

Back to Week at a Glance

NEEDS ASSESSMENT CASE STUDY

As a counselor, you will individualize services for clients. It is important for you to understand how to conduct a needs assessment to help you know how to create new services that will meet the needs of your clients or the clients of an agency. Keep in mind that a needs assessment and program evaluation are not synonymous. A Needs Assessment will show you what services are needed for your clients, while a program evaluation will tell you whether services that have already been delivered were effective for your clients. You will dig deeper into program evaluations next week.

For this Assignment, you will review a case example of a needs assessment and make a recommendation for program development based on the data that was collected.

RESOURCES

Be sure to review the Learning Resources before completing this activity. Click the weekly resources link to access the resources.

WEEKLY RESOURCES

To Prepare

- Review the Needs Assessment Worksheet found in the Learning Resources and consider the requirements for this Assignment. Specifically:
 - Review the case study.
 - Answer all questions in the worksheet.

Assignment

Imagine you are a task force or part of a task force charged with making a decision about the development of a new program. Your job is to review the data that was collected and complete a Needs Assessment Worksheet that will help you determine whether a new program should be developed and for which populations it will be helpful.

- As an individual part of a task force or in your small group task force, complete the Needs Assessment Worksheet.

Note: Please include your name on the worksheet in the section if you worked individually or include your name along with the names of the group members if you worked as part of a group.

COUN_6626F_Week8_Assignment_Rubric

Criteria	Ratings			
<p>This criterion is linked to a Learning Outcome Responsiveness: By Day 7, complete and submit your Needs Assessment Worksheet Assignment.</p>	<p>4 to >3.5 pts A (90.00% to 100.00%) Paper is responsive to and exceeds the requirements given in the instructions. It:... 1.) Responds to assigned or selected topic;... 2.) Goes beyond what is required in some meaningful way (e.g., ideas contribute a new dimension to what we know about the topic, unearths something unanticipated, etc.)</p>	<p>3.5 to >3.1 pts B (80.00% to 89.9%) Paper is responsive to and meets the requirements given in the instructions. It:... 1.) Responds to the assigned or selected topic;... 2.) Addresses each point of the assignment.</p>	<p>3.1 to >2.7 pts C (70.00% to 79.9%) Paper is somewhat responsive to the requirements given in the instructions. It:... 1.) Somewhat misses the point of the assigned or selected topic; and/or... 2.) Addresses less than all of the points of the assignment but more than half.</p>	<p>2.7 to >0 p F (0% to 0%) Paper is unresponsive to the requirements given in the instructions. It... 1.) Does not address the point of the assigned or selected topic; 2.) Does not address any of the points of the assignment.</p>

COUN_6626F_Week8_Assignment_Rubric

Criteria	Ratings			
<p>This criterion is linked to a Learning Outcome</p> <p>Content Knowledge: The extent to which the content in the paper or writing assignment demonstrates an understanding of the important knowledge the paper/assignment is intended to demonstrate.</p>	<p>8 to >7.1 pts A (90.00% to 100.00%) The paper demonstrates:... 1.) In-depth understanding and application of concepts and issues presented in the course (e.g., insightful interpretations or analyses; accurate and perceptive parallels, ideas, opinions, and conclusions) showing that the student has absorbed the general principles and ideas presented and makes inferences about the concepts/issues or connects to them to other ideas;... 2.) Rich and relevant examples;... 3.) Thought-provoking ideas and interpretations, original thinking, new perspectives;... 4.) Original and critical thinking; and... 5.) Mastery and thoughtful/accurate application of knowledge and skills or strategies presented in the course.</p>	<p>7.1 to >6.3 pts B (80.00% to 89.9%) The paper demonstrates:... 1.) Understanding and application of the concepts and issues presented in the course demonstrating that the student has absorbed the general principles and ideas presented;... 2.) Relevant examples;... 3.) Thought-provoking ideas and interpretations, some original thinking; and... 4.) Critical thinking; and... 5.) Mastery and application of knowledge and skills or strategies presented in the course.</p>	<p>6.3 to >5.5 pts C (70.00% to 79.9%) The paper demonstrates:... 1.) Minimal understanding of concepts and issues presented in the course, and, although generally accurate, displays some omissions and/or errors; and/or... 2.) Few and/or irrelevant examples; and/or... 3.) Few if any thought-provoking ideas, little original thinking; and/or... 4.) "Regurgitated" knowledge rather than critical thinking;... 5.) Little mastery of skills and/or numerous errors when using the knowledge, skills or strategies presented in the course.</p>	<p>5.5 to >4.7 pts D (60.00% to 69.9%) The demonstration of understanding of concepts and issues presented in the course, and/or inaccurate information; and/or errors; and/or... 2.) Few and/or irrelevant examples; and/or... 3.) Few if any thought-provoking ideas, little original thinking; and/or... 4.) "Regurgitated" knowledge rather than critical thinking; and/or... 5.) Little mastery of skills and/or numerous errors when using the knowledge, skills or strategies presented in the course.</p>

LEARNING RESOURCES

Required Readings

- Agramovich, R. L. (2011). *Needs assessment: A key evaluation tool for professional counselors* Download *Needs assessment: A key evaluation tool for professional counselors*. Retrieved from http://www.counseling.org/resources/library/MISTAS/2011-V-Online/Article_41.pdf
- Ellison, M., Mueller, L., Smelson, D., Corrigan, P. W., Torres Stone, R. A., Bokhour, B. G., & Drebing, C. (2012). Supporting the education goals of post-9/11 veterans with self-reported PTSD symptoms: *A needs assessment* [Links to an external site.](#) *Psychiatric Rehabilitation Journal*, 35, 209–217. doi:10.2975/35.3.2012.209.217.
- Harrar, W. R., Affsprung, E. H., & Long, J. C. (2010). Assessing campus counseling needs. *Journal of College Student Psychotherapy*, 24(3), 233–240. doi:10.1080/87568225.2010.486303
Note: You will access this article from the Walden Library databases.
- **Document:** *Needs Assessment Worksheet*

Needs Assessment Worksheet

Name of Student:	Names of Group Members:
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Read the following case study, review the data set, and answer the subsequent questions:

Case Study: Laurie is a professional counselor who works for a community mental health center in a rural area. In consultation with her colleagues, Laurie has identified 14 adolescents who currently participate in outpatient individual services who could potentially benefit from services specific to sexual abuse. Laurie would like to develop a psychotherapy counseling group to meet the needs of teens who have been sexually assaulted as an alternative or enhancement to individual therapy.

