselors to participate in social advocacy, that by its most basic definition involves helping and or assisting marginalized communities (Meyers, 2014). Sevelius et al. (2020) defined marginalized communities as "… *those excluded from mainstream social, economic, educational, and/or cultural life where marginalization occurs due to unequal power relationships between social groups*" (p.1). Examples include seniors, minorities, military service members and families, combat veterans, the disabled, the mentally ill, the homeless, and the GLBT+ community (Garret, n.d.; Graham, 2023: National Academy of Sciences, 2022; Sevelius, et al., 2020).

While I am interested in advocating for all military service members, the scope of this advocacy is combat veterans who served in the Gulf Wars between 1990 and the present. This advocacy portfolio examines the scope and consequences of my advocacy, the particular social-ecological model of choice for social advocacy, theories of prevention, diversity and ethical considerations, the critical mental health issues facing these combat veterans and consequences, social-economic constraints, and concluding with identification of advocacy barriers involving the Multicultural and Social Justice Counseling Competencies (MSJCC) at community, institutional and public policy levels.

PART 1: SCOPE AND CONSEQUENCES

The target population of this advocacy statement are combat veterans that have served in the 33 year period starting in August 1990 with the Gulf War, through the events of September 11, 2001 up to the present covering the period of the War on Terror in the Middle East, such as Operation Desert Shield and Operation Enduring Freedom; 1990 to 2001 and post 9/11 to the present. The scope of this advocacy statement focuses on the severity of mental health issues, problems, and challenges faced by these combat veterans, the significant consequences, and a call to action.

Scope

The prevalence of mental health issues facing the 7.7 million combat veterans that served in the Gulf Wars during the War on Terror from August 1990 to the present (Vespa, 2020) has been widely reported by veterans organizations such as the Wounded Warrior Project (2022). There has been elevated public concern and media attention given to the extent of combat veteran's mental and physical health challenges. Mental health challenges that have received the most coverage include PTSD, sleep deprivation, anxiety, depression, suicide and substance abuse (Inoue et al., 2023).

Veterans by Period of Service: 2018

(Numbers in thousands)

Periods of service	Number of veterans		
	Total	Men	Women
All service periods	17,960	16,310	1,653
Post-9/11 (September 2001 or later)	3,764	3,132	632
Gulf War (August 1990 to August 2001)	3,804	3,247	557
Vietnam Era (August 1964 to April 1975)	6,384	6,146	238
Korean War (July 1950 to January 1955)	1,306	1,268	38
World War II (December 1941 to December 1946)	485	463	22
Pre-World War II (November 1941 or earlier)	12	11	1
Peacetime only (All other periods not listed above)	4,034	3,653	382

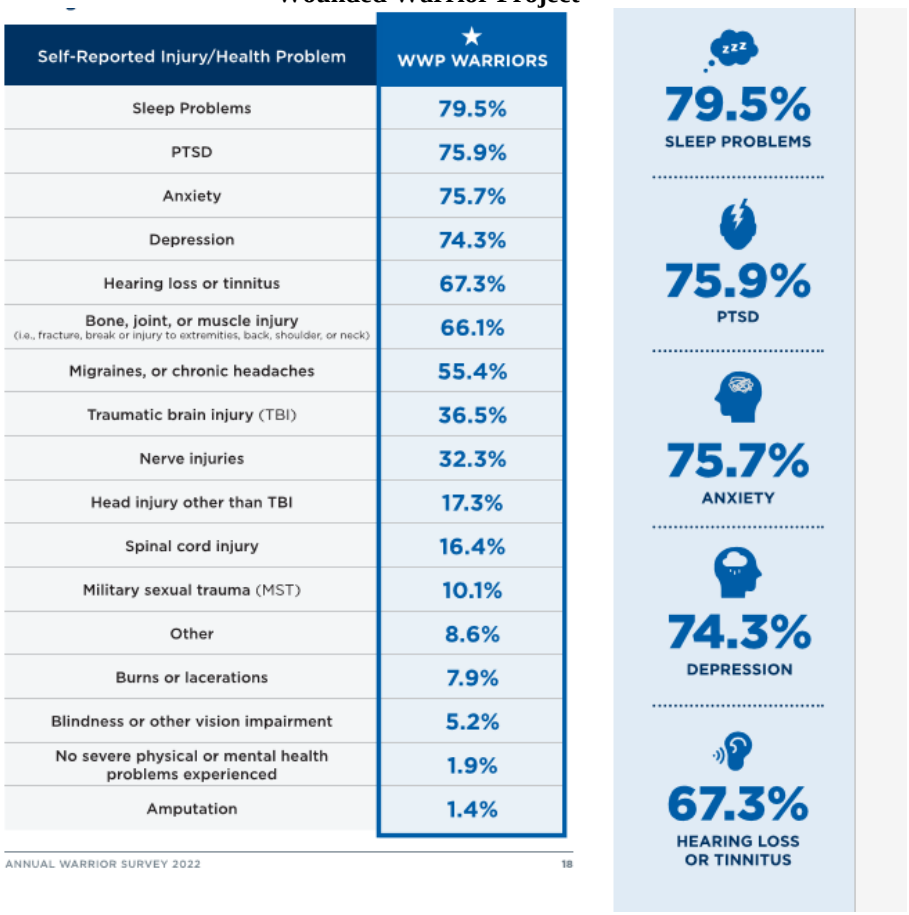
Note: Except for peacetime only, the periods of service are not mutually exclusive. Veterans may have served at any point during the time listed for the service periods; they may not have necessarily served in the war for which the period is named. Data based on sample. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see <www.census.gov/acs>.

Source: U.S. Census Bureau, 2018 1-Year American Community Survey.

Adapted from *Those who served: America's Veterans from World War II to the War on Terror* by J. Vespa, 2020. U.S. Census Bureau. American Community Survey Report.

Of the 7.7 million combat veterans who served between 1990 and the present, Wounded Warrior Project (2022) membership is approximately 165,000 of these combat veterans, where sleep deprivation, PTSD, anxiety, and depression are the leading mental health issues.

Combat Veteran Self-Reported Service-Related Injuries and Health Problems, Wounded Warrior Project



Self-Reported Injury/Health Problem	★ WWP WARRIORS
Sleep Problems	79.5%
PTSD	75.9%
Anxiety	75.7%
Depression	74.3%
Hearing loss or tinnitus	67.3%
Bone, joint, or muscle injury (i.e., fracture, break or injury to extremities, back, shoulder, or neck)	66.1%
Migraines, or chronic headaches	55.4%
Traumatic brain injury (TBI)	36.5%
Nerve injuries	32.3%
Head injury other than TBI	17.3%
Spinal cord injury	16.4%
Military sexual trauma (MST)	10.1%
Other	8.6%
Burns or lacerations	7.9%
Blindness or other vision impairment	5.2%
No severe physical or mental health problems experienced	1.9%
Amputation	1.4%

Adapted from *Annual Warrior Survey 2022.* Wounded Warrior Project. 2022.

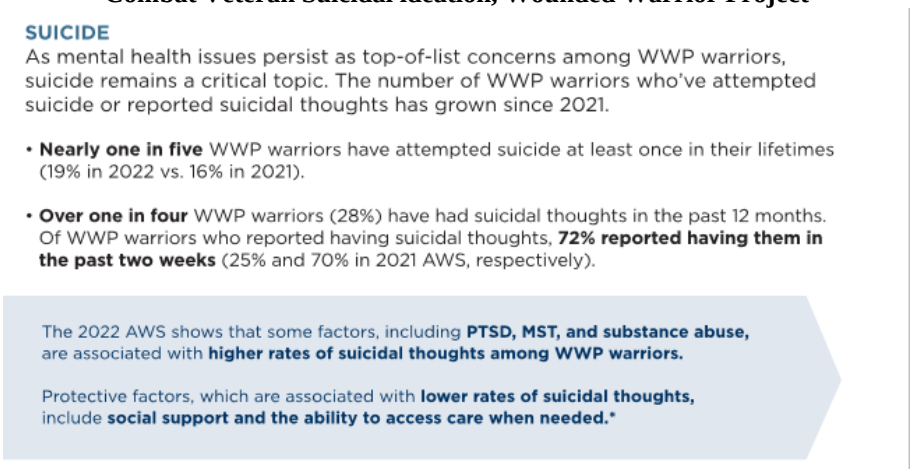
On a state basis, Alabama's reported veteran population as of 2019, was approximately 368,000 (National Center for Veterans Analysis and Statistics,2023). On a pro-rated basis using national data (Inoue et al., 2023; Vespa, 2020; Wounded Warrior Project, 2022) as a baseline, the estimated number of Alabama veterans that served in the Gulf War between August 1990 and August 2001, and those that served Post September 11, 2001, to the present is 154,600;,42 percent of the state veteran population. Assuming national trends for the veteran population in

Alabama, 74 to 80 percent are experiencing sleep problems, PTSD, depression and anxiety as the leading mental health issues in the state. By this measure between 114,000 and 123,000 veterans are experiencing significant mental health problems.

Consequences

The real and actual consequence of critical mental health issues that include PTSD, depression and substance abuse for combat veterans from the Gulf War between August 1990 and August 2001, and those that served Post September 11, 2001 to the present, is the possibility of suicide. According to Wounded Warrior Project (2022), nearly one in five combat veterans in their annual survey have attempted suicide, where another one in four have contemplated suicide pointing to the increased need for social support and access to requisite clinical mental health care.

Combat Veteran Suicidal ideation, Wounded Warrior Project



Adapted from *Annual Warrior Survey 2022.* Wounded Warrior Project. 2022.

Wounded Warrior Project (2022) reported that these mental health issues have remained at the top in 2021 and 2022, and comprise a significant percentage of this veteran population. A positive consequence of advocacy for this marginalized combat veteran population is the potential that these veterans would increase their involvement in support services such as

counseling, family and friends encouragement, and utilizing Veterans Administration mental health services.Wounded Warrior Project reported that of those combat veterans that have sought care for mental health issues, 66 percent confide in family and friends, over 60 percent interact with other veterans, nearly 60 percent take medication and about 55 percent seek care from the U.S. Veterans Administration or or participate in physical activity.

Mental Health Care and Support, Wounded Warrior Project

Adapted from *Annual Warrior Survey 2022.* Wounded Warrior Project. 2022.

Social Change Portfolio Goal Statement

The goal of Combat Veteran Mental Health Care Advocacy is to promote, support and draw attention to critical combat veteran mental health issues, such as PTSD, depression and substance abuse, where the real and actual consequence may lead to suicide.

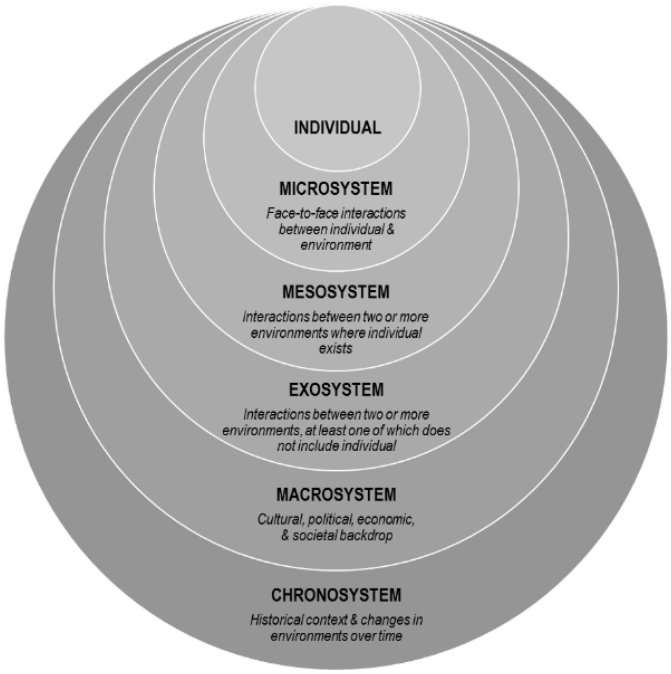
PART 2: SOCIAL-ECOLOGICAL MODEL

The Social-Ecological Model (Ecological Systems Theory, 2022; Hosek et al., 2008; Rogers et al., 2018) involves how the individual develops within a string of interconnected schemes where personal characteristics and environmental settings influence development. This interconnectivity continues throughout the life-span becoming more complex with reciprocal

exchanges involving individual, societal, and environment; comprised of local, regional, national and global communities referred to as ecological.

The Social-Ecological Model's design is concentric consisting of a individual, microsystem, mesosystem, exosystem, macrosystem and chronosystem scheme (Ecological Systems Theory, 2022; Hosek et al., 2008; Rogers et al., 2018). At the core of the Social-Ecological Model is the individual concentric circle or stage influenced by genetic

The Social Ecological Model



Adapted from *Utlizing an Ecological Framework to Enhance Counselor's Understanding of the U.S. Opioid* Epidemic by J.L. Rogers, D.D. Gilbride and B.J. Dew. 2018. *The Professional Counselor*, *8*(3), 226.

characteristics; birth date, gender, physical form, height, weight, hair color, eye color, skin color, and personality. This can be revised somewhat to include sexual orientation. The second concentric stage is microsystem that addresses the interactions an individual has on a face-to-face basis with people and their environment such as family, friends, classmates, teachers, teammates, coaches, colleagues, managers and bosses, spouse, and children on a daily basis (Ecological Systems Theory, 2022; Rogers, et al., 2018). The third concentric state is

mesosystem where interactions between two or more microsystems occur such as coach and parent or teacher and parent, on a positive or negative basis that may heavily support or hinder individual development throughout the life-span (Ecological Systems Theory, 2022; Rogers, et al., 2018). Environments where this broader interaction occurs include an individual's home, school, workplace or office, church, professional office, recreational complex, or medical and mental health clinic.

The fourth concentric circle is exosystem where two or more of the individual's environments interact, however at least one excludes the individual directly (Ecological Systems Theory, 2022; Rogers et al., 2018). In this system external events or circumstances outside the scope or purview of the individual affect them in a positive or negative manner. For instance, a hiring policy that excludes combat veterans on the basis that they are too emotional could limit their job opportunities, possibly resulting in unemployment and or homelessness.The fifth concentric circle macrosystem involves cultural, political, economic, societal and environmental systems that influence the community, state and region the individual lives in, the schools or universities available, education requirements for employment, occupational choices, maritial choices, and what medical and mental health services are available(Ecological Systems Theory, 2022; Rogers et al., 2018). The sixth concentric circle chronosystem centers on how the individual lives as a result of their developmental history which coalesce with the influences of their personal experiences, life transitions, and life events molded by cultural, political, economic, societal and environmental circumstances affecting development (Ecological Systems Theory, 2022; Rogers et al., 2018).

Risk and Protective Factors Relevant to Community Target Problem

Risk and protective factors for combat veterans from the Gulf War between August 1990 and August 2001, and those that served Post September 11, 2001, to the present have been researched and studied relevant to deployment and post-deployment mental health (Adams, et al., 2019; Adams et al., 2017). These studies have looked at deployment stressors such as combat exposure, unit cohesion, post deployment social connections and support, and demographic socio-economic status and gender. Risks include depression, substance and alcohol abuse, trauma such as PTSD and TBI, suicide ideation, direct combat stress and anxiety, noncombat stress of divorce and life experiences such as adverse childhood.

Preventive factors include strong social connections, social support, and psychological resources such as mental health therapy and counseling (Adams, et al., 2019; Adams et al., 2017). Veterans who have good to better social support have improved mental health and a reduced need for mental health service use, whereas those veterans with poor to bad mental health and high mental health service use have poor social help to manage psychological issues (Adams et al., 2017). The important of strong social connections and support cannot be undervalued (Ozbay et al., 2007). Social connections include family, friends, co-workers and acquaintances. Social support involves both the physical and emotional comfort given by social connections at the individual and community levels (Ozbay et al., 2007).

Social-Ecological Model Intersystem Influences

To understand how the combat veteran interconnects with others, the Social Ecological Model provides a format for this. We can use this model as described previously to illustrate the stages of life development and how the combat veteran interconnects with spouse, family, friends, colleagues, co-workers as well as to places or settings in a positive or negative way. At

the individual stage life-span development involves how the combat veteran self-identifies with their life experiences such as adversity, trauma, isolation. At the microsystem stage, the combat veteran is involved or not involved with social connections involving spouse, family, friends, colleagues, and co-workers. At the mesosystem stage, the combat veteran is or is not interconnected with social support, and mental health services that provide a positive or negative outcome influencing behavior. At the exosystem stage, the combat veteran is affected by federal policy concerning veteran mental health care treatment for PTSD, depression, substance/alcohol abuse and suicide ideation. At the macrosystem stage, political, social and economic policy changes affecting employment, social acceptance influence the combat veterans' life, interconnection with family, others. At the chronosystem stage, the positive or negative aggregate life span experience directly impacts how the combat veteran engages mental health services, interacts with others.

PART 3: THEORIES OF PREVENTION

Combat veteran substance abuse and alcoholism that leads to a compendium of substance related and addictive disorders calls attention to the essential importance of prevention strategies that include evidence-based therapy interventions to enhance and optimize treatment premised on health promotion and psychological theories (Castro, 2014; VA, 2022a). For the combat veteran community initial substance related and addictive disorders prevention comes about through deliberate and purposeful mental health care and support.

According to Wounded Warrior Project (2022), nearly 70 percent of combat veterans have sought help for combat related mental health issues resulting in stress, emotional difficulties and family problems that have lead to substance related and addictive disorders. Evidenced-based prevention and intervention strategies to optimize treatment for substance related and

addictive disorders in the combat veteran population are centered on three principal practices: increased screening and intervention, improved access to support services through the integration of mental health and substance abuse care, and enhancing coping skills for at risk veterans with or a potential of PTSD (EDC, 2017).

Combat Veterans Mental Health Care Support, Wounded Warrior Project

Adapted from *Annual Warrior Survey 2022.* Wounded Warrior Project. 2022.

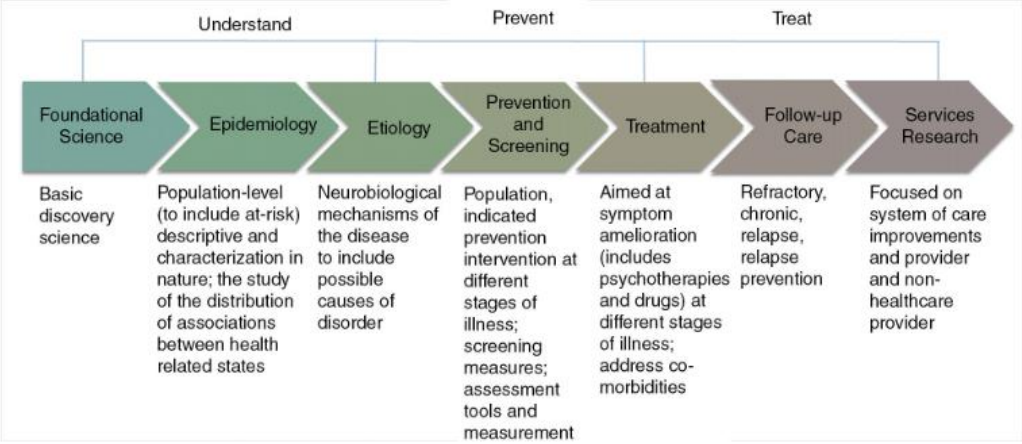
In a study by the Rand Corporation (Pedersen et al., 2020) four key findings were developed amplifying the need for mental health care treatment for post 9/11 combat veterans with a comorbidity of substance use disorders; apply to combat veterans of the Gulf Wars pre 9/11 as well. These findings are presented in the insert. The fourth finding on the integration of evidenced-based strategies is the fundamental focus of PART 3: *"…integrated, evidence-based approaches that address both substance use disorders and mental health disorders concurrently and provide ongoing support for recovery can improve outcomes for this population…"*(Pedersen et al., 2020).

Theoretical Models

Theoretical models that have applied evidenced-based pedigrees are strategic in the application of preventive measures for substance related and addictive disorders (Castro, 2014; VA, 2022a) resulting from combat trauma, as well as non-trauma. Effective programs that provide mental health care, reduce mental illness risks, promote positive mental health and impart mental health coping skills to enhance and boost the well-being and self-sufficiency of individuals and families that are founded on sound theoretical models and practices establish the foundation of and for evidence-based interventions (Rimer and Glanz, 2005). In conjunction with the Social Ecological Model for understanding how combat has affected life-span development for veterans that served from 1990 to the present, theories of evidenced-based prevention and treatment strategies for PTSD, other mental health disorders and substance abuse provide the technical knowledge for use in determining what advocacy issues essential help the combat veteran.

Understanding theoretical models of prevention and treatment and how they are used in the prevention and treatment of mental health illness, promote positive mental health and impart mental health coping skills enhance that boost the well-being and self-sufficiency of combat veterans and families is essential when advocating for improved health care for veterans. Two models that have applied evidenced-based pedigrees include: the military Psychological Health Research Continuum model or PHRC (Castro, 2014), and the Social Cognitive Theory, or SCT, model (Rimer & Glanz, 2005) is associated with CBT's cognitive processes-goals, goal setting, and development of self-efficacy focused on changing personal behavior from negative to positive.

Psychological Health Research Continium Model



Adapted from *The U.S. Framework for Understandin, Precenting, and Caring for the Mental Health Needs of Service Memvbers who Served in Combat in Afghanstand and Iraq: A Brief Review of the Issues and the Research*. C. A Castro. 2014. *European Journal of Psychotraumatology*. 5, 10.3402/ejpt.v5.24713.

The PHRC (Castro, 2014) is arranged into three primary contimuum stages: Understand, Prevent, and Treat. The Understand stage contains three domains: Foundational Science, Epidemiology, and Etiology. The Prevent stage contains the Prevention and Screening domain and shares the Treatment domain with the Treat stage that contains Follow-up Care and Services Research domains. Prevention involves screening and assessment, whereas Treatment involves the actually execution of therapies to ameliorate or improve the substance related and addictive disorder. See the Psychological Health Research Continiuum Model graphic.

The Social Cognitive Theory, or SCT, model (Rimer & Glanz, 2005) is premised on three influential health processes: personal, environmental and human behavior affected by three factors: self-efficacy, goals, and outcome expectations. Fundamentally associated with CBT in terms of the cognitive processes of goals, goal setting, and development of self-efficacy, the SCT focuses on changing personal behavior from negative to positive. Similarly based on Bandura's Social Learning Theory (Bandura 1977, 1999; Bandura & Locke, 2003), Deci and Ryan's Self-Determination Theory (Ryan & Deci, 2000), and Skinner's operant conditioning theory (Skinner, 1963), SCT emphasizes that the individual learns by personal experience, observation,

The Social Cognitive Model

Concept	Definition	Potential Change Strategies
Reciprocal determinism	The dynamic interaction of the person, behavior, and the environment in which the behavior is performed	Consider multiple ways to promote behavior change, including making adjustments to the environment or influencing personal attitudes
Behavioral capability	Knowledge and skill to perform a given behavior	Promote mastery learning through skills training
Expectations	Anticipated outcomes of a behavior	Model positive outcomes of healthful behavior
Self-efficacy	Confidence in one's ability to take action and overcome barriers	Approach behavior change in small steps to ensure success; be specific about the desired change
Observational learning (modeling)	Behavioral acquisition that occurs by watching the actions and outcomes of others' behavior	Offer credible role models who perform the targeted behavior
Reinforcements	Responses to a person's behavior that increase or decrease the likelihood of reoccurrence	Promote self-initiated rewards and incentives

Adapted from the *Theory at a Glance: A Guide for Health Promotion Practice*. B. K. Rimer and K. Glanz, K. (2005). Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Cancer Institute.

and self-effiacy. The model's foundation is based on six concepts: reciprocal determinism, behavorial capability, expectations, self-efficacy, observational learning, and reinforcement, where self-efficacy is the most critical.

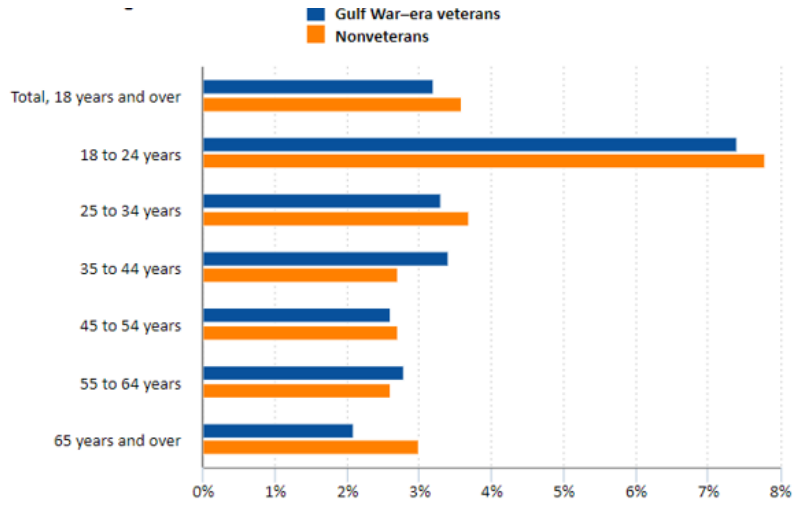
Therapy modalities in support of the PHRC and SCT models that have been found to have efficacy in helping combat veterans with a compendium of substance related and addictive disorders that are premised on cognitive and exposure therapies (American Psychological Association, 2017; Castro, 2014; Galovski, et al., 2022; VA, 2022 a; VA, 2022 b; Watkins, et al., 2018) include cognitive behavior therapy (CBT), cognitive processing therapy (CPT), and cognitive therapy (CT). According to Watkins, et al. (2018), "*each of these treatments has a large evidence-base showing their effectiveness. These treatments are all trauma-focused, which means they directly address memories of the traumatic event or thoughts and feelings related to the traumatic event".*

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

The issue of diversity is of particular importance within the U.S. demographic, and includes the targeted marginalized population of combat veterans from the Gulf War between August 1990 and August 2001, and those that served Post September 11, 2001. So why is the targeted marginalized population of combat veterans from the Gulf War between August 1990 and August 2001, and those that served Post September 11, 2001considered for possible diversity and ethical considerations. Brooks (2021) in her online article *"How To Include Veterans In Your DEI Plan"* answered the question in writing that DEI (diversity, equity, inclusion) plans that typically involve culture, age, gender, sexuality, disability, race, and nationality, must also include veterans. Gonzalez and Simpson (2020) contend that a diversity perspective gives insight into including veterans as a diverse social group in the workplace.

A critical by-product of combat veteran mental health issues is unemployment. The most affected subgroup of combat veterans perhaps facing the most diversity are 18- to 24-year-old combat veterans with the highest rate of unemployment of all veterans in the total Gulf War era veteran population, as well as non-veterans that cover the same period (Williams, 2020). This group includes young men and women from all representative races and ethnicities in the military veteran population. The following graphic presented by the U.S. Bureau of Labor Statistics (Williams, 2020) illustrates the significance of this issue in terms of the relative percentage size of the 18 to 24 year old Gulf War era veteran.

Unemployment Rates of Gulf War Era-Veterans and Nonveterans by Age, 2019 Annual Averages



Adapted from *Gulf War Era Veterans in the Labor Force.* J. Williams. 2020. U.S. Bureau of Labor Statistics. Division of Labor Force Statistics

The incidence of unemployment in the 18 to 24 year old subset of the population of combat veterans from the Gulf War between August 1990 and August 2001, and those that served Post September 11, 2001 to the present, is further evidenced by the Bureau of Labor Statistics (Williams, 2020) employment status of veterans as of 2022 illustrated by the following table. For the Gulf War era total 18 to 24 year old unemployment is 8.8 percent, the largest unemployment subset of this population.

Employment Status of Persons 18 Years and Over By Veteran Status for Gulf War Veterans and Total Veterans, 2022 Annual Averages

[Numbers in thousands]

Veteran status, age, and period of service	Civilian noninstitutional population	Civilian labor force						Not in labor force
		Total	Percent of population	Employed		Unemployed		
				Total	Percent of population	Total	Percent of labor force	
TOTAL VETERANS								
Total, 18 years and over	18,370	8,807	47.9	8,557	46.6	250	2.8	9,563
18 to 24 years	297	204	68.7	186	62.7	18	8.8	93
25 to 34 years	1,460	1,225	83.9	1,176	80.6	49	4.0	235
35 to 44 years	2,140	1,793	83.8	1,752	81.9	41	2.3	347
45 to 54 years	2,542	2,092	82.3	2,047	80.5	45	2.2	450
55 to 64 years	3,400	2,188	64.4	2,139	62.9	50	2.3	1,211
65 years and over	8,531	1,305	15.3	1,257	14.7	48	3.7	7,226
Gulf War era, total								
Total, 18 years and over	8,138	6,222	76.5	6,053	74.4	169	2.7	1,916
18 to 24 years	297	204	68.7	186	62.7	18	8.8	93
25 to 34 years	1,460	1,225	83.9	1,176	80.6	49	4.0	235
35 to 44 years	2,140	1,793	83.8	1,752	81.9	41	2.3	347
45 to 54 years	2,293	1,903	83.0	1,862	81.2	41	2.1	390
55 to 64 years	1,393	962	69.0	944	67.8	17	1.8	432
65 years and over	555	136	24.4	132	23.8	4	2.8	419

Adapted from *Employment Situation of Veterans-2022.* Bureau of Labor Statistics. 2023. News Release. Bureau of Labor Statistics. U.S. Department of Labor.

For the female veteran in the 18 to 24 year old age bracket; see the following table, unemployment is at 10.2 percent of the total for the gross veteran population, as well as for the Gulf War era population.

Employment Status of Women 18 Years and Over By Veteran Status for Gulf War Veterans and Total Veterans, 2022 Annual Averages

[Numbers in thousands]

Veteran status, age, and period of service	Civilian noninstitutional population	Civilian labor force						Not in labor force
		Total	Percent of population	Employed		Unemployed		
				Total	Percent of population	Total	Percent of labor force	
VETERANS, WOMEN								
Total, 18 years and over	2,027	1,191	58.7	1,158	57.1	33	2.8	837
18 to 24 years	81	43	53.1	39	47.7	4	10.2	38
25 to 34 years	259	209	81.0	202	78.3	7	3.3	49
35 to 44 years	408	326	79.9	319	78.1	7	2.2	82
45 to 54 years	368	274	74.4	269	73.0	5	1.9	94
55 to 64 years	456	259	56.8	253	55.5	6	2.2	197
65 years and over	455	79	17.3	75	16.5	4	4.5	376
Gulf War era, total								
Total, 18 years and over	1,369	971	70.9	946	69.1	25	2.6	398
18 to 24 years	81	43	53.1	39	47.7	4	10.2	38
25 to 34 years	259	209	81.0	202	78.3	7	3.3	49
35 to 44 years	408	326	79.9	319	78.1	7	2.2	82
45 to 54 years	326	243	74.6	239	73.2	4	1.8	83
55 to 64 years	225	133	59.2	131	58.4	2	1.4	92
65 years and over	71	16	22.9	16	22.5	0	–	55

Adapted from *Employment Situation of Veterans-2022.* Bureau of Labor Statistics. 2023. News Release. Bureau of Labor Statistics. U.S. Department of Labor.

Possible reasons for high unemployment within the 18- to 24-year-old combat veteran population include lack of relevant qualifications and experience, difficulty in translating military skills to civilian, adverse employer view of young veterans, culture, gender, and physical and mental health disabilities (Fisher et al., 2021); although this impacts the aggregate combat veteran target population as well. Most likely, key reasons are lack of transferrable skills, education, job opportunities as well as diversity issues of race, gender, culture, and ethnicity. In relative terms then, of the 18 to 24 year old combat veteran population facing their own set of diversity issues, nearly 20 percent are women veterans that adds another layer of diversity barriers.

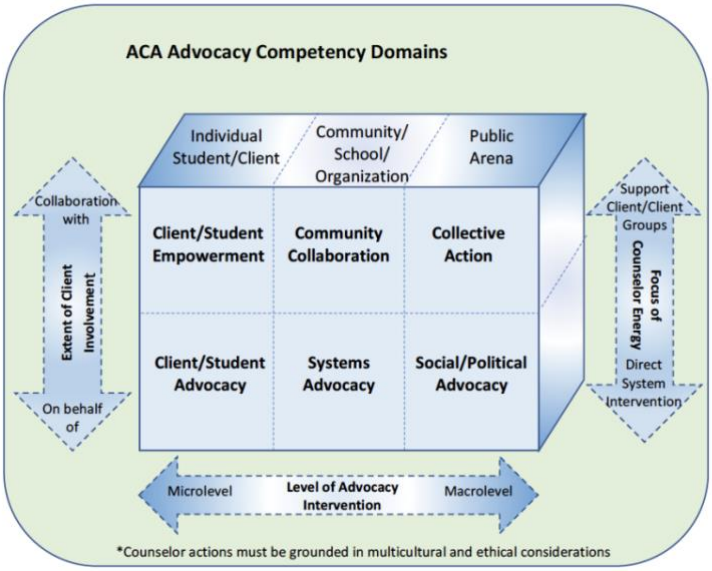
The American Counseling Association Code of Ethics (ACA, 2014) Section B, subsection B.1.a. Multicultural/Diversity Considerations requires counselors to respect diversity

and multicultural confidentiality. Section C, subsection C.2.a. addresses the counselor's professional responsibility to "*gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population*." (Graham, 2022). Ethical considerations involve awareness, understanding and sensitivity of the mental health impact PTSD, TBI, depression, substance abuse, and the potential for comorbidity of mental health issues that affect the combat veteran exiting from the military. One critical consideration is an understanding of how these mental health issues affect the combat veterans' employment opportunities, particularly the 18- to 24-year-old combat veteran. Acknowledgement and understanding of diversity and ethical issues facing the combat veteran, as well the mental health issues that affect all aspects of the combat veterans' life including unemployment opportunities, is necessary in advocating for all of them.

PART 5: ADVOCACY

ACA Code of Ethics, Section A.7. Roles and Relationships at Individual, Group, Institutional, and Societal Levels, subsection A.7.a. Advocacy, requires mental health counselors to advocate at *"individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients*" (ACA Code of Ethics, 2014). ACA Multicultural and Social Justice Counseling Competencies' Doman 4: counseling and advocacy interventions (Ratts et al., 2016; Toporek & Daniels, 2018) indicate these barriers include individual, community and political power, privilege, oppression and social group statuses that impact and may thwart the success of social justice advocacy. As a guide in challenging these barriers, the ACA has developed Advocation Competency Domains for individual, community and public advocacy intervention that ranges from the microlevel to the macrolevel (Toporek & Daniels, 2018) in meeting ACA Code of Ethics, Section A.7 objectives (ACA Code of Ethics, 2014).

ACA Advocacy Competency Domains



Adapted from *Advocacy Competencies.* R. L. Toporek & J. Daniels. 2018. American Counseling Association

Ratts et al., (2016) suggest employing advocation interventions and strategies *"at the intrapersonal, interpersonal, institutional, community, public policy, and international/global levels"*. Advocating on behalf of veterans mental health care needs, services and socio-economic inclusivity requires a much bigger, collaborative effort to influence and affect social-political mental health issues that falls within the macrolevel arena (Toporek & Daniels, 2018). An example of a macrolevel advocacy for the the target marginalized population of combat veterans from the Gulf War between August 1990 and August 2001, and those that served Post September 11, 2001 is to promote, support and as much as possible campaign for federal legislation that improves their mental health care and services. Using the ACA Advocacy Toolkit (ACA, n.d.) and collaborating with the American Psychological Association, the American Psychiatric Association, and veterans groups and organizations such as Wounded Warriors Project, PTSD Foundation of America, AMVETS, and DAV, advocacy actions can be undertaken to improve, combat veteran mental health care inclusivity.

Presently, they are three pieces of Federal legislation before Congress that will improve mental health care for all veterans, including, and perhaps especially for the target marginalized population of combat veterans from the Gulf War between August 1990 and August 2001, and those that served Post September 11, 2001. These are:

- STRONG Veterans Act of 2022 (H.R.6411) – To amend title 38, United States Code, to make certain improvements in the mental health care provided by the Department of Veterans Affairs, and for other purposes.
- Honoring our PACT Act of 2021 (H.R.3967) - The bill provides eligibility for Department of Veterans Affairs (VA) medical care, including mental health services and counseling, to veterans who (1) participated in a toxic exposure risk activity (a qualifying activity that requires a corresponding entry in an exposure tracking record system), (2) served in specified locations on specified dates, or (3) deployed in support of a specified contingency operation.
- Improving Access to Behavioral Health Integration Act (S.4306) – Bill supports integration of behavioral health services into primary care practices and amends the Public Health Service Act.

To summarize this author's perspective on why advocating for improved and full coverage of mental health benefits for veterans, particularly those in the targeted marginalized population of combat veterans from the Gulf War between August 1990 and August 2001, and those that served Post September 11, 2001, reference to a combat veteran's own personal experience explains why. Tom Smoot (2023) is a combat veteran from this marginalized population who has PTSD and experienced suicide ideation. Smoot (2023) states that veterans do not feel understood by the civilian population and that they are not seen as a viable part of the

menal illness issues of this country, principally about the degree and level of their invisible wounds.

The combat veteran feels isolated, misunderstood and tends to disassociate from family, friends, people, and in general avoid dealing with or confronting popular misguided and erroneous misconceptions about combat veterans and their invisible wounds. This heavily influences how often they use mental health care services at the U.S. Department of Veterans Affairs, as well as from individual mental health care providers, or simply not at all. Taking the step to stand with these heroes in an advocacy position supporting federal legislation and efforts by veterans groups like Wounded Warrior Project (WWP) through their WWP Operation Advocacy; see https://www.woundedwarriorproject.org/programs/government-affairs/operation-advocacy, in effort to include them as a represented marginalized population is my advocacy position. I can say I am from a military family, I stand with you, and I understand your invisible wounds.

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