

A VETERAN'S JOURNEY HOME:
REINTEGRATING OUR NATIONAL GUARD
AND RESERVISTS INTO FAMILY,
COMMUNITY, AND WORKPLACE



The 26th Annual Rosalynn Carter
Symposium on Mental Health Policy

NOVEMBER 3 AND 4, 2010

THE
CARTER CENTER



Waging Peace. Fighting Disease. Building Hope.

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WELCOME

Nina Berman, M.S.

Freelance Documentary Photographer

Shortly after the war in Iraq began, I started photographing and interviewing seriously injured soldiers and marines who had returned home. I visited them in their hometowns after they had been medically discharged. I was meeting them at particularly vulnerable moments in their lives as they began the transformation from able-bodied GIs with a clear, clear path and purpose, to disabled veterans brought back into the civilian world with no clear direction, and with enormous physical challenges that were not present when they deployed.

In my photographs, the veterans are pictured alone. That is how I saw them: isolated and disconnected. Veterans living in more rural areas were even more so, and I speak here anecdotally, simply from my experiences.

For instance, this young man, Sam, has been blinded and has lost a leg. He had been sent home to rural Pennsylvania where, at the age of 21, he was living in a trailer by himself. He already had a difficult family life, and within two years of his return, he attempted suicide on several occasions. To



my knowledge, he is not being treated on any regular basis for his psychological distress. I believe distance to a veteran's facility, his inability to drive, and his drug use are all factors. One night, he set fire to his girlfriend's trailer. She escaped with her two children, and he was arrested for attempted homicide. He was sentenced to the state penitentiary. Now, he is a criminal justice problem.

For other veterans, there are predictable problems in their relationships. One young man, paralyzed from the waist down, separated from his young wife shortly after he returned. Another vet, a guardsman with



brain damage, relies on his wife to take care of him. She describes this experience as having a child who came home from war instead of the man she knew.

My most extensive investigation of the impact war has on family life was the story of a marine reservist. Wounded in a suicide car bombing, he has made an astonishing recovery through force of will and modern medicine. He and his high school sweetheart married in a kind of love-conquers-all wedding. But the narrative became impossible for the young couple to sustain. They separated shortly after they were married and later divorced. According to the Marine, he was distant, depressed, and their marriage was unsatisfying.

More recently, I began photographing veterans who had suffered environmental exposure in Iraq, specifically exposure to the open-air burn pits on

large U.S. military bases. For this group, there is extreme anxiety and frustration because they feel their physical suffering is not being treated seriously. And they feel powerless and angry as their health steadily worsens.

I met two veterans who said they had been diagnosed with PTSD as a result of their service; one spoke of enormous alcohol abuse. For this group of vets, I have encountered a new problem: although the VA has been very sensitive to their PTSD issues, the sensitivity seems to provoke anger in the veterans. Their main problem, or so they see it, is the dramatic decline in their physical health and no clear treatment plan in sight. The families truly feel helpless.

I hope these images provide an intimate, albeit very brief, look at the stories of some of the individuals who are living day-to-day with the issues to be discussed at this conference.

OPENING REMARKS

Rosalynn Carter

Chair, Carter Center Mental Health Task Force

We've learned that people all over the country are interested in and concerned about veterans' mental health issues. I have been travelling over the last few months to promote my book, "Within Our Reach: Ending the Mental Health Crisis." The question I got everywhere I went on the book tour was, "What are we going to do about our veterans? Can't we help them more?", which means that more people know about post-traumatic stress disorder than ever before, there is more research going on than ever before, and Congress is paying more attention to a mental health issue than ever before. I am particularly excited that the public is so concerned because that is when things get done.

I would like to acknowledge a very special person, the First Lady of Colorado, Mrs. Jeannie Ritter. She has developed one of the best programs in the country for welcoming returning soldiers home, the Civilians for Veterans Fund. In every community, participating centers provide veterans access to free and confidential mental health and substance abuse treatment services near their homes. Mrs. Ritter has become a champion of mental health issues in her state and I am so pleased to know her.

The goal of our symposium is to nurture the development of both a national leadership focus and a public policy action agenda to address mental health services for veterans, especially for members of the National Guard and military reserves. Since the beginning of the U.S. presence in Afghanistan in 2001 and Iraq in 2003, more than 1.7 million American troops have been deployed. As I mentioned, there has been increased public and political concern about the consequences of these war experiences on soldiers and their families, specifically around post-traumatic stress disorder (PTSD) and traumatic brain injury, but also around issues of suicide, substance abuse, stigma and discrimination, and resilience of returning soldiers. Members of the National Guard and reserves and their families are particularly

vulnerable to mental health risk, as they do not have the same access to health care services as active duty personnel. Active military troops more often than not come home to bases, where they may receive support and services. The Guard and reservists come home to communities, families, nonmilitary jobs. They must rely more on public and private providers in the communities in which they live than do the regular forces. This difference is reflected in the figures: National Guard and reservists represent roughly one-third of the deployed troops in Iraq and Afghanistan, but in a study conducted in 2005, they accounted for 53 percent of the suicides among all veterans of the two conflicts. This symposium will focus on improving the mental health delivery systems in the local communities of veterans and their families, which includes a great majority of our communities.

The federal government has taken measures to address the mental health issues increasingly faced by returning veterans. This year, President Obama proposed an 11 percent increase in the budget for the Department of Veterans Affairs (VA), with a focus on increasing eligibility, technology, and quality in order to enhance delivery systems. I had the chance to meet with First Lady Michelle Obama earlier this year and she is very interested in this issue. We were talking about children and trauma, and she told me that about two weeks before I got there she met a woman who asked her to do something about PTSD and families. This woman told Mrs. Obama that she had a son who was 7 years old and every day when he came from school, he told her, "Somebody asked me again today when my daddy was going to get killed." That was shocking to me, but it hits home.

There are some good things going on. The Department of Defense health care system now prioritizes care to active duty military and their families through on-base facilities and clinics, but they also are providing services to eligible retired veterans as well as some National Guard and

reservists and their families. The VA also has policies to address these changes, including providing benefits to families of returning veterans, primarily by sharing the cost of services with the beneficiary. In addition to improving our community-based care, many new initiatives are attempting to create a strong context of

community for returning veterans by addressing stigma, discrimination, employment, and education. We are grateful for all that is being done, and we look forward to hearing from our presenters, but we can and must do more. Too many good people are falling through the cracks.



Hon. Patrick Kennedy

U.S. Representative, Rhode Island

More and more of our service men and women are ending up in the criminal justice system because of their untreated, invisible wounds. Is this the best way we can respond to our veterans' invisible wounds of war: welcoming them home and then locking them up?

At a symposium on shared neuroscience, a Rhode Island National Guard serviceman, who had been to Iraq twice as a medic, showed a picture of an IED having turned over a convoy. He said:

"We were taking incoming. We lost some of my fellow soldiers. But I'm also losing my fellow soldiers when they get home because of the wounds they incurred then and at other times. I don't know if America gets it. Our terrorists are fighting an asymmetric war. They don't care when they get us, they just want to get us. When they get us on the field, it's one thing; but when they get us five years later because a veteran takes his own life, or a veteran has a neurological

disorder because of a traumatic brain injury (TBI)—because we know there will be a record rate of Alzheimer's among veterans with severe traumatic brain injury, or Parkinson's or multiple sclerosis (MS)—it is a win for the terrorists."