In an effort to establish services that will best meet the needs of the clients, Laurie has conducted a Needs Assessment. She will present her findings to the mental health center administrators as evidence to support her group counseling proposal. Analyze the following data and determine whether enough evidence exists to support the development of the psychotherapy counseling group.

Survey

After securing parental permission, adolescents were asked to answer the following questions. Results for each question are included.

1. Age
2. Gender
3. Interest in group counseling
4. Topics of interest for a psychotherapy counseling group

Participant #	Age of Child	Gender	Interest in Group Counseling
1	15	F	Yes
2	10	M	Yes
3	13	F	Yes
4	12	F	Yes
5	10	F	Yes
6	14	F	Yes
7	17	M	No
8	16	M	No

9	12	M	Yes
10	11	F	No
11	15	M	No
12	9	F	Yes
13	11	F	No
14	16	M	No

4. Rank the TOP THREE issues that you feel would be most important to you in a psychotherapy counseling group

1. Anger Management
2. Stress Reduction
3. Coping Skills
4. Assertiveness Training
5. Alcohol and Drug Prevention
6. Peer Pressure
7. Grief
8. Self Esteem
9. Recovery from Sexual Abuse/Assault
10. Communication Skills

Participant #	1st Choice	2nd Choice	3rd Choice
1	9	2	3
2	3	8	9
3	7	8	9
4	5	9	3
5	6	9	10
6	9	7	8
7	9	3	2
8	2	9	8
9	8	6	9
10	3	9	8
11	9	8	3
12	4	6	10
13	8	2	9
14	10	9	3

What is the purpose of Laurie's Needs Assessment? (Remember to consider the initial reason Laurie is considering a psychotherapy counseling group.)

What is the population of interest and who are the stakeholders for this Needs Assessment? (Think about everyone that is involved in this situation.)

Compute the mean age of all proposed participants in the psychotherapy group.

What percentage of adolescents expressed interest in the proposed psychotherapy group?

Based on the data provided, how did teens rank the topics presented as possible options for the therapy groups? What topics were identified as the top three?

Based on the information provided, what evidence exists that supports establishing a psychotherapy counseling group addressing student recovery from sexual abuse/assault? Is there other information that is missing that could be useful to make this decision?

In your opinion, did Laurie's approach to data collection address the purpose of the Needs Assessment? Why or why not? (Did Laurie get the information she needed to support creating a psychotherapy counseling group?)



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VISTAS Online

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Suggested APA style reference: Astramovich, R. L. (2011). *Needs assessment: A key evaluation tool for professional counselors*. Retrieved from http://counselingoutfitters.com/vistas/vistas11/Article_41.pdf

Article 41

Needs Assessment: A Key Evaluation Tool for Professional Counselors

Randall L. Astramovich

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Needs assessment methods have been promoted by counseling researchers and practitioners for several decades (Cook, 1989; Erford, 2008; Newton, Angle, Schuette, & Ender, 1984). Information gathered through needs assessments may help professional counselors in various specialties to identify critical needs of the populations to whom they provide services. In today's era of managed care and educational accountability, needs assessment data can play a central role in advocating for funding and resources to provide counseling services to clients (Astramovich & Hoskins, 2009). This article reviews basic needs assessment concepts and highlights a four stage needs assessment approach for use by professional counselors.

Counseling Needs Assessment Concepts

In the field of professional counseling, needs assessments have been used in various practice settings including schools (Cohen & Angeles, 2006), universities (Harrar, Affsprung, & Long, 2010), mental health agencies (MacDevitt & MacDevitt, 1987), and correctional facilities (Laux et al., 2008). The needs of various demographic groups have also been examined to help identify their unique counseling needs including children and adolescents (Drefs, 2002; Kroll, Harrington, & Bailey, 2000), refugees (Chung & Bemak, 2002), rural clients (MacDevitt & MacDevitt, 1987), and lesbian, gay, bisexual, and transgender people (Smith, McCaslin, Chang, Martinez, & McGrew, 2010). These published needs assessments suggest that professional counseling practice is ultimately enhanced when practitioners recognize the specific needs of the populations which they serve and then implement targeted counseling services to address those needs.

In general, needs assessment refers to the evaluative process of gathering and interpreting data about the need for programs and services (Gupta, Sleezer, & Russ-Eft, 2007). Needs assessments often serve as a foundation upon which organizations make decisions about where to invest their resources and what populations to target for their services (Witkin & Altschuld, 1995). In addition, needs assessment information can help organizations and individuals prioritize their services and refine existing programs to

meet the needs of various subpopulations (Astramovich, Hoskins, & Erford, 2008). Organizations that seek funding through grants and foundations often must conduct needs assessments in order to demonstrate a demand for the services they provide (Soriano, 1995).

Needs assessments may be conceptualized as part of the larger counseling program evaluation process that helps inform counseling practitioners about the outcomes of their services and the impact of their programs on various stakeholder groups (Astramovich, Hoskins, & Coker, 2008). Counseling needs assessments should therefore specifically help counselors refine existing programs or create new services designed to meet specific client population needs in order to provide optimal outcomes. For example, a counseling agency in a demographically diverse urban setting might use needs assessments as a means for identifying the types of small group counseling services that should be offered. In an era of budget reductions and increased competition for funding, the agency may thus maximize its impact by providing critically needed services to the community. Ultimately, professional counselors may use needs assessment data as one means to advocate for services with minority and underserved client populations (Astramovich & Hoskins, 2009).

