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BRIDGING THE GAP: G.I. BILL POLICY REFORMS FOR MENTAL HEALTH EQUITY

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Abstract
Following World War II, an influx of 15 million servicemen and women returned to the United States, yearning to reintegrate into civilian life. The instrumental intervention of the G.I. Bill, championed by the Roosevelt administration, proved pivotal in providing federal support for crucial services like healthcare, education, home acquisition, and entrepreneurial endeavors. Through multiple amendments, including the Post 9/11 G.I. Bill, the focus has shifted towards bolstering access to benefits, extending entitlements to families, and addressing disparities in educational accessibility (Kleykamp, 2013). However, the specter of invisible disabilities, particularly mental illness, continues to cast a long shadow over this population. While strides have been made in the transitional process, veterans grapple with formidable obstacles, often facing unperceived and unmet needs within a system meant to support them (Boulton, 2014). Despite soaring demand, mental health services for veterans remain hindered by formidable barriers, and in some instances, remain frustratingly inaccessible (Spirada et al., 2020). It is imperative to acknowledge that deeply ingrained social challenges often trace their roots to longstanding policies. Effecting change in the lives of veterans requires a thorough reexamination of the G.I. Bill.

Keywords: G.I. Bill, Veterans, Mental Health, Accessible Services, Social Policy.

1.1Brief Policy Description and Presenting Conflicts

By the end of the second world war, there were roughly 15 million men and women of service returning home to the United States hoping to resume civilian life. If not for the Roosevelt administration‟s G.I. Bill, many of those men and women would have been returning to poor if any prospects. The G.I. Bill provided federal aid for services such as healthcare and education, as well as assistance in the ability to purchase a home or start-up capital for a business. The bill has been amended several times, one of the more recent amendments being the Post 9/11 G.I. Bill which focused on access to benefits, family entitlement to benefits, i.e., the transfer of benefits from veterans to dependents, and inequities in education accessibility (Kleykamp, 2013). The invisible disability of mental illness continues to plague the population. Whereas some change can be measured between past and present, veterans are encumbered by considerable barriers in their return from service and their needs go unseen and unmet by entities designed to care for them (Boulton, 2014). Despite high demand, mental health services for vets, continue to be impeded by barriers if accessible at all (Spirada et al., 2020). Complex social issues are often rooted in older policies. Dismantling social issues that impact veterans cannot be done without taking a closer look at the G.I. Bill.

Following World War II, The G.I. Bill, then titled The Servicemen‟s Readjustment Act of 1944, was designed to help veterans make a smoother transition from military to civilian life. The more pertinent needs highlighted by the G.I. Bill focused on reintroducing veterans returning from war into the

workforce by providing housing, education, and vocational opportunities. The G.I. Bill proposed to meet important needs and provide resources, although had and continues to have limitations and gaps. Catastrophically, the G.I. Bill overlooked the complex mental health needs veterans require upon return from service.

Given the time of the G.I. Bill‟s design, mental health needs were not accounted for or even spoken much about for that matter, however, decades and several amendments later, the G.I. Bill and other policies surrounding vets continue to miss the mark on mental health. Initially termed "soldier‟s disease", which was replaced by

"shellshock",

What is now clinically labeled as Complex Post Traumatic Stress Disorder (C-PTSD) was not considered an endemic plague because symptoms were not as tangible as physical disease and disability were thus not quantified or considered in the same way (Loughran, 2012). Had mental health needs been given their due attention, they would have likely been quantifiable and understood for what they were. The problems were there, just not spoken about. At the time, mental health was an almost unknown vernacular, and several decades later still bears a strong stigma because of the inaccurate stereotypes attached to mental illness and the implicit shame felt by many in pursuing treatment (Boulton, 2014). Paradoxically, unmet mental health needs were and continue to be what most commonly account for the challenges and pitfalls veterans face. Furthermore, since the mid-1940s, the era of the G.I. Bill's advent, the definition of what deems one a veteran in application to eligibility for services and benefits has narrowed which further compromises accessibility.

A dishonorable or administrative discharge prohibits accessibility to post-service benefits and resources whereas an honorable or general discharge does not (Gannon, 2015). Lack of accessibility to effective mental health services, and for some, complete denial of access pending discharge status are two substantial challenges the population is impeded by (Okun & Selkow, 2015). As highlighted by Bovin et al. (2019), recent findings report that over 50% of service members in need of mental health services use neither Department of Veterans Affairs Services (VA) nor non-VA-based services. A concerning truth is that a large percentage of veterans are not receiving adequate or any treatment for serious conditions such as addiction, anxiety disorders, major depression, sleep disturbances, and C-PTSD. Most often these conditions present as a byproduct of experiences germane to war and deployment. Lack of access to services is a reoccurring conflict articulated by veterans, and there seems to be a lack of awareness about knowing what is offered under VA benefits and what constitutes eligibility. The VA has been under fire in recent years for issues such as paperwork processing delays, long wait times, and poor quality of mental health services **(**The Daily Journal of the United States Government, 2019). In fact, a growing trend is suicide completion in VA parking lots as a final expression of disdain (Axelrod, 2019); the GI Bill has not been amended to address this endemic crisis. War has a profound effect on members of service. Traumatic events and prolonged trauma exposure are often insurmountable for the human psyche to process and in speaking to the veteran population, become further compounded by physical disabilities and brain injuries. One way to measure the magnitude and consequences of unmet mental health needs is to examine the correlation between

suicide completion and veterans. Always a leading cause of death, suicide completion is now the leading cause of death for vets. With an average of 22 losses per day, suicide completion well exceeds combat and other war/deployment-oriented mortalities in veteran mortalities. It should be noted that the quantified 22 per day is likely inaccurate and quite lower than the reality as suicide completion can compromise access to benefits for survivors and affects a family‟s decision to disclose suicide as the cause of death (Cerel et al., 2015). The reason one takes their own life can never be understood or explained with absolute certainty, nor can the blame be assigned to another party. Alas, there are critical risk factors to consider that were likely present and going untreated or inadequately treated for the individual that takes their own life.

2.1 Socioeconomic, Sociopolitical & Psychosocial Factors That Explain the Problem

The U.S. military is a large organization with a long-standing history, and like all larger organizations, it has a specific culture, code of conduct, and even language. Although the military is one large institution, it is comprised of five branches (Coast Guard, Navy, Army, Marine Corps, Air Force) and is governed by three departments (The Department of the Navy, The Department of the Air Force, The Department of the Army). Not all branches of the military see combat, although all branches are intensely trained and prepared for war and defense whether domestically or overseas (Coll et al., 2010; DoD, 2017). It has been called to question if early traumatization begins in the training process. It is essential for soldiers to be trained for war and prepared for difficult operations, though such bears weight on the human psyche and deeply affects other parts of a soldier‟s life. It is also important to consider the trauma that one enters the service with. Military service has been a long-standing opportunity for young men and women who are a part of disenfranchised groups to be awarded greater advantages following service, making it more likely for those entering service to already have a history of trauma thus having a greater vulnerability in developing mental health challenges (Boulton, 2014; Gannon, 2015). Over time, the barriers surrounding access to quality care have exacerbated.

The different branches of the U.S. government designated to intervene in and mitigate such an endemic crisis still cannot seem to get it right when it comes to veterans and mental health. It would be unfair to place the entire blame of any complex issue on one party, although the onus of human services within the military is covered under the U.S. Department of Veterans Affairs, an agency of the federal government (Bovin et al., 2019).

When redesigning policy, it is the U.S. Department of Veterans Affairs and the legislation regulating it that must be reevaluated with the greatest rigor. A strong character aligned with an ethos bound by values such as courage, integrity, honor, loyalty, and commitment are characteristics often seen in members of service (Burton, 2020; Coll et al., 2011). Those that enlist, particularly when on the younger side, often come from complex backgrounds. As previously highlighted, joining the military for many is an opportunity to escape a dire situation. Enlisting with a potential history of trauma becomes further compounded by the experiences of war, making one more vulnerable to developing mental health issues (Boulton, 2014; Gannon, 2015). The stated complex backgrounds and potential history of trauma can make it challenging for a mental health provider to discern the genesis of a mental health issue; regarding systems, vets are multi-dimensional. Mental healthcare providers must see the individual in

context and comprehensively, making the social work lens ideal as it is a lens that measures systems and the impact those systems have had on an individual (CSWE, 2015; NASW, 2021). Clinicians are often working within the extremely narrow parameters of bureaucratic restrictions dictated by the VA. For example, limited session numbers and time windows, and a lack of funding allocations for clinicians to be trained in innovative treatment modalities designed to treat CPTSD. It can be argued that a central reason military-oriented policies, legislature, and systems often fail members of service is that they fail to see the individual both comprehensively and in context; symptoms are treated to poor effect, not the holistic individual (Russell, 2016; Spirada et al., 2020).

Most veterans receiving mental health services carry a diagnosis of Complex Post Traumatic Stress Disorder

(C-PTSD) (Cerel et al., 2015; Cloitre et al., 2021). C-PTSD is a neurological condition requiring a specific skill set to treat and often beyond the scope of practice for most clinicians within the network of what the Veterans Health Administration (VHA) will cover (Russell, 2016). Such is an example of how inequity creates barriers to accessing effective treatment. It should also be underscored that when C-PTSD is further compounded by a Traumatic Brain Injury (TBI), not uncommon given the population, the treatment approach becomes even more complex thus requiring a greater scope of practice on the clinician‟s part and a vastly different treatment plan (Okun & Selkow, 2015). As stated, clinicians of this caliber and skill set are commonly inaccessible and out of network which speaks to the greater crisis of managed care systems. High costs of treatment met by insufficient insurance coverage are the leading barriers as to why vets, most Americans for that matter, do not pursue mental health services (Russell et al., 2016; Seal et al., 2011). Service members and their families seem to place the onus of present disparities on the U.S. government and managed care systems not allocating enough funding or accessibility supports (Seal et al., 2011). Whereas lack of mental healthcare resources and barriers to accessibility are nationwide crises impacting all groups, in speaking to members of service, these needs should be addressed and met by policies such as the G.I. Bill. Since its inception, the G.I. Bill has been amended several times to meet the changing needs of veterans, yet mental healthcare gaps continue to be met with poor effect or overlooked entirely.

Although the more tangible barriers to treatment have been highlighted, veterans eligible for and able to access any treatment at all are sometimes the lucky ones. It is not just cost, insurance limitations, and geopolitics that present as barriers to treatment (Kleycamp, 2013). Accessibility is secondary to eligibility and eligibility to entitlement benefits weigh on the grounds of discharge. Vets being discharged without honor or administratively discharged are no longer eligible for certain resources and benefits. Although not as dire as a dishonorable discharge, administrative discharges greatly inhibit eligibility for benefits. Paradoxically, such discharges are often secondary to an act or behavior that occurred because of an untreated mental health issue. For example, common reasons one may find themselves being administratively discharged are substance misuse, conduct issues, conflict with peers and superiors, or insubordination. More reprehensible acts such as sexual assault or physical assault are examples of what would be cause for a dishonorable discharge. Acts such as the stated are often the consequence of extenuating circumstances meeting mental duress/mental illness. They are acts

committed by an individual lacking a sound mind and without treatment. A conundrum that is seen frequently within the general U.S. criminal justice system and very much so within the military (Day, 2010; Tarbet et al., 2020). The irony with veterans and mental healthcare is that their mental duress is often a byproduct of their experiences with the military- the same system that abandons them for afflictions incurred. The stated disparities of discharge status and what deems one an honorable veteran deserving of benefits become further compounded by race, which will be further expanded.

It is common, even probable for challenges to present after new policies are passed, i.e., conflicts in the implementation process. Between policy deliberation and actual implementation gaps are inevitable and most often found in equity; the population of interest often faces great barriers in accessing resources (Burtin, 2020; DeNitto & Johnson, 2016). It appears that some of the more fundamental intentions of the G.I. Bill were lost when put into effect, as it was then and remains to be not entirely inclusive or equitable. The advent of new bills such as HR 4683 and HR 4684 were designed to protect veterans from the inequities that present surrounding terms of discharge but have not been as effective in implementation as they were on paper (Burtin, 2020).

Suicide completion, the leading cause of death for veterans, is frequently the cause of death for veterans suffering from untreated or inadequately treated C-PTSD (Loughran, 2012). C-PTSD is quantified by a multisymptom profile and is a common reason for a soldier‟s inability to reacclimate well into civilian life, yet C-PTSD is not always considered as the untreated impetus that tragically results in a soldier taking their own life (Steinhauer, 2021). Mental health needs must be taken into greater consideration when designing policies and bills surrounding vets. More effective mental healthcare supports must be both available and perhaps more importantly, accessible. It is important to note that it is not just baseline mental health services that are needed. Mental health services must be provided by clinicians extensively trained in treating complex trauma because traditional talk-oriented modalities are at best moderately effective if effective at all, and at worst retraumatizing consequently making matters worse (Cloitre, 2021). Veterans present with a complex set of needs and understandably the more tangible and explicit needs, e.g., physical disability/disease are what have always garnered the most attention and advocacy. With mental health garnering more focus in the healthcare community, mental health services are becoming integral parts of treatment plans. The time has come to reform policies surrounding veterans, their specific needs, and most importantly, accessibility to effective services (Russell et al., 2016; Seal et al., 2011).

2.2 Disparities of Race

As with most U.S. policies and legislature surrounding larger institutions, disparities of race prevail. A first of its kind in providing men and women of service with the type of resources one might say are civil rights, the G.I. Bill was not inclusive. Minority groups such as African Americans were unable to access many of the benefits granted by the G.I. Bill, particularly housing opportunities, and the healthcare disparities surrounding African Americans were as present then as they are now (Day, 2010). Within the military criminal justice systems, African Americans are the first to be considered suspect and consequently investigated in the event of unlawful activity, another historical consistency that can still be seen across U.S. criminal justice systems. Veterans are at the behest of the Uniform Code of Military

Justice (UCMJ) and within that governing body, there are two ways service members face punitive charges. The first is court-martial, a stringent disciplinary system, the second is non-judicial punishment (NJP), a lenient disciplinary system by comparison. Recent statistics support that on average African American army veterans were 61% more likely to face court-martial in comparison to white veterans, specific to the Air Force, 71% were more likely to face court-martial, and within the Marines, 32% were more likely to be found guilty of crimes their white counterparts were exonerated from in both court-martial and NJP proceedings (Harmstrong, 2020). By comparison, African American veterans have historically received longer sentencing and more severe punitive actions. In a recent court hearing, testimony from the Government Accountability Office (GAO) established African American veterans were twice as likely to be tried both in the special court-martial and the general court systems (Burk & Espinoza, 2012). It appears that there is a systemic bias in how criminality is profiled within the military, which as stated, aligns with the general U.S. criminal justice system. These legal ramifications bear great weight on how one is discharged thus impacting terms of discharge and accessibility to services, resources, and treatment (Day, 2010; Horton, 2020). The highlighted disparities are unaccounted for in the G.I. Bill and left out of important conversations surrounding amendments, inclusion, diversity, and equity.

3.1 Policy Critique and Recommendations

Concerning mental health, the egregious suicide completion statistics are the loudest measure of veterans continuing to be a deeply underserved population. Suicide completion is a national health crisis greatly impacting members of service, and proactive action must be taken and regarded as the highest clinical priority surrounding vets (Hester, 2017). Combating this endemic will demand not only governmental action but the action of all public and private organizations. Reallocating existing funding to accommodate military mental health needs during active-duty years and requiring military personnel to have routine mental health check-ins facilitated by a mental healthcare provider must be a consideration for future practice.

Mental health providers consistently checking in on mental health status is akin to physical health being measured by fitness drills and regular physicals- a holistic approach that includes measuring mental health is imperative. Additionally, requiring mental health services beginning in the initial recruitment process through service completion would act as a proactive measure in keeping vets mentally sound. A stronger value for mental health, required check-ins, and the accessibility of services within or near bases will lend in keeping the mind well during active duty the way the above-stated physical fitness and physical check-ups keep the physical body healthy. Furthermore, if receiving regular mental health services was a requirement and something all members of the service were doing, the stigma often attached to mental health treatment might begin to dissipate. A broad range of mental health interventions and suicide prevention services are strategies that must be implemented to get ahead of the suicide completion rate.

The setbacks that present as a byproduct of government and bureaucracy are something to consider as well. Programs, benefits, and services provided are failing the population when put into practice by a broken system. As with all entities of government, the VA is encumbered with an excess of bureaucratic

red tape. The intake process alone is overwhelming, and the system is not easy to navigate (Bovin et al., 2019). Simplifying and modernizing the referral, paperwork, and intake process would likely be received well while benefiting both service recipient and provider. Inundating amounts of paperwork coupled with conservative reimbursement for limited sessions are often articulated by seasoned clinicians as the primary reasons they do not want to work with healthcare provided by the VA systems (Seal et al., 2011; Spirada et al., 2020). Most individuals are apprehensive and feel vulnerable when taking those initial steps in seeking mental health treatment. Bureaucratic systems are cumbersome and require a great deal of work on the part of the service recipient to receive services. Many individuals become disheartened before they have even made their first appointment. The bureaucracy and systems that entangle the VA and its subsequent branches can be discouraging when one is already feeling vulnerable, overwhelmed, and suicidal.

Policies can take a significant amount of time to be implemented. Strategies that advocate for federal, state, and local policy change such as those outlined by The National Roadmap to Empower Veterans and End Suicide must be put into action (The Daily Journal of the United States Government, 2019). For instance, regarding the stated 2019 executive order, practice implementation remains to be seen. Simultaneous support from social, community, and faith-based resources should also be considered adjuncts to treatment and necessary parts of the services veterans need. Such networks connect vets to a sense of community and belonging which is imperative in acclimating back to civilian life while honoring their experiences with military service. The first-year post-discharge appears to be the most critical and high-risk window for service members (Okun & Selkow, 2015). During this time a higher value should be placed on early engagement in connecting with vets and connecting vets to one another. Community-oriented, datadriven policies must be the wave of the future in treating the leading mental health challenges and barriers to accessibility that plague the population. Although not directly a mental health condition, homelessness is something to consider as well, for homelessness is quite often a consequence of mental illness and another endemic within the veteran population (Russell et al., 2016). During the first-year post-discharge the VA and other vet-oriented agencies/foundations, etc. must be proactive in regularly contacting recently discharged military personnel. Consistent outreach via home visits, phone, and email contact with an assigned caseworker would help make the transition to civilian life more seamless for individuals newly returning from service. For example, a social worker to explain VA benefits, begin paperwork processes, and attach veterans to services. It is also important to note that many are returning from service with physical disabilities as well as mental health disabilities. These needs must be considered and met. Speaking to the previously highlighted barriers that present pending one‟s discharge status- there is simply no room for such stipulations. Eradication of all policies and legislature supporting stipulations to service accessibility is paramount.

Barriers to accessibility appear to be the most prevailing gap- both tangible and cultural. If the G.I. Bill took greater consideration to mental health needs, the bureaucracy surrounding the VA might be easier to move through. Several decades and amendments later, the G.I. Bill, among other local, state, and federal policies continues to fall short in providing accessible and effective mental health interventions. In seeking care, allowing veterans to go outside of their incredibly bureaucratic healthcare network

would allow them to work with professionals clinically trained to treat their complex needs. The ability to work with mental healthcare providers having such a background is ironically not a guarantee of what veterans‟ benefits will cover through the VA. In more remote parts of the country, the odds of working with a clinician trained in treating trauma become even narrower (Coll et al., 2011; Hester, 2017).

Coordinating with nonprofit organizations and academia can provide important research information to VA and subsequent VA systems that can be used to develop better evidence-based practices. For example, identifying where the research gaps are by interviewing agency staff that serves the population or running meta-analyses on existing data to better identify high-risk factors. Requiring future clinicians and currently employed clinicians to be trained in the specific modalities that treat C-PTSD and other mental health issues densely afflicting vets must be a strong consideration as well.

Of utmost importance surrounding all legislature and policy- members of the population the proposed policies will serve must be involved in the policy-making process as no other party can identify their needs with greater accuracy (DeNitto & Johnson, 2016). Whereas policy reform is necessary, and must evolve to meet changing needs, so must the schools of thought surrounding mental health and accessing services. It would be unfair to ignore that seeking help goes against the grain of military culture. It is a greater system ingraining the school of thought that seeking help is contradictory to perseverance. The shame and stigma attached to mental illness and seeking mental health services are exacerbated within military culture, creating an intrapersonal barrier to service in addition to other conflicts of accessibility (Coll et al., 2011). Culture reform and the stereotypes attached to accessing mental health services must begin to reflect a different narrative. Mental health awareness must be embraced as a sign of strength and intelligence by military culture, not weakness and incompetence. The need for one to exemplify courage and strength under all circumstances must change to embrace the nuances of human experience.

4.1 Summary

Hope is not lost, and actual change might be underway. Congress‟s acknowledgment and interest in the conflicts highlighted is a start. In speaking to policy and legislative change, the attention of Congress is always imperative. Although systemic changes require more than a few policy modifications, recent policies such as section 5401 of the 2020 National Defense Authorization Act support movement in the direction of sustainable systemic change, as does section 5401 of the 2020 National Defense Authorization Act which requires the Secretary of Defense to assess disparities of not just race, but other minority identities within the military justice system (Harmstrong, 2020; National Defense Authorization Act, 2020). In assessing such disparities, long-overdue change is being galvanized to address the foundations of those disparities in pursuit of eradicating them. Furthermore, men and women of service in the early stages of training are advocating for change, equality, inclusion, and better support systems; grassroots sociopolitical evolution is on the rise. Generations ago newly minted service members would not dare push back or protest for better resources, services, and general treatment. The unmet mental health needs impacting veterans are being exposed as hard conversations are had and awareness is raised (Steinhauer, 2021). For now, like the rest of the country, the military

continues to push forward while wrestling with pervasive social issues such as access to mental health treatment and criminal justice reform. Veterans and advocates are asking for change and better in terms of equality, equity, and access to what are essentially human rights resources. Human rights that should not be grossly hedged by legislature and policy, alas, they are.

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