The battlefield is over there, and that it ends when the soldiers come home is the biggest misconception going. When we say combat operations are over, we mislead the American public to think that the war for these veterans is over when they come home. When we say we are not going to leave our soldiers behind, we put the full might of military power behind going in

there and setting them free. We do not leave our soldiers behind. So why are we leaving our soldiers and veterans as prisoners of war right here at home today?

Our veterans demand better than people just looking out for their own self-interest. This is a national interest.

They are prisoners of their war injuries—TBI and PTSD—and they are held hostage right now by depression, by addiction. And they are held behind the enemy lines of stigma and an attitude that says we cannot do the research to find out how we are going to bring them home, not only in body but in mind as well. If America had the same commitment about saving our heroes if they were held behind enemy lines in Iraq and Afghanistan, we would have a different story here at home right now.

On May 25, 2011, we will mark John F. Kennedy's famous speech to go to the moon and return a man safely before the decade is out. I talked to folks who were around at that time. They said, "Congressman, everyone thought: 'Who is he talking to? How in the world are we going to get this done? How is this going to happen?'" But he made it a national priority and said that nothing would stand in our way as a country to beat the Russians to the moon—and do this before the decade is out. We did it because we had national leadership.

We need to brand our generation's new frontier as "the last medical frontier." We have to go to "inner space" and explore the galaxies of neurons in the mind and unlock the mysteries that are holding too many of our Americans, all Americans, hostage. Those Americans, most notably our veterans, include our parents and grandparents with Alzheimer's. They include our children with autism and people with Parkinson's and MS, depression, and addiction. We're all in it together.

Let us get behind our veterans and allow them not only to take down the doors overseas but to come home and kick down the doors here, the doors of siloing medical research that says we have Alzheimer's over here, Parkinson's over here, epilepsy here, and depression over there. Everyone guards their own resources, saying, "I want my patent, I want my Nobel Prize, I am not going to share a bit of research." Our veterans demand better than people just looking out for their own self-interest. This is a national interest.

Now, I do not have the expertise in neuroscience and mental health, other than being a good consumer of its services. But I have had the best teacher anyone could ask for, growing up, in how to put things together politically. And I am telling you now, with the way Washington is moving, we are not going to get new money for Alzheimer's and Parkinson's and epilepsy and autism. The National Institutes of Health has been capped in discretionary spending; it is subject to a budgetary cap. But, thank God, the VA is not, and neither is the Department of Defense. They are going to receive all the new money for brain research.

We need to reach out to the private sector also. It is a little-known fact that the financial reform bill is going to transfer upwards of \$35 billion a year from the bank to the retailers. This appears to help mom and pop small retailers, but guess who gets 80 percent of that? Wal-Mart, Target. If the American people fully understood this is a windfall, they would have sent up an even bigger message in the recent election than they did, because all we ended up doing was transferring wealth from this crowd to that rich crowd without any of it being directed to our American heroes.

It would be great to say, "Let's do it for Alzheimer's; it is a scourge, everybody is getting mobilized." But then, people are going to say, "What about cancer? What about diabetes?" If it is the United States veteran—our soldiers, sailors, airmen, Coast Guard, and Marines—you are not going to have those problems politically, because it is going to be the one fund that we can create with a reallocation of the interchange rate (take a few basic points on all debit swipes, trillions of debit swipes, for every single American; that is pennies on every purchase).

The time is now to set up a veterans fund to say, "Listen, they are the ones who kept those terrorists over there as opposed to here." It is time to step up to the plate and be there for our American heroes just as they were there for us. I think it is going to be the catalyst, politically, of putting together the mission to the moon, the moon shot to the brain.

Let's map the atlas to the brain; let's map the genetic markers and do the brain bank. Let's get the sequencing of every major neurological

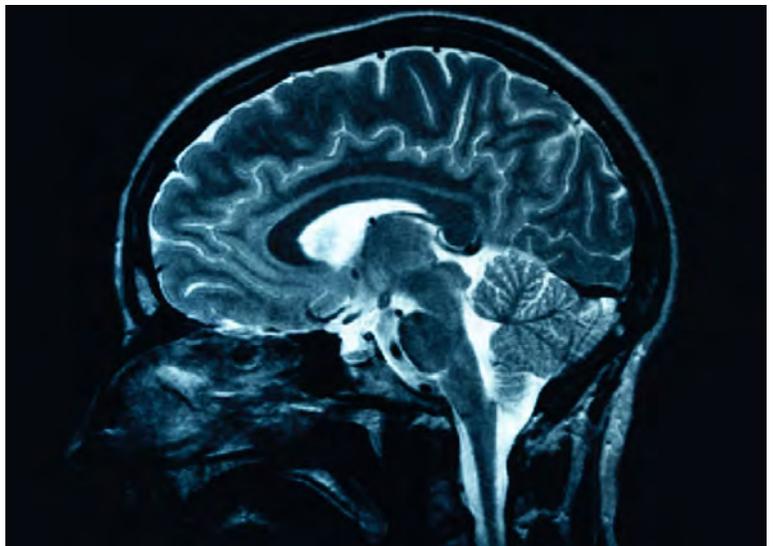
disorder. If we do that in advance, it is Alzheimer's research, it is autism research, it is depression and addiction research.

As Albert Einstein said, "We don't know what we don't know." We do not even have common data elements to describe TBI. It is 10 years into the war, and we cannot even connect a neuroscientist from San Diego with one from Providence and let them know it is apples to apples. What is the description, what is the nomenclature for TBI, the single greatest injury of this war?

We now have more soldiers taking their own lives as soldiers ... we are talking active duty soldiers taking their own lives by their own hands in greater numbers than are taken by the enemy in combat.

We now have more soldiers taking their own lives *as soldiers*. We are not talking veterans now, we are talking active duty soldiers taking their own lives by their own hands in greater numbers than are taken by the enemy in combat. Now that is startling. That should be sobering to the American public. Frankly, I am shocked at the silence that is out there right now.

I say stigma is what is killing these veterans because, when the VA and the DOD issued their Suicide Commission Report, did they talk about the physiological impact of getting your brain rattled by IUDs, about that as a contributing factor to suicide? No. Did they talk about PTSD, a physiological change to the brain? No. These soldiers have been subjected to heavy doses of cortisol pumping through their brains for protracted periods of time, which may have



changed the neurocircuitry in the brain and contributed to a higher suicide rate. Not one word about this as a combat wound. Shame on us.

And then we wonder why these veterans find there's no way out other than to take their own life. It's because, to them, it is a moral failure to have an addiction, a moral failure to lash out in

anger at their spouse or their children.

The fact of the matter is those are symptoms of a psychological wound, no different than if they were continuing to bleed after getting one of

their limbs blown off. We do not think about it that way. They are invisible, and what we say is, these veterans cannot pull themselves together.

We talk a good game about mental health, but when we call it mental health, we re-stigmatize it. This is from the guy who passed parity. I thought it was going help us move this thing, but I am afraid it is only going to entrench discrimination and stigma more. Why? Because *Plessey vs. Ferguson* said it all: separate but equal is unequal. We cannot have veterans come home to see their doctors, and then have someone say, "Oh, you have one of those illnesses, you go to this system over here." It is a separate water fountain for character flaws only. President Kennedy said it in his civil rights address,

"Who amongst us would change the color of their skin and be content with the counsels of patience and delay?"