Erford (2008) distinguished data-driven needs assessments from perception-based needs assessments. A data-driven needs assessment relies primarily on existing data as a means for objectively identifying needs of client populations. Conversely, perception-based needs assessments utilize surveys and focus groups to identify the subjective needs of various client populations. Ultimately, utilizing both data-driven and perception-based needs assessment methods can provide critical information to counseling organizations and professional counselors to inform the planning and delivery of their counseling services (Astramovich & Coker, 2007). The following four stage model for conducting counseling needs assessments utilizes information gathered from both data-driven and perception-based methods.

Four Stages of Counseling Needs Assessment

Stage One: Identify Guiding Questions and Goals

Counselors planning to conduct a needs assessment should begin the process by identifying specific guiding questions and goals. Effective guiding questions can help counselors focus their assessment in order to provide the most useful information. For example, a school counselor may be interested in assessing the counseling needs of students receiving special education services. In this case, guiding needs assessment questions might include: "How do students receiving special education services currently utilize counseling?" and "What gaps in counseling services exist for students receiving special education instruction?"

Guiding questions are then helpful in the identification of specific goals for the needs assessment. Without a clear goal or purpose, needs assessments may generate data that is unclear or not applicable to the counseling setting or process. Continuing with the previous example, the school counselor then might develop the following three goals for the needs assessment: 1) Identifying ways children in special education currently utilize counseling services; 2) Identifying specific counseling programs and services that might

be helpful for children in special education; and, 3) Identifying potential barriers to accessing counseling services.

During the development of guiding questions and goals, it is essential to consider the feasibility of carrying out the needs assessment, especially in terms of the volume of information to be gathered and the manageability of the data. If too many guiding questions or goals are identified, the needs assessment evaluation process could become overwhelming (Soriano, 1995). Ultimately a needs assessment must be realistic in its scope for it to be successfully implemented. Therefore, generating a few guiding questions and goals will help keep the process focused and manageable.

Stage Two: Identify Populations to be Assessed

Once guiding questions and goals for the needs assessment have been determined, the next stage of the process involves specifically identifying the population or populations from whom information will be gathered. Various stakeholder groups may have different perceived needs and gathering as many perspectives as possible can help ensure that all voices are heard. In school settings, counselors might assess the needs of students, parents, teachers, administrators, as well as needs of the local community. In community agency settings, counselors might assess the needs of current and former clients, counselors working for the agency, supervisors, and advisory boards. Finding convergences in the needs of various populations being assessed can help counselors and counseling organizations to prioritize their services (Astramovich, Hoskins, & Coker, 2008).

After target populations have been identified, counselors must then consider the number of individuals who will participate in the needs assessment. For example, a large community agency may have a caseload of over 450 clients who are being seen by 20 different counselors. If a supervisor is interested in assessing the needs of clients as they transition to aftercare, it may be unfeasible to assess all current agency clients. Instead, a smaller sample of the current client population could provide meaningful data to help address aftercare concerns. In this situation, the supervisor may ask each counselor to identify three current clients about to transition to aftercare to participate in the needs assessment. This would provide a more manageable sample of about 60 clients from whom needs about aftercare could be assessed.

Stage Three: Collect Needs Assessment Data

Collecting needs assessment information should ideally come from perception-based measures as well as objective or archival data sources. Data collection methods should be focused in order to answer guiding questions and address the goals of the assessment. Three essential means for collecting needs assessment data include survey instruments, focus groups, and exploring existing data sources.

Survey instruments. Survey instruments offer counselors an efficient way to collect perception-based needs assessment information. In general, needs assessment survey instruments should be simple to complete and as brief as possible while still gathering necessary data. Survey instruments may include demographic questions, scale questions, ranking questions, and open-ended questions. The specific types of questions utilized will be based on the guiding questions and goals of the needs assessment.

Obtaining demographic information from respondents allows for later disaggregation of the results based on various demographic variables (Erford, 2008). For example, a college counselor conducting a needs assessment of students seeking career counseling might want information about participants' sex, age, ethnicity, and number of college credits completed. These variables could help identify unique needs of subgroups that may not be reflected in the overall findings.

Scale questions can be helpful in determining levels of agreement or disagreement about a particular topic or levels of interest or importance of a particular service. Needs assessments often use point scales with lower numbers representing lesser agreement or interest and higher numbers representing greater degrees of agreement or interest. A commonly used 5-point scale might utilize the following descriptors: Strongly disagree, disagree, neutral, agree, and strongly agree. By assigning numbers to each point on the scale (i.e., 1 = strongly disagree and 5 = strongly agree), results can be analyzed quantitatively with means and percentages. An example of an item that might be assessed with this 5-point scale is: "I am interested in following-up my counseling by attending a structured weekly aftercare group".

Ranking questions can be helpful in prioritizing the needs of specific populations. For example, a school counselor might conduct a needs assessment of students to help inform the content of classroom guidance lessons. A needs assessment instrument could ask students to rank from high to low their needs for guidance lessons on specific topics. Results from this ranking question could then help the counselor plan to address the highest expressed needs in upcoming classroom guidance lessons.

Open-ended questions are another means for gathering data that can provide more individualized and richer information about needs. Often a series of scale or ranking questions is followed by an open-ended question to allow for elaboration by participants. Examples of open-ended questions that might be used on a counseling needs assessment include: "What are your primary support systems?" and "What small groups would you be interested in attending?"

Focus groups. Another useful means for gathering perception-based needs assessment information involves conducting structured focus groups. In this approach about five to ten participants from a target population participate in an information gathering session led by a facilitator. An advantage of focus groups is the dialogue that can occur as the facilitator processes answers to questions being posed of the group. As major themes emerge during the discussion, the focus group facilitator records the perspectives of the members and provides a summary of the key findings. An inner city mental health counseling agency might conduct a focus group with leaders in the local community as a way to identify the counseling needs of low-income community members and to help identify funding sources for counseling services.

Existing data sources. In addition to perception-based needs, counselors can often utilize existing data as a means for more objectively identifying the needs of various client populations. In school and college settings, counselors may examine campus-wide data about class enrollment, attendance, grade point averages, and drop-out patterns as a means to identify needs among the student population. In community settings, statistics about suicide rates, drug and alcohol abuse, and epidemiological data can be means for identifying potential client needs. Ultimately by analyzing existing data

along with gathering perception-based needs information, counselors will have a broader perspective on the needs of their client populations.

Stage Four: Analysis and Interpretation of Data

The final stage of the needs assessment process involves careful analysis of the data and interpretation of the findings. Results from survey instruments may be analyzed and graphed with spreadsheet software and focus group results can be summarized into a list of key findings. Careful analysis of the data also may involve disaggregating the results by various demographic groups (Erford, 2008). For example, disaggregated results from a needs assessment about aftercare might show that minority male clients have the highest expressed need for aftercare services. These findings might help inform the agency to focus special attention on the aftercare planning of its minority male clients.

Findings of counseling needs assessment can have important implications for the mission of the counseling program and the specific services offered to clients. Translating identified client needs into specific program goals and objectives helps counselors and counseling agencies to monitor the outcomes of services and to assess if the needs of clients are being appropriately met. Finally, conducting needs assessments should be considered as part of an ongoing counseling program evaluation process that helps professional counselors ensure optimal services and outcomes for their clients (Astramovich & Coker, 2007).

Conclusions

Counseling needs assessments offer several benefits to professional counselors and counseling organizations. Conducting needs assessments can help counselors identify potential gaps in services and can help counselors refine their services to fit the needs of the various demographic groups they counsel. Needs assessment findings can also be integrated into a larger counseling program evaluation process that can ultimately strengthen the quality of services offered to clients. In years to come, the profession of counseling will undoubtedly be shaped in part by the unique needs of client populations in our changing world.

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Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://counselingoutfitters.com/vistas/VISTAS_Home.htm

Supporting the education goals of post-9/11 veterans with self-reported PTSD symptoms: A needs assessment.

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Source: [Psychiatric Rehabilitation Journal](#), Vol 35(3), Win 2012. Special Issue: Young Adults with Mental Health Challenges. pp. 209-217.

NLM Title Abbreviation: Psychiatr Rehabil J

Publisher: US : International Association of Psychosocial Rehabilitation Services and Department of Rehabilitation Counseling, Sargent College of Health and Rehabilitation Services, Boston University

Other Journal Titles: Psychosocial Rehabilitation Journal

Other Publishers: US : Educational Publishing Foundation
 US : International Association of Psychosocial Rehabilitation Services and Department of Rehabilitation Counseling, Sargent College of Allied Health Professions, Boston University

ISSN: 1095-158X (Print)
 1559-3126 (Electronic)

Language: English

Keywords: posttraumatic stress disorder, military veterans, mental health, war, needs assessment

Abstract: Purpose: The influx of young adult veterans with mental health challenges from recent wars combined with newly expanded veteran education benefits has highlighted the need for a supported education service within the Veterans Administration. However, it is unknown how such a service should be designed to best respond to these needs. This study undertook a qualitative needs assessment for education supports among veterans with post-9/11 service with self-reported PTSD symptoms. Methods: Focus groups were held with 31 veterans, 54% of whom were under age 30. Transcripts were analyzed and interpreted using a thematic approach and a Participatory Action Research team. Results: Findings indicate a need for age relevant services that assist with: education planning and access, counseling for the G.I. Bill, accommodations for PTSD symptoms, community and family re-integration, and outreach and support. Conclusions and Implications for Practice: The veterans recommended that supported education be integrated with the delivery of mental health services, that services have varied intensity, and there be linkages between colleges and the Veterans Health Administration. (PsycInfo Database Record (c) 2020 APA, all rights reserved)

Document Type: Journal Article

Subjects: [Military Veterans](#); [Needs Assessment](#); [Posttraumatic Stress Disorder](#); [War](#); [Mental Health](#); [Psychiatric Symptoms](#)

Medical Subject Headings (MeSH): [Adult](#); [Community Mental Health Services](#); [Counseling](#); [Educational Status](#); [Female](#); [Health Services Research](#); [Humans](#); [Male](#); [Mental Health](#); [Needs Assessment](#); [Stress Disorders, Post-Traumatic](#); [Training Support](#); [United States](#); [United States Department of Veterans Affairs](#); [Veterans](#); [Veterans Health](#); [Vocational Guidance](#)

PsycInfo Classification: Neuroses & Anxiety Disorders (3215)
Military Psychology (3800)

Population: Human
Male
Female

Location: US

Age Group: Adulthood (18 yrs & older)

Grant Sponsorship: Sponsor: US Department of Veterans Affairs, Health Services Research and Development office, Office of Research and Development, Veterans Health Administration, US
Grant Number: RRP 09-113
Recipients: No recipient indicated

Methodology: Empirical Study; Quantitative Study

Format Covered: Print

Publication Type: Journal; Peer Reviewed Journal

Release Date: 20200604

Correction Date: 20200604

Copyright: Trustees of Boston University, 2012

Digital Object Identifier: <http://dx.doi.org/10.2975/35.3.2012.209.217>

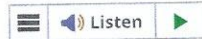
PMID: 22246119

PsycARTICLES Identifier: prj-35-3-209

Accession Number: 2012-02499-006

Supporting the Education Goals of Post-9/11 Veterans with Self-Reported PTSD Symptoms: A Needs Assessment / ARTICLE

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Acknowledgement: This research was funded by the Health Services Research and Development office, Office of Research and Development, Veterans Health Administration, Department of Veterans Affairs, RRP 09-113. The views expressed are entirely those of the authors and do not represent the endorsement or policy of the VHA, the Department of Veterans Affairs, or the United States government.

Introduction

The opportunity to obtain an education through the Department of Veterans Affairs (VA) benefits is a strong motivation among young people for joining the military (Kleykamp, 2006; Wilson et al., 2000). Given the previous success of the GI Bill program and the recent conflicts in the Middle East, the Post 9/11 GI Bill was passed. This legislation greatly increases veterans' educational tuition and related benefits (Department of Veterans Affairs, 2011b). There are a rapidly increasing number of applicants for GI Bill

benefits ([Sabo, 2010](#)) as well as a growing number of veterans with psychiatric disabilities on college campuses ([Vance & Miller, 2009](#)). However, war related trauma and consequent impairments can hinder educational attainment among veterans with disabilities including those with post-traumatic stress disorder (PTSD) ([Kraus, 2010](#)). Supported education (SEd) is an emerging evidence-based practice that has successfully addressed disability-related educational challenges for adult civilians with serious mental illnesses ([Cook & Solomon, 1993](#); [Hoffman & Mastrianni, 1993](#); [Mowbray, Collins, & Bybee, 1999](#); [Nuechterlein et al., 2008](#)). However, little is known about how such a service should be designed or adapted from civilian models to be used in the VA. Also unknown are the educational barriers that veterans with PTSD symptoms perceive themselves to need. This study attempted to fill this knowledge gap by performing qualitative interviews to examine the perceived educational needs of younger (age 18 – 29) and older adult veterans (age 30+) with self-reported PTSD, and to thus inform consideration of an age-tailored supported education service in the VA.

This research pays specific attention to young adult veterans and does so for two reasons: 1) their substantial proportion (41%) among post-9/11 veterans who are seeking VA health care ([Dept. of Veterans Affairs, 2011a](#); [VA Office of Public Health and Environmental Hazards, February, 2010](#)); and 2) literature and research supports that young adults differ from mature adults in treatment needs and responses ([Arnett, 2000](#); [Davis, 2003](#); [Haddock et al., 2006](#); [Uggen, 1999](#); [Rice, Longabaugh, Beatties, & Noel, 1993](#); [Clark & Unruh, 2009](#)). This research includes Veterans with self-reported PTSD symptoms because studies have shown elevated rates of PTSD among recently returning service members ([Hoge et al., 2004](#)), with the youngest among these being at greatest risk for receiving a PTSD diagnosis ([Seal, Bertenthal, Miner, Saunak, & Marmar, 2007](#)). It is anticipated that the mental health needs of veterans will be substantial in the decades ahead ([Wells et al., 2011](#)). In addition, PTSD is associated with various cooccurring disorders, social role, functional, and cognitive impairments that can impact educational attainment ([Thomas et al., 2010](#); [Stein & McAllister, 2009](#); [Najavits, Highley, Dolan, & Fee, in press](#); [Sareen et al., 2007](#); [Vasterling et al., 2008](#); [Vasterling, Verfaellie, & Sullivan, 2009](#); [Kotler, Iancu, Efroni, & Amir, 2001](#); [Church, 2009](#)). Despite recent advances in VA and Department of Defense (DoD) treatments that have resulted in earlier and stronger attempts to address PTSD ([National Center for PTSD, 2009](#)), PTSD and its sequelae can be chronic and impairing for a substantial number of veterans.

Methods

Participants and Data Collection

This needs assessment collected data primarily through focus groups held in 2009 - 2010. Study participants were recruited from the housing and mental health services at the Bedford, Massachusetts VA Medical Center (VAMC) and Boston area Veterans Upward Bound programs (a federally funded program that provides academic preparation services for veterans in the community). The study was approved by the Institutional Review Board of the VAMC and all participants were compensated \$25 for their participation. Eligibility criteria for the study included: (a) military service since 2001 and deployment in the Middle East; and (b) an educational goal (to either continue education if enrolled or to begin or go back to school or training). In the interest of preserving a very brief screen on entry to the study, we used the following questions to determine likely presence of PTSD: "Do you consider yourself to have war related problems that may be signs of PTSD (for example: having flashbacks, trouble sleeping, feeling edgy or easily angry, feeling numb or withdrawn)"; and "Have you even been diagnosed as having PTSD by a mental health professional?" Although we do not presume these self-report questions to be equivalent to an actual

diagnostic interview for PTSD, it indicates a notable presence of likely PTSD in our sample.

A total of 29 veterans participated in eight focus groups and two veterans participated in individual interviews (for reasons of scheduling at their convenience) using identical questions.

The focus group protocol and interview guide was developed by the research team and brought to the PAR team (described below) for review. During each data collection session, participants were asked about their military service, their educational background and goals, steps they had taken to pursue their education, facilitators and barriers in pursuing their education and/or goals, and what types of VA services would help them to achieve educational goals.

The study also used a Participatory Action Research (PAR) approach in which a team of stakeholders collaborated with researchers in a "colearning" context that can ensure relevant, meaningful and actionable findings ([Danley & Ellison, 1999](#); [Rogers & Palmer-Erbs, 1994](#); [Minkler & Wallerstein, 2003](#)). A PAR team was convened of 12 individuals consisting of 7 veterans (3 were young adults and all were employed as service providers to other veterans in varying capacities), a VA mental health practitioner, 2 community college academic Deans and 1 administrator, and another state veteran service provider. The PAR team met with Investigators of this study as a group five different times in person or via phone. Meetings were used to review project procedures and materials, data analysis and interpretation, and recommendations.

Data Analysis

Focus groups were audio recorded and transcribed by a professional transcription service and reviewed for accuracy. The research investigators and PAR team reviewed the transcriptions to code passages and organize categories. Initially each passage was "open coded" to identify the concept it represented using QSR NVivo (ver. 8) software. Researchers met to review the transcripts, and consensus meetings were held with three independent coders in order to establish the open codes for the first three transcripts. Subsequently, consensus meetings with two coders were held for the remainder of the open coding process. This process resulted in 23 codes (e.g., education strategies, reintegration to civilian life, unmet education needs).

Our interest was to understand the unique needs of younger veterans as well as issues that were common to both age cohorts. We chose a cut-off of age 30 for age group division. The actual age of stabilization of developmental changes among young adults is an empirical question and is unknown for young adult veterans. However, this cut-off is consistent with developmental psychology that suggests that early adulthood launches adult role functioning and is completed by age 30 ([Arnett, 2000](#)). Initial open coding was across age groups because transcripts were de-identified for the name or the age of the veteran speaking. Open codes were then classified as belonging either uniquely to younger veterans that were not expressed by older veterans, to older adults, or as ones that were common to both groups. For the next step codes were organized into larger or axial categories of meaning (e.g., clinical related issues, reintegration context, school related challenges).

Portions of transcripts and coding categories were distributed to the PAR team and discussed in team meetings to finalize interpretation.

Subsequently, axial categories were then grouped into three larger headings: 1) barriers to educational attainment, 2) recommendations for

supported education services, and 3) other needs related to educational support.

Results

Demographics of focus group participants

The demographic data on the participants are displayed in [Table 1](#). Slightly more than half of the total sample was under age 30, (54%, n=17). Most young adults were male (88%), white (82%), single (64%), and roughly half (47%) had a high school diploma only. In contrast, older adult participants (46%, n = 14) had a smaller proportion that were single (29%) and that had only a high school diploma (36%). For both age groups roughly one quarter were currently enrolled in school, the remaining had a goal to begin or return to school. In keeping with our inclusion criteria, all veterans were on active duty since 2001 with 30 out of 31 having served in Iraq or Afghanistan.

	Under age 30 (n=17)	Over age 30 (n=14)
Gender		
Male	88% (n=15)	100% (n=14)
Female	12% (n=2)	0% (n=0)
Race		
White	82% (n=14)	79% (n=11)
African American	6% (n=1)	14% (n=2)
Other	12% (n=2)	7% (n=1)
Hispanic Ethnicity		
Yes	12% (n=2)	14% (n=2)
Marital Status		
Single	64% (n=11)	29% (n=4)
Married	12% (n=2)	36% (n=5)
Divorced/Separated	24% (n=4)	36% (n=5)
Educational Attainment		
High School	47% (n=8)	36% (n=5)
Some College	35% (n=6)	36% (n=5)
Associate or College Degree	18% (n=3)	29% (n=4)
Currently Enrolled in School		
Yes	23% (n=4)	29% (n=4)
Branch of Service		
Army/Marines/Air Force	76% (n=13)	86% (n=12)
National Guard/Other	24% (n=4)	14% (n=2)

Veteran Focus Group Demographics by Age Group (Total N=31)

Barriers to educational attainment among potential GI Bill beneficiaries

The barriers to education centered on four codes, two of which were especially relevant to young adults: educational planning and reintegration challenges. Two codes were common to both age groups including: using GI Bill education benefits, and coping with PTSD symptoms.

Educational planning

For the younger veterans, education meant starting post-secondary schooling and this presented numerous challenges. Several noted worry about meeting the demands of the academic environment and both desired and were anxious about initial assessments for academic readiness. As one veteran noted, "Let's face it, many of these guys went into the service because they were no good at school." Others didn't know what kind of program to enroll in, or where. There were discussions about the ramifications and requirements of one degree vs. another. They had not the opportunity to receive counseling about these questions; as one said, "no one ever asked him before" about his education goal. One young veteran noted how he found by chance a website about a veteran-friendly campus and moved cross county to enroll with little other information or preparation.

Among the older veterans in the groups, educational planning needs were less expressed. Many had a clear occupational goal and understood the education requirements they needed to achieve that goal, and many were planning to return to schooling that had already begun.

Education goals occur in a challenging context of re-integration into civilian life

Reintegration difficulties were pronounced for the younger veterans because many went into the service straight from high school and then returned as young adults, but without having learned the skills needed for living independently as a civilian. We heard from the participants that there was no "basic training" for getting back to civilian life. The younger veterans described rapidly changing social/psychological/environmental contexts that were less pronounced for older veterans. This included homelessness, disintegrating family support, urgent clinical needs such as addiction relapses, physical injury and disability, and an adjustment process to civilian life that was at times over-whelming. For example, one veteran said:

I know four vets, they just got into school and couldn't handle it, and ended up in a major depression because they dropped out of school and had no support. And here they are back, needing to go back inpatient because they got so overwhelmed at school they couldn't handle it and had no one to talk to... a lot of these vets end up either hitting the bottle or drugs or whatever the case may be and they end up here [hospital inpatient services].

Financial issues were pressing for these veterans and many were unsure how they could balance their education goals with their living needs. As one veteran said:

Mostly everybody who is just out of the military...you're probably not going to want to go home and live with mom and dad, so you've gotta get your own place to live. ... it all comes down to having a stable place to live, transportation, bills... Because you can't focus on school if you're worrying about how you're gonna make your car payment, or how are you going to feed yourself tonight, you can't do it.

GI Bill Education benefits and VA Benefits counseling

A theme across both age groups was difficulties with accessing and using the GI Bill and related VA rehabilitation supports. Both younger and older veterans described difficulties such as: reaching a live person on the phone to ask questions, not having a knowledgeable person to answer questions or to assist with the application, not understanding the various types of GI Bill or other VA benefits or the ramifications of choosing one over another. A related barrier that was described is the current GI Bill requirement for nearly full-time credit load. The veterans told stories of having to start with a full-time caseload which turned out to be too much, and then having to drop classes and finally dropping out of school altogether as stress mounted. For some of the older veterans an added difficulty was making the forced choice between the Montgomery education benefits and the Post 9/11 GI Bill as there were differing requirements and benefit packages.

Impact of PTSD on educational attainment

Veterans in both age groups reported that PTSD symptoms posed additional challenges. They described feeling overwhelming anxiety during some class time. This was set off by differing circumstances such as loud and sudden noises, encountering roadwork reminiscent of scouring for roadside bombs, or other reminders of recent combat. Some reported using substances to alleviate the anxiety, or coping by always sitting at the back of the class where no one can come up from behind. Veterans voiced a need for classes with fewer students, isolated settings for test taking, and evening or online classes to reduce anxiety. For example one veteran stated:

I couldn't be in some classrooms. It was too hard being around some people ... I dropped out because it was too much anxiety, especially during tests - because I was already stressed out, then I'd have added stress, and I wouldn't have enough time to finish what I was doing. I figured I can't do this [school] so I'd stop.

Another common issue involved difficulties with perceived impairments in memory and concentration, and an overwhelming flow of information. The veterans reported a need for accommodations such as tape recording classes or extensions of time for assignments. As one veteran stated:

For me, you know, my mind don't work normal anymore, it's hard for me to live in a normal situation. I always need more time because my brain works slower. In the normal case scenario, say, well, you got a term paper due Friday and you just learned about it on Monday. It's gonna take a couple of weeks for me to get that done because, you know, my brain don't function fast anymore.

Veteran recommendations for supported education and rehabilitation services

The veterans had numerous suggestions about the context and types of services that would be beneficial to them in reaching their educational goals. Some suggestions mirrored the needs previously described (i.e., provide benefits counseling). Other additional recommendations are described below. The first of these, "outreach and services" pertained to the younger group of veterans we talked with, while the remaining recommendations were common to both groups.

Outreach and services to young veterans

Several veterans noted how existing VA services were not age appropriate for them. They reported finding it hard to relate to clinical groups composed of veterans who were old enough "to be their fathers." They preferred contact with veterans of similar age or at least of similar military experience. They noted that outreach should occur at gathering places normal for this age group, such as at "tattoo parlors and hockey games" as one noted. We found further evidence of the "generation gap" in existing veterans' services. Our recruitment efforts identified several existing veteran support groups that were composed of older veterans. Though they wished to, they had not been able to engage the younger OIF/OEF veterans. As one young veteran said,

I had gone to a couple of Vietnam veteran groups and I'm like 'Oh my G-d.' Big room. Big people. Big and loud. I didn't just go once and get a lousy opinion of it and not come back. I went a few times and it was - it was tough.

Younger veterans voiced interest in having access to technology to get information on school and benefits, particularly at VA hospitals. The veterans who were residing at the hospital or shelters complained that they did not have access to computers except under highly restrictive and monitored sessions.

Peer Support

The veterans we spoke to both young and old voiced the need to hear information and get help from other veterans who have overcome similar problems. The value of peer support is reflected here:

...when I first came to the VA I had serious problems, I was thinking, there's no help here, until a peer said they had the same problems. That was the first time I thought, well, there might be something to this ... We went to hockey games and it's comfortable because you're around people like yourself so if you have anything going on, there's support right there. It would be nice if there was someone that went through the college experience and they can say, "here's a bunch of information, this is what I had to do, this is what I went through, and this is how I got past that." Peer support is just huge because they understand... It would help a

lot to make veterans feel more comfortable and more willing to go through school... I think everybody would be more comfortable with a fellow veteran.

Veterans turned to each other for information through word of mouth. Often the focus group itself turned into information-sharing activities among the veterans present. There is an immediate extension of trust between veterans who may not know each other but who have both been in combat situations. The veterans expressed an interest in having other veterans provide counseling and supported education though some were cautious about having veterans with active PTSD provide the help.

Veteran-driven intensity of services including one to one assistance

Both younger and older veterans in the focus groups described different levels of service needs. Some veterans desired autonomy in the process of preparing for and going back to school. "I mean I don't think people should be spoon-fed all this, at least give them the resources. ...as long as I have the resources and I know where I can go ... it's up to me to do it." Other veterans were looking for more active and intensive assistance with entering and being successful in college. These intensive supports include not only enrolling in school, but also access to follow-along supports.

Having someone who is going to mentor you, someone who is going to say: "okay, these are the courses you're going to take, this is what you've got to be prepared for." Someone who is going to have all your information and set it out for you and help you plan, I think is something that is really needed. ... This way you're not going into something and you have no idea what to expect.

SEd integration with clinical team and VA clinical programs

Many veterans in the focus groups indicated that they were interested in having the VA educational services connected with their clinical services, due to the complexity of their various needs such as therapy, case management, medical, and school related. As one said,

Well, you would need like an integrated team for this. You would need someone to help with going back to school...you would need someone to help with the case management. You need someone to help if someone's in therapy. You need all these things. These are the things we have, we're faced with. We're in therapy, we're in doctors' appointments. It's not going to be an easy fix, but we need something like that, where it was all put together.

Some veterans mentioned that they would like their clinical and rehabilitation services at VA to offer opportunities to engage in education-oriented activities. They suggested, for example, having a location at the VA facility where school representatives could be present to answer questions about procedures, or to conduct sessions for hospital patients on topics such as educational benefits, time management, or study skills.

Recommendations for Colleges and for College/VA integration

Another theme common to both age groups was the need for the colleges and universities to be better connected to the VA. This could involve scheduled visits on campus by veteran groups, or having colleges come to VA hospitals. In the absence of these supports, several veterans spoke highly about the use of an individualized advocate who could provide the one to one support to walk them through the admissions, financial aid, and enrollment process and could run interference with professors. The following is a list of suggested activities schools can consider to support veteran education.

- College counselors and veterans' representatives having specific VA contacts for medical or mental health services for veterans who request it
- a VA benefits information session at the beginning of the semester
- a formal student veteran organization

- informal student veteran social events
- veteran-specific floors in dorms
- veteran support groups run by peers on campus
- academic and administrative services having drop-in hours for the veterans' representative
- professors and college administrators having knowledge about PTSD symptoms
- educational accommodations for attending needed health care appointments

Other needs related to educational attainment

Three other related findings are described here, the first two being unique to young veterans.

Adjusting from military to civilian culture

A theme that was unique to young veterans was that that military life fostered a kind of dependency where you were not encouraged to ask questions and you could rely on commanding officers to be told what to do. Civilian life in contrast was less structured, and relied more on personal persistence to get information and make decisions. Veterans described a difficult adjustment to the myriad of choices facing civilians and frustration at not having simple and clear information on which to base decisions. As one said,

I mean we used to be told to go here, there, and everywhere, but if you don't know really what you're looking for, it's kind of hard to find it. ... (In the military) there was always a commanding officer to tell you what to do and how to do it.

Loss of social networks

Having gone through a life-changing experience of combat and trauma, veterans had trouble "fitting in" with prior social networks. While the older veterans tended to have some civilian family or social supports and were returning to established lives, many of the younger veterans seemed to have none and were returning to the tumultuous years that are common for young adults. The following statements exemplify this:

Someone who just came back, that has enough problems to readjust, hasn't been able to fit in with his friends, his family, nothing, and is faced with all this stuff and making these decisions....it's – forget about it, it's way too much.

That's why my wife divorced me, was my PTSD. ...I've pretty much abandoned my family. I don't consider them family. My family is my veteran friends and my friends that I was actually in combat with. They're friends, my family for life.

Need for outreach and support to access and use clinical services, though once accessed VA clinical services were valued

Despite significant clinical challenges veterans both young and older told us that upon returning home, they were unaware of the clinical supports that were available to them, that they didn't know where to go for help, or that when such information was given they were not ready or able to hear it. Many spoke of "finding the VA" after crises and homelessness. For example one said,

I never really knew the VA was there. I never thought to use it, never learned about it, never got any information whatsoever even through discharge from the military and all that, and so it's really poor on their part to just send me out and not have any knowledge of where I should go, what I should do, or what is available.

They also spoke about how current military procedures to identify veterans who need help would backfire, such as when screenings were held at the point of demobilization, when veterans were simply seeking the fastest way home. Other obstacles with using the VA clinical system were voiced. One was the substantial amount of documentation and paperwork encountered when accessing services. They described how the smallest barrier or

setback could elicit a response of "I'm out of here." Several of the older veterans and PAR participants noted that reintegration is a process of healing that can take years. Older veterans suggested that outreach needs to persist over many years while veterans cycle through periods of recognizing needing help and of trying to "tough it out" on their own.

Although difficulties with adequate outreach to the VA was voiced, many veterans both young and old spoke with appreciation about the VA services they received. Several credited VA mental health, addiction, housing and case management services with getting them out of crises and on the road to reclaiming their lives.

Discussion

Veterans voiced several important challenges to achieving their educational goal. Some reported having limited information, support or guidance with which to navigate the large systems of the VA and community educational institutions. Additionally, results show that a new supported education program cannot be delivered in a vacuum. Other pressing life needs including clinical issues, housing, and income should be addressed in these programs. This is especially true for younger veterans who are in a rapidly changing stage of life that is normal for their age. The need for an empowered case management system that can address education needs within a bio/psycho/social framework became evident. Existing support models that combine case management and peer support service can serve as a model for a new supported education service design ([Smelson, Sawh, Kane, Kuhn & Ziedonis, 2011](#)).

Our age group analysis holds implications for designing an "age-tailored" supported education service. Research indicates that while older adults prefer face-to-face contact, young adults are satisfied with or prefer communication through texting or social media. A comprehensive array of services is indicated to meet the educational needs of post-9/11 veterans, but the content of these needs will vary by age group. Older adults may tend to have more stable civilian lives but other needs may be pressing such as physical disabilities, cognitive impairments, family counseling and parenting. Also, although a service array is indicated the veterans suggested that the intensity of services should vary according to veteran wishes. Sometimes only simple information or guidance is needed while other times multiple services need to be accessed.

The veterans in this study expressed frustration in acquiring GI Bill information and in navigating benefits plans, and this has been found in other research ([University of Arizona, 2011](#)). There are notable recent efforts by the Veterans Administration to provide benefit counseling on campuses together with outreach and peer services as well as to streamline and improve benefit enrollment and web-based interface (Dept. of [Veterans Affairs, 2011c, 2011d](#)). This research supports the importance of these efforts.

A recurrent thread in the discussions is the importance of veterans to each other. For veterans, connection with others who have "been there" seemed essential to rehabilitation and recovery. Also it appeared that the shared experience of military service was more salient to these veterans than were any differences due to age.

Some aspects of the findings for supported education correspond to principles of supported employment, an evidence-based practice presently implemented in the VA ([Resnick & Rosenheck, 2007](#)). These include: (a) integration of rehabilitation service with a clinical team, (b) primacy of individual preferences, (c) benefits counseling, d) use of integrated

community settings for employment (Bond, 2004). Accordingly, the existing structure of supported employment in the VA may be adapted for supported education. However, presently there is no legislative authority for the VA to implement this new service which may be needed to provide supported education as part of standard medical care.

Study Limitations

Like all qualitative studies our findings cannot purport to be generalizable in the traditional sense. Our analysis by age groups was also compromised by the fact that we could not tease apart transcripts by age group, and in hindsight we recognize that having the specific age of participants rather than age groupings would have been beneficial. Also, it is possible that were data gathered in different parts of the country or in different service systems, findings would also differ. However, using qualitative concepts of data saturation and redundancy, we found that after the first few transcripts were coded, all utterances could be categorized without creating any new categories, suggesting that we had exhausted the content. In conclusion, post-9/11 veterans with self reported PTSD symptoms describe a variety of components that will help them succeed in using GI Bill benefits and in attaining their educational goals. To respond to these needs a new age-relevant VA SEd service should include principles of supported employment, along with peer support, case management, assistance with navigating both VA and educational environment, connections between the VA and colleges, and continuous outreach at age-relevant venues.

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Source: Psychiatric Rehabilitation Journal, Vol. 35, (3), Win 2012 pp. 209-217)

Accession Number: 2012-02499-006

Digital Object Identifier: 10.2975/35.3.2012.209.217

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