These veterans do not think of themselves as disabled; they want out. We could say this to them: "It is going to take years, because this is a complex thing, and it costs a lot of money. We are going to get there as fast as possible and not make you wait one day longer." But if we sit back on our hands and say that this is too costly, this is too expensive, this is too complex, to what are we consigning those veterans?

We are consigning them to wait. Now is not the time. Thinking of Dr. King's "Letter From a Birmingham Jail," now is not the time unless it is you sitting in that prison of depression, that prison of addiction, that prison of stigma. Then it is very real. Until we understand that we are all in this together, because there but for the grace of God go I, we are not going to get this national message. And frankly, if we cannot do it for the veterans, how are we going to do it for everyone else?

The veteran is going to be our hero again. Vets stood up for freedom, fought tyranny, and they are coming home. They are going to fight tyranny again, the tyranny that makes people believe these are character flaws, not neurological disorders. If we do that, we will win this modern day civil rights fight, and we will do it for our nation's veterans.

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KEYNOTE ADDRESS

A. Kathryn Power, M.Ed.

Director, Center for Substance Abuse and Mental Health Services Administration (SAMHSA)

In May 2010, First Lady Michelle Obama and Dr. Jill Biden rolled out a national call to action for military families. They noted that 1 percent of our population is doing 100 percent of the fighting. Their message: We need 100 percent of Americans to support our troops and their families. Supporting and strengthening our military families is not only critical to our national security, but it is a national moral obligation.

On Aug. 20, 1940, at the height of the Battle of Britain, Prime Minister Winston Churchill famously said:

“The gratitude of every home throughout the world goes out to the British airmen who, undaunted by odds, unwearied in their constant challenge and mortal danger, are turning the tide of the World War by their prowess and by their devotion. Never in the field of human conflict was so much owed by so many to so few.”

Impact of Service

In the nine years since Sept. 11, over 2 million U.S. troops have deployed to Iraq and Afghanistan. As of Oct. 20, 2010, the Department of Defense reports that 5,700 deaths and more than 40,000 injuries have occurred in our two conflicts. Many of those who have been injured return home with post-traumatic stress disorder, depression, traumatic brain injury, and substance abuse, and far too many die from suicide.

Mental health disorders caused more hospitalizations among U.S. troops in 2009 than any other reason. For the first time ever:

- The rate of suicide among active duty military has surpassed the civilian suicide rate.
- The cumulative length of deployments is associated with more emotional difficulties among military children and more mental health problem diagnoses among U.S. army wives.

- More than 100,000 veterans are homeless.

But we are not statistics. We are serving people. We are serving military spouses who manage through multiple deployments but who have trouble sharing responsibility when their partners come home. We are serving children whose visits with their mothers and fathers over multiple deployments are limited to grainy and time-delayed images on Skype. We are serving people like Michael.

While on patrol with his Marine unit in Iraq in August 2004, Michael was severely wounded by a roadside bomb. He sustained a crushed skull and right hand, traumatic brain injury, and lost both of his eyes. Michael writes:

“Those of us with post-traumatic stress disorder feel like strangers here. [We] carry around a burden many people are unaware of or just can’t understand. I fly off the handle. My emotions often come out quickly and unchecked. I try to figure out who I am in all of this. I am a husband. I am a stepfather. I am a student. I am a Marine. I am a combat veteran. I am a man who was violently attacked and left blind and tormented. I want to be normal. I don’t want to feel the anger. I don’t want to feel the guilt. I don’t want to feel the shame.”

We know the women and men who serve in our armed forces are incredibly resilient, as are their families. Most service members have very strong psychological health that enables them to deal successfully with isolation, multiple relocations, and new environments, in addition to combat-related stressors and trauma.

While the adverse affects of trauma receive the greatest attention, psychologist Michelle Sherman notes that many survivors also experience what is called post-traumatic growth. They become more aware of inner strength and

Mental health disorders caused more hospitalization among U.S. troops in 2009 than any other reason. For the first time ever, the rate of suicide among active duty military has surpassed the civilian suicide rate.

courage. They build empathy for others. They grow spiritually, and they appreciate the opportunity for a fresh start. Military families also show active coping strategies and very high levels of community and other social support, which are important resilience factors.

Challenges

Today's servicemen and servicewomen face some unique challenges. Since the advent of the All Volunteer Force in 1973, we have more families who are service-connected. In 2010, 51 percent of the active duty military National Guard and Reservists are married; more than 43 percent of them have at least two children. Of the nearly 2 million military-connected children, 225,000 have a parent currently deployed.

Protracted conflict has increased the common stress of military life to uncommon levels. As

As many as one-fifth of married service members who are deployed for longer than a year consider divorce.

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Some children of deployed military members act out more, do poorly in school, and have more physical health problems.

We also have more citizen soldiers. Nearly 40 percent of those who have deployed to combat operations since 2001 are National Guard and Reservists. Individuals in the reserves are not attached to local military bases, which often serve as sources of both tangible support and social connectedness so vital to an individual's mental and physical wellbeing.

Instead, they exist in isolated units scattered throughout the country with no emotional, physical, or practical connection with their Gaining Command (active command to which a Reservist or unit is staffed to support.) When

Current deployments are the lengthiest since World War II. Longer deployments increase the risk for psychological and physical health problems, and for family disruptions and breakdowns.

I commanded a unit, my Gaining Command was in Memphis, Tenn., and I was in Providence, R.I.

National Guard members are attached to state

units and live in communities that are widely scattered across the individual states. Our servicemen and servicewomen are serving longer tours of duties. Current deployments are the lengthiest since World War II. Longer deployments increase the risk for psychological and physical health problems, and for family disruptions and breakdowns.

Improvements in medical technology have resulted in the highest casualty survival rates in the history of U.S. conflicts, currently 90 percent. Although this translates to fewer individuals killed in action, it also increases the number of severely wounded individuals needing ongoing care and support from their families and communities. Individuals with a psychological problem are significantly more likely to leave military service in the year following deployment. Very clearly, this means that the responsibility of providing behavioral healthcare is shifting to the civilian sector.

Brigadier General Loree Sutton, who recently retired from leading the Defense Centers for Excellence for Psychological Health and Traumatic Brain Injury, said the invisible wounds of war are a national challenge that touches everyone because we are all part of the military family. If a service member is deployed, we must step in to share the burden and help lighten the load. If a warrior is injured physically, mentally, or emotionally, we must reach out and provide the best possible care and support. And when one of our own pays the ultimate price of freedom with his or her life, we must remember their service, support their families, and honor their sacrifice.

What Needs to Be Done?

What will it take to honor the sacrifice of all who have served this nation both on the battlefield and at home? First, it will take courage to help them overcome the fear, discrimination, and prejudice that keep individuals from seeking help for behavioral health problems. Just as in the civilian population, only about half the service members who need help for behavioral health problems seek it. Everyone must see seeking help for the emotional wounds of war as an act of courage and strength, not as a weakness.

Second, it will take commitment at all levels of government and by service providers and the public and private sector, veterans and their families, and the general public to address the behavioral health needs of returning veterans and their families as an urgent public health priority. We know that behavioral health is essential to health. We know that prevention works, that treatment is effective, and we know individuals recover. Let's send that message.

Third, it will take unprecedented collaboration among all of these groups to promote resilience, recovery, and reintegration for all our returning soldiers and their families. No one agency or unit of government can do this alone.

We know that families find both the pre- and post-deployment stages particularly disruptive, due to the increased stresses and unique challenges associated with those transitions. The departure or return home of a service member sets in motion a series of changes that may disrupt family routines and decrease the level of family stability. We need to help families

understand that what they are feeling is normal and give them positive ways to strengthen their family bonds.

Reintegration

Reintegration into the workplace is a particular challenge for National Guard and Reservists whose jobs may be disrupted by their military service. Military spouses also list employment as one of the most significant needs. We need to help employers understand the importance of hiring, supporting, and retaining qualified workers, including veterans with disabilities. We also need to help service members reintegrate into their communities, because individuals and families recover in community.

Around the country, there are inspiring examples of what it means to truly welcome our returning warriors home.

Everyone must see seeking help for the emotional wounds of war as an act of courage and strength, not as a weakness.



- California: Operation Welcome is a comprehensive reintegration initiative that seeks out recently returned veterans to connect them with benefits and services. All of its 300 employees are recently separated veterans.
- Minnesota: Beyond the Yellow Ribbon Communities connect existing support organizations and agencies and programs to leverage sustainable resources and community support.
- Maryland: The Partners in Care Program is an initiative of the Maryland National Guard Chaplain's Office to unite the needs of guard members and families with the resources of faith communities, which are offered to all guardsmen free of charge and without regard to the recipient's religious affiliation.

These are just a few examples of what is happening in towns and villages, in cities and in states across this country.

Federal Initiatives

We have been busy addressing issues like this at the federal level as well. Although active duty troops and their families are eligible for care from the Department of Defense, and National Guard and Reserve troops who have served in Iraq and Afghanistan are eligible for behavioral health

services from the Department of Veterans Affairs, some are unable or unwilling to access those services. Many of these servicemen and women and their families seek care from state, territorial, local, and private behavioral healthcare systems. Those are the groups that are the focus of SAMHSA's Military Families Initiative.

SAMHSA is providing support and leadership to improve the behavioral health of our nation's military families by:

- increasing access to appropriate services;
- preventing suicide;
- promoting emotional health; and
- reducing homelessness for military service members, veterans, and their families.

SAMHSA and the National Guard Bureau are involved in an innovative demonstration project to link zip codes of National Guard service members who are deploying or returning with mental health and substance abuse treatment needs with providers in their communities.

Recently, SAMHSA awarded a contract for a new, nationwide support/resource center to strengthen behavioral healthcare systems and services for returning service members and their families. Through our partnership with the Department of Veteran Affairs, SAMHSA has

created a special feature of our National Suicide Prevention lifeline. Today, when an individual calls the lifeline, 1-800-273-TALK, you hear this:

"If you are a U.S. military veteran or current service member, or you are calling about one, please press 1 now."

Callers who press 1 are routed to the Department of Veteran Affairs Call Center,



which is staffed by trained VA counselors. In the three years since that program started, calls from individuals identifying themselves as veterans or family members have led to more than 33,000 referrals to suicide prevention coordinators and more than 10,000 active rescues—calls to police or emergency medical personnel for immediate response for those judged to be at imminent risk.

In addition to its own website, the lifeline has established a strong presence on the Internet and among social networks. The search engine Google, in collaboration with the lifeline, hosts the toll-free number at the top of the page when users search words such as “suicide” or “ways to kill myself.” SAMHSA is also working with the Department of Defense to assess the value of providing technical assistance to selected community behavioral health centers interested in becoming credentialed for the military’s Tri Care network.

What We Can Do Now

We can do this. In every community every day, we can find concrete ways to show our military families the respect and gratitude that each of us holds for them. They deserve our support long after the welcome home ceremonies are over. You don’t have to come from a military family, have a base in your community, or be an expert in military issues to make a difference. Every American can do something.

Working together at the local, state, and federal level, we can continue to battle against the discrimination, intolerance, and fear that keep individuals from getting the mental health and addiction services they need and deserve.

We can build awareness and education that psychological health and emotional health are fundamental to wellbeing.

We can continue to crusade, and provide accessible and appropriate services for military members, veterans, and their families, who have sacrificed their health and safety to protect ours.

And we can continue to fight for the rights of all servicemen and women to be full participating members of their communities. We must be willing to understand how they think, what they feel, and what they need to be successful.

Maurice, who deployed to Iraq in 2003 as a Squad leader, now lives with his family in Brooklyn, NY, and is studying at Columbia University. On the night that President Obama announced the end of combat operations in Iraq, Maurice wrote:

“Recently, I took my seven-month-old daughter for a walk around our Brooklyn neighborhood. As

we walked, her little body bounced happily. After a few minutes, I found myself adjusting the straps of the carrier making it tighter and placing her in a higher position. I did this without consciously thinking.

“Tightening the straps makes carrying heavy loads more bearable, a technique I learned in the Marines. We carry these wars inside of us. They tag along in our lives as stories and memories, dreams and nightmares living just below the surface, raging back at times. These wars are part of our collective memories.

“Soon, my daughter will be old enough to ask about Iraq, and when she does, I intend to be candid with her. I intend to tell her what it was like and allow her a window into our war through my memories. I intend to let her know that, for some people, wars are never quite over.”

The poet Carl Sandburg once wrote, “Sometime they’ll give a war and nobody will come.” Until that time, and in the meantime, the work we are doing is making a difference in the lives of the individuals we are privileged to serve. Together I believe we are helping pave the road home for our brave servicemen and servicewomen and their families with our hope, with our hearts, and with our hard work.

You don’t have to come from a military family, have a base in your community, or be an expert in military issues to make a difference. Every American can do something.

PANEL I: REINTEGRATION INTO FAMILY

Ron Capps

Freelance Writer; U.S. Army Reserve, Retired

I went off to my first war about 15 years ago, and in the course of a career, I have served in a number of wars and conflict zones: Rwanda, coast of Afghanistan, Iraq, and the Gulf War. In each of these places, I was a party to violence as both witness and participant. In all of these wars, I participated in the diminution of humanity, mine included.

In each of these places, my perception of what it means to be human, of what is allowable or even possible in human interaction, was altered

In all of these wars, I participated in the diminution of humanity, mine included.

until my worldview, my understanding of how the world works, was changed irrevocably. I found that I could not function in the world I knew. Having seen and taken part in so much violence altered the way my brain worked. My reaction was, of course, perfectly normal. I had a perfectly normal reaction to totally abnormal circumstances. I lost control of my mind.

At night in Afghanistan, I would lie in my rack shaking and crying, terrified because all I could see in my mind's eye were images of the dead and the mutilated. During the day, I would have to leave the headquarters because I was shaking and so out of control I was afraid I would end up in a ball crying under my desk, which is not exactly the image you try to cultivate as a commander. At some point, I began to classify my mental state as being all right, vaguely not all right, or seriously not all right.

My reaction was, of course, perfectly normal. I had a perfectly normal reaction to totally abnormal circumstances. I lost control of my mind.

of a workday, screaming at the jets flying 500 feet over my head, "Can't you guys do that somewhere else?" I may have used slightly different language. I remember laughing at

that moment, because it actually is pretty funny to be screaming at jets, "What do you think this is, a combat zone?" as they are going out to bomb people. This is what we call a blinding flash of the obvious—that you are completely out of your mind. And I was.

Perhaps that day, or a day later, I was in my team room when a message came in from one of our teams out on the Pakistan border asking for some very specific instructions on an operation we had sent them on. I remember having been seriously not all right that morning, having gotten back to a point where I decided, okay, I am probably not in the best frame of mind to be tasking soldiers who are walking into a firefight. That is when I knew I needed help.

So I went to the Combat Stress Center to see the Army psychiatrist and we talked. I told him about being dragged out of a vehicle and having some thug put a pistol against my head and scream that he is going to kill me. And I told him about having my aircraft shot through a few times by ground fire, about surviving a mortar and a rocket attack, and about watching an IUD hit a bus full of German soldiers who were on the way to the airport to fly home. In turn, the psychiatrist talked about medication and therapy. He talked about protecting my privacy and helping me keep my top-secret security clearance. He said he could help me.

I made it through my year in Afghanistan, and miraculously, I had brought all of my soldiers home alive. Then I went home to my wife, and I tried to put it all behind me. I returned to my civilian job at the Department of State, where my first task was to draft a note for the Secretary of State declining to attend a gallery opening in Paris. My first attempt was a little too breezy; my second attempt a little too dour. Each time the message would come back with a snippy little note from the Secretary's staff, which earned me looks of disdain from my colleagues. Sadly, this really was the high point of the job. I was just back from a war and, with no transition, stuck in

I do not remember actually denying to myself that this was happening. But I do remember I was shaking and crying and hiding in a bunker in the middle

of a workday, screaming at the jets flying 500 feet over my head, "Can't you guys do that somewhere else?" I may have used slightly different language. I remember laughing at

a desk job feeling very much like Goldilocks trying to draft an RSVP for the Secretary of State: It is too hot, no, it is too cold. Enough.

A friend who worked in the Middle East Bureau stopped in to ask if I would be interested in going to Iraq to debrief terrorists. I jumped at the opportunity, and just under six months after I had left Afghanistan, I landed in Iraq. To synopsise: I went to Iraq, came home for four months, and then I went to the Gulf War. When I came home, my mom died. Then, I have an affair that ends my 20-year marriage. A pistol in my hand, I come very close to killing myself. And then I go back to the Gulf War where I self-medicate with whiskey and leftover Prozac, which for the record, is not very effective. Eventually, I ask for help again, and when I returned to the United States, I began to get adequate care.

But even with that care, I struggled. My brain did not and still does not work right. I have memory problems. One particular egregious

memory lapse caused me my security clearance, which ended both my civilian and military careers. I get lost driving in my neighborhood. I have panic attacks. I will not go to movies or restaurants. I have trouble distinguishing the mundane from the critical because everything seems critical. Every day is the Super Bowl. I am on medication, I am in counseling, and I am trying therapy. But all these things take time.

What I lack is a community of support. I have tried joining existing veterans groups, and I felt somewhat unwelcomed among the Korean and Vietnam veterans. I signed up with a group organized for Iraq and Afghanistan veterans, but I have not felt the love there either. Maybe it's me; but maybe not. Maybe there is some piece of this puzzle that is still missing, some place in my community that is not set up for veterans only, where veterans are segregated

I have trouble distinguishing the mundane from the critical because everything seems critical.



and isolated. Maybe it is a place that helps veterans integrate gradually back into their communities, sort of a halfway house where veterans and non-veterans can sit together and talk.

A place like this exists in every town and every city in America. It is called the community recreation center or the local church or mosque or synagogue or the corner bar. It is the gym around the corner, the auto parts store, or the Piggly Wiggly grocery store out on Route 40. It is any place where a member of the community can and does reach out to returning veterans to welcome them home and to integrate them back into that community.

Mara Boggs, M.S.

Major, U.S. Army

I am an active-duty service member; my husband is serving in Kandahar, Afghanistan; and I am the mother of two small children, an eight-week-old, and a two-year-old. War has an impact, not only on service members, but also on military families.

Recently, I was at Bethesda National Naval Medical Center, the finest military medical care

Family members have just as much stress on them as someone who is in combat, and I am saying that as someone who has seen combat.

in the Navy. My husband was not with me, as he is in Afghanistan, but too many people were in the delivery room with me: my

mom, my sisters, and my mother-in-law. It was a very long labor. I asked the nurse what happens if a young woman does not have this type of support while her husband is deployed and she has a small child. The nurse said, "Well, we pitch in." Then, her face took on a really pained look, and she said, "But sometimes we get too busy; sometimes that child has to be here."

That really struck me how difficult that must be not only for the child but also for the mother who is going into labor, one of the most stressful things that you can do in your life. Family members have just as much stress on them as someone who is in combat, and I am saying that as someone who has seen combat. Having and

These are not our first wars. We know what war does to people's minds, and we know—or at least we are learning—a lot about what Johnny and Jane need when they get home. The Army cannot do this alone, nor can the VA. And if we are going to avoid the public health catastrophe of half a million Americans coming home with mental health trauma, it is going to take all of us working together in our communities.

A soldier can arrive back home from the war in just a few days. You get on the plane in Afghanistan, and three or four days later, you are in your hometown. Sometimes it takes a little bit longer for your mind to catch up.

raising an infant when my husband is not here, I have felt as much stress in the past eight weeks as I ever had when I was in Iraq or Afghanistan.

Deployment

My husband and I have both been deployed three times. This is the first deployment where we have had kids. I had not thought about the impact deployment has on fathers and mothers and just how much the thought of those children are constantly on their minds. In some respects, as hard as it has been, I think that it must be even harder on my husband to be over there and not be able to hold his infant son. That is what it is like for millions of parents and brothers and sisters who are serving over there.

Some of the challenges that I have observed are the frequent and lengthy deployments and the lack of predictability that comes with those deployments. Not knowing when you are coming home certainly stresses out the family members as well as the service member. The therapy plane crash survivors receive from psychologists and psychiatrists may correlate to what the service member and family member go through after they think, "Well, I have been deployed three times. Will the fourth time be my last?" Or, "I do not think I will make it home," but I do.

Coming Home

First and foremost on the minds of many returning veterans, whether they are National Guard or active service members, is transitioning to the civilian sector. Some simply have served their time and served it honorably. A lot of stress goes with that, compounded by any combat that they have seen, or any of the stresses the family member has felt. Certainly, financial issues really compound stress.

Access to healthcare and childcare and maintaining contact with your unit after separation are critical. One of my soldiers is not doing so well. He needs to keep a vibrant social network, and utilizing Facebook helps. But if you do not have that, to whom do you talk? You talk to the VA. You talk to DOD. There are people like you that work on these issues who will help.

Joyce Raezer

Executive Director, National Military Family Association

One of the things First Lady Michelle Obama says, when she talks about the stress of war, is that military families are resilient, but they do not always show it. And they are proud, so they do not always talk about it. Many Americans do not always see it, but these are the hard realities that families know. We are here to talk about, and work on, how we address those realities and those challenges.

Today's warrior and warrior family are much different from previous warriors and warrior families. Not that far back, my husband retired from the Army; he did two year-long deployments in five years in the late 90s, and we thought that was a lot. Now, our service members are deploying multiple times. And so our warrior is different, our warrior family is different.

Some things remind me of that difference. Early last month, an obituary appeared in the local paper about a Sergeant First Class who died in Afghanistan. He was on his 12th combat deployment, his 8th in Afghanistan. He left behind a wife, two young children, and a baby on the way. Our association sponsors a scholarship program for military spouses. When we ask spouses why they want this educational assistance

One of the biggest challenges that I think returning veterans—those in the Guard, Reserve, and active—face is that they do not know all the programs that are out there. Operation Welcome Home in California connects the 30,000 veterans who return home annually. That is a lot of veterans returning home annually to California to access programs in the community. We are working to get better about that, but it is certainly a challenge.

We need to understand the culture of the military and what it takes to serve overseas. It takes a certain mentality to jump out of an airplane or to walk the streets of Baghdad and be able to function and, then, come back home and have to switch that off. That is very difficult.

and what they want to do, the answer that is becoming more frequent is, "I want to be prepared in case I have to be the breadwinner."

We also sponsor a summer camp program for military children called Operation Purple. The mostly civilian camp directors tell us some of the older kids take a couple of days before they get into the swing of camp because they are too busy worrying about how things are going at home. They are becoming the caregiver. Another frightening statistic is that half of those 2 million military kids are eight years of age or younger. All these children have known is war, and so we have to address those concerns as we look at deployment and reintegration—look at multiple deployments as a continuum, not a cycle.

Our association is relatively small, and we collect a lot of stories from military families. Our volunteers, our staff members tell stories of their deployment experience. But what we did not see was actual research on how military families were doing. It would have been nice when those first troops went to Afghanistan in October 2001 if somebody had conducted a pre-deployment survey, not only for the service member, but talk to and follow the families as well.

We are starting to see a body of research with findings indicating some of the stresses, issues

Camp directors tell us some of the older kids take a couple of days before they get into the swing of camp because they are too busy worrying about how things are going at home. They are becoming the caregiver.

with children and school performance, and mental health issues related to military spouses and multiple deployments.

We wanted to learn about older kids and caregivers, so we looked at two key issues:

- How are school-aged military children fairing?
- What issues do military children face related to deployment?

Our sample of 1,500 children and their caregivers came from our Operation Purple camp applicant pool in 2008. We reached kids ages 11 to 17 and their at-home caregiver, mostly their mother. We had a cross-service, cross-component sample to look at some of these issues based on gender mix consistent with the military, and we followed these families over the course of a year for several touch points. The baseline findings were printed in January 2010.

Children's Status

So, how are our children doing? In some ways, it is good. Military kids generally function above the U.S. average in other child studies, in terms

Girls were reporting more issues, especially with reintegration.

of academic engagement and peer relationships. However, they fall below their civilian peers in three areas: family relationships, anxiety, and emotional difficulties. Our researchers found that twice as

many military children were experiencing elevated anxiety symptoms and a moderate to higher number of emotional difficulties than their civilian peers.

Four factors stood out above anything else that determined how children were dealing with either deployment or reintegration.

1. Older teens were having a harder time.
2. Girls were reporting more issues, especially with reintegration.

3. Total time deployed mattered to a child's wellbeing: the longer the cumulative time the service member spent away from home, the more trouble those children were having in dealing with deployment and reintegration.
4. Caregiver mental health mattered. What is showing up in a lot of other studies as well is if mom is not doing well, then the children are not doing well.

The numbers are high in terms of the deployment challenges children face. Older kids are also talking about the care-giving duties that they are asked to perform. Especially important in the Guard and Reserve population (but not exclusively), they also talk about the fact that people around them do not understand what they are going through. It is sad that people in their schools and in their communities do not understand their life as a military child, and that they do not have anyone to talk to about these feelings.

The at-home parent talked about the responsibilities they were taking on: juggling work, keeping things normal for their kids. They also talked about isolation, about not having someone to talk to, about feeling that people in their communities did not get what life was like for them.

Reintegration

The spouse and older kids talked about the difficulties in reintegrating the deployed parent into the family life. One big worry is the worry about the next deployment. If all you have known is deployment, you know it is going to happen again. And so while trying to reunite as a family, you are thinking about down the road and being apart again. That is having an effect on the reintegration. Spouses and children talked about the returning service member's mood changes and the struggle in dealing with them, again asking where do they go for help.

Targeted Support

Research—ours as well as that of others—tells us that, in terms of helping families, we need to look at targeted support. If girls and older teens are reporting more reintegration challenges, how

do we address that, not just with the kids but also with that deployed service member? How do we help that deployed service member maintain a relationship with those kids while that service member is gone? We need to look at support across the entire spectrum of deployment, including reintegration, while remembering that deployment challenges change with every deployment. And deployment with a toddler is very different from a deployment with a teenager.



So how do we help those families? How do we recognize that just because you have made it through one deployment, the next one may not go off like clockwork? How do we help that non-deployed caregiver with the support they need? I have seen what happens to a lot of us who want to be the super mom during a deployment. I have friends who bend over backward and sacrifice their own wellbeing to keep things normal for their kids. How do we get to them with the message that one of the best ways you can take care of your kids is to take care of yourself? And how do we engage communities to support that parent in those care-giving needs?

Community Support

We talked about the higher rate of anxiety and emotional difficulties in our military sample, as opposed to rates in civilian communities, but we still have many military families that are doing

well. If cumulative time away matters and deployment continues, how do we help the families who are currently doing well stay that way? It is a big challenge for all of us, and that means communities have to show they care. We want to be a resource, as we release the next results of our study, as we look at preparing information that communities can use, whether it is through our organization or other organizations working together to embrace military families wherever they are: schools, workplaces, youth sports, other activities, and religious organizations.

We have created a teen toolkit, based on what we heard from kids, kids who say they are proud of their service member and want others to show that pride. Kids are reminding their teachers that when they talk about war, it is not an abstract for military kids; it is the real thing.

DINNER KEYNOTE

Antonette Zeiss, Ph.D.

Acting Director, Chief Patient Care Services Officer for Mental Health, Department of Veterans Affairs

Behind the questions asked about VA is some skepticism about how ready we really are to take care of people. Questions have arisen about how we approach things and how well we can work with others to serve these enormously important needs that people are bringing to us as they return from the wars in Iraq and Afghanistan. And I want to honor that skepticism, as I understand where some of it comes from. Therefore, I will talk about things that I believe we are doing very well in VA and important changes that have occurred in the last several years.

Changes in the Veterans Administration

The VA provides a summary of benefits for Reserve and Guard, many of whom are unaware of what benefits they are eligible for through VA. Another handout is about the congressional act that makes all veterans who have served in Iraq or Afghanistan or other related combat areas eligible for VA care for five years after they have been discharged from active duty. We want very

much for all of these returning veterans to come into VA during that five-year period so that, even if later they might not be eligible for care from VA, they will remain eligible if they get started during this window, barring congressional actions that might undo that.

Over the last five years, tremendous transformational work has taken place in terms of VA mental healthcare. In the last fiscal year, the VA saw 1,259,214 veterans for care for mental health problems, out of 5.2 million veterans who are seen for healthcare. This is a fairly high percentage of the veterans who have mental health problems seeking care from VA, and we believe that is because of our outreach efforts and our efforts to make sure that veterans' mental health needs are identified and served.

We track and keep several data sources for veterans returning from Iraq and Afghanistan. About 47 percent of those who seek healthcare from VA are from Reserve and Guard, and 53 percent are from active duty who have ended their military commitment. We also track the kinds of health problems that are flagged in their electronic medical record when they enter the VA system. The most common problems are muscular-skeletal, but the second most common are mental health problems. The third most common problem is symptoms that do not map onto a diagnosis easily, vague symptoms that do not lead directly to a clear diagnostic category. We believe many of these veterans also have mental health issues.

For veterans who use VA, mental health problems are very common, and for this returning group, mental health problems are identified at very high levels.



In fiscal year 2006, VA treated a little over 900,000 veterans for mental healthcare, so it has been a large increase in those we are serving. During that period, mental health staff has increased from about 14,000 in fiscal year 2006, to almost 21,000 currently. Patients seen for mental health problems grew by 39 percent from 2006 to 2010, while the mental health staff grew by 56 percent.

We are preparing for higher quality care and for a potential increase in utilization of VA, as there is a surge home. We also are increasing that staff to correct for former attrition. There was a period in the late 1990s and early 2000s when VA mental health staff was very much reduced. I think some of the skepticism about VA comes from a period when, in fact, there was real attrition of VA mental healthcare. There also was a lack of resources and little emphasis on other aspects of increasing the quality of VA care.

VA care did improve dramatically during that period in some other ways, but we have turned around what I think was a real problem in terms of mental health: not enough staff, nor new models of care, nor a commitment to quality of care. We need to sustain that increase in mental health staff and make sure that, if there is a need to increase it more, there is energy behind that. Our staff delivers state-of-the-art treatments, psychotherapies, and biomedical treatments for mental health problems. We have put tremendous energy into training staff to deliver effective, evidence-based psychotherapies.

The National Center for PTSD runs a wonderful mentoring program to try to increase the consistency of care across VAs. They have focused on training in biomedical treatments, particularly for PTSD, but also for associated health problems. The majority of veterans who come to VA do not have just one mental health diagnosis. Someone who has PTSD may also have substance use problems, depression, and/or grief. They also may have bipolar disorder. There are a number of ways in which there are co-morbidities and there are certainly co-morbidities with physical health problems. Our staff had to think about how to craft care that is specifically targeted for a particular diagnosis but that is also sensitive to the multiple diagnoses with which people present to VA.

In recent years, we have expanded our justice outreach. One of the great tragedies for veterans is ending up in prison as a result of impulsive or angry behavior driven by symptoms of a mental illness. We started with something fairly simple. Because of federal regulations, we cannot serve veterans while they are in a prison. But we started a program where we will connect with every veteran who is within six months of discharge from a prison and make sure that they have a treatment plan, housing plans, and that all the resources will be ready to be delivered to them the minute they are released from prison. We also have been able to develop a liaison with Veterans Courts, a terrific, developing project.

We also are doing a great deal of training with police departments to deal more effectively with individuals who have mental health problems. This is very new to us in VA, and we will do much better as we get more experience with them.

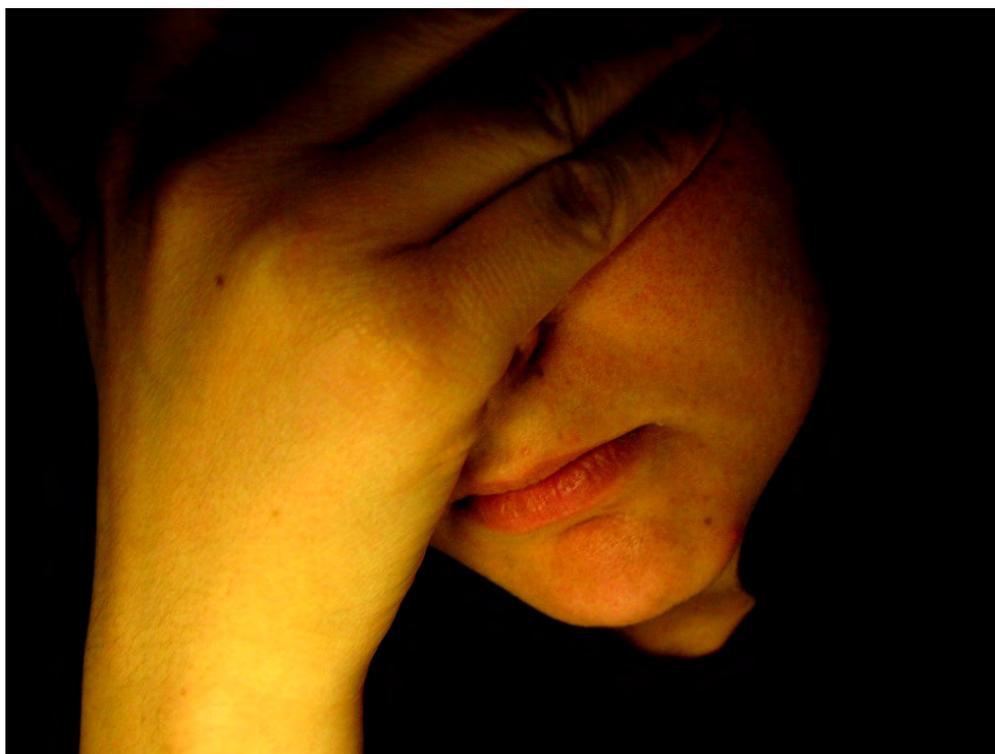
VA Plans Forward

I am passionate about our commitment to integrate mental healthcare into primary care. Integrated care will mean that mental health is seen as overall health and that care for mental health problems is recognized as just a natural component of healthcare so people do not get flagged.

We will always need specialty mental healthcare. We will always have specialty mental health inpatient units and outpatient programs. But people will go to those more readily if they have made a connection with mental health providers in the primary care setting, if they have had that treated as an essential and logical part of their care by their primary care provider. They have to develop trust that their mental health provider is not labeling or stigmatizing them but, instead, is recognizing that part of what the system needs to provide them is

The majority of veterans who come to VA do not have just one mental health diagnosis.

Our staff had to think about how to craft care that is specifically targeted for a particular diagnosis but that is also sensitive to the multiple diagnoses with which people present to VA.



mental health services that are well integrated into what they are getting for the other problems that they bring to VA.

In primary care, we also screen every veteran who comes for healthcare. When they first get to primary care, they are screened for PTSD, depression, problem drinking, military sexual trauma history, and for traumatic brain injury. If they screen positive, they will get a full evaluation for those problems. If they screen positive for PTSD or depression, they will also get a suicide risk evaluation. There will be resources brought to bear to respond to the results of those evaluations.

The next steps include a public health model. In some ways, VA has been a traditional healthcare system, not a public health system. We believe that the real challenge facing us now is to make that transition and to do it as much as possible in collaboration with the Department of Defense. From oath to discharge from the military, people are taken care of by DOD; the VA will take care of them for the rest of their lives. We need connections between the Department of Defense and VA to do that optimally.

VA has always focused on providing clinical service to people who have been identified as having a mental health problem. Historically,

that has been our mission. It is a critical mission and one that we will continue to commit to and to ensure that we have adequate resources to provide. But we want to start thinking beyond that, about other levels of need and how VA can be responsive to them. For example, when we talk about prevention, we are talking about services that identify people who are in at-risk groups, like the currently returning veterans, Guard and Reserve, services that will offer skills to help them avoid developing a mental health problem further down the road.

We are also focusing on communities. Communities include families, employers, a community's larger mental care health system, and colleges and universities. A huge number of veterans are going back to school on the GI Bill. We need to expand our ability to implement public health-oriented programs with veterans and their families and communities.

We can also try to de-stigmatize help-seeking and perhaps address some of the skepticism about VA and the role it could have in returning veterans' lives. So we are trying to expand our involvement with veteran families in treatment identification, planning, and care delivery. We are developing several Web-based mental health program materials to facilitate working with employers, and to facilitate mental healthcare on college and university campuses.

Impact of VA

We all work and try to accomplish the goals that we have set. We also try to develop collaborations and a shared commitment to making sure that the return for these veterans is different from that of Vietnam veterans, that they are being taken care of, welcomed home, and get the services they need.

Let me tell you a story about David, a veteran who called the Suicide Prevention Hotline. Some of this story is in his own words and highlights some of what I believe VA is doing very well but, also, the challenge we have to face.

David arrived in Las Vegas in early October. He did not come to start a new life in that city: "I started wandering the streets of Las Vegas. I came to Las Vegas with the intention of committing suicide."

After a failed attempt, David says he was ready to try again. That is when he said fate intervened and something caught his eye: "I saw a bus stop in the shade. I thought I could take a rest; I'd been walking for miles. I sat down at the bus stop. There was a sign, which read, 'It takes the courage and strength of a warrior to ask for help,' and it had the number of the hotline."

Immediately, David made that call for help. It was a call that not only saved his life but helped him realize he needed medical attention: "I found out I had been suffering from depression, and that got me admitted to a hospital."

He is now living at U.S. Vets, which houses Veterans and is a VA-community collaboration. He is getting all the help he needs to get back on his feet: "They clothed me, fed me, gave me counseling, job training."

There are about 90 bus stop shelter ads. David is glad he made that stop that day and will forever be grateful to the person on the other end of the line who simply listened and helped save his life, a person who was very understanding and very compassionate: "At that time, I had no one in the world with me. All it took was just someone to show they cared a little bit."

The number for the Suicide Prevention Line is 1-800-273-TALK. It is a 24-hour hotline, and also is for military families as well as anyone else who needs help.

Many family members call because they are worried about veterans. Recently, we responded to a hostage situation where a vet threatened to kill himself, his children, and other family members. The hotline staff worked through it and involved the police. That police training helped; the police did not escalate the situation, they worked with it. There were calls back and forth, and they got everyone out. The person who was calling the hotline and threatening harm is in care, as are all the people who were with him.

So there is a safety net. We can help those like David who learn about it and use it. And we can help those who come to VA for care and who accept screening and services. But the big issue is this: What about those people who do not know where to turn, who are not coming to VA, who do not stop at the vet shelter, who are struggling and do not know that there is help, that there are so many things we in VA can do for them, offer to them? That is the major issue.

It is great that we have resources, that they are working well, that they really provide hope and help. But we need to talk and continue to push in terms of what more we need to do to reach all of those who have not found the safety net and are struggling and desperately need what we all want to provide.

"It takes the courage and strength of a warrior to ask for help."

At that time, I had no one in the world with me. All it took was just someone to show they cared a little bit.

PANEL II: REINTEGRATION INTO THE WORKPLACE

Ronald Finch, Ed.D., Moderator

Vice President, National Business Group on Health

The National Business Group on Health is a membership organization of large employers. We have 302 members, depending on what day of the week it is, on who is buying whom, and on who is merging with whom. But our member companies provide healthcare benefits to about 60 million employees and their families. Veterans, Reserves, and Guard are all employees and are in our employee families, and they are affected by the wars in Iraq and Afghanistan and by other wars against terrorism.

Admiral Mullen, the chairman of the Joint Chiefs of Staff, made a comment that challenges us to think: Veterans are American citizens who have gone off, done our country's bidding without question, and sacrificed. We owe them.

Secretary Shinseki [Secretary of Veterans Affairs] talks about veterans who are driven. They are not clock-watchers; they are focusing on serving the customers' problems and providing goods and services, and they do it on time. Clients and partners value their skills, knowledge, and attributes, and are eager to work with them again.

GE started a program to hire a minimum of 200 veterans a year. Jack Welch, who was chairman of GE, said officers have a can-do, upbeat attitude, and they make yes and no decisions on the spot. Their people skills are superb, and they tend to be great motivators and team builders. He also said, "Your toughest location as an employer might be better than the best outpost they have endured."

Quite often, I think we focus on the problems, and we do not focus on the value of those Reservists, veterans, and Guard in the workplace. We do not think much about the decisions that they are asked to make daily. That lance corporal who is out in the field in Afghanistan, who has an M16, may be making a more important decision at any given moment than any corporate CEO. And we bring that person back to this country, back into the workplace, and expect them to adapt overnight.

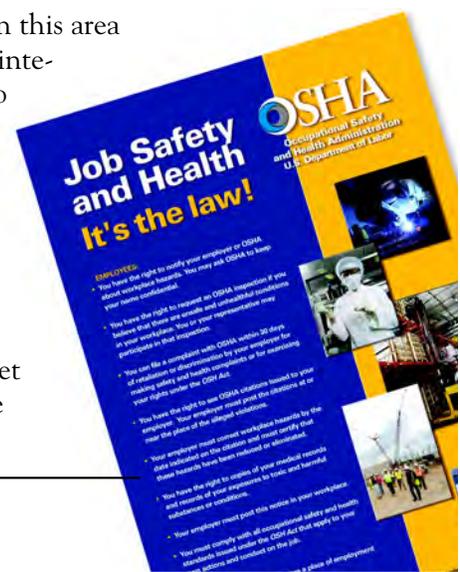
We need to think about this: What programs, services, provider networks in our mental health programs, and provider networks in our general medical networks are in place to serve that population and their healthcare needs so they can remain whole, and so we can create the culture that nourishes all employees, including veterans, Reservists, and Guard?

John Howard, M.D., Main Presenter

Director, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention

The National Institute for Occupational Safety and Health (NIOSH) is the sole federal agency responsible for worker health. We are part of the Occupational Safety and Health Act of 1970, which chartered the Occupational Safety and Health Administration (OSHA) and is the primary research agency for OSHA and for the Mine Safety and Health Administration (MSHA). We generate new knowledge in the field of occupational safety and health and hand that knowledge off to practitioners.

We are interested in this area of military civilian reintegration because we do a lot of work in emergency responder areas. We administer the World Trade Center Health Programs, which now are in the ninth year. We also get involved in hurricane



response and with the responders. Recently, 300 of our personnel were involved in the Deepwater Horizon oil spill.

We are very interested in the psychological as well as the physical issues confronting responders. That particular interest has led us to look at the categories of responders: professional responders, firefighters, police officers, protective services and security personnel, and just-in-time responders—people from all walks of life who undertake response work for long periods of time, as in the case of the World Trade Center. We are also interested in situations where there are body parts, fires, all sorts of toxic environments, and in building resiliency among responders. The transition of looking at a war fighter versus an emergency responder is really not that significant in our world.

In this area, NIOSH is interested in categorizing the risk for Guards or Reservists in terms of their experience at work—and here, the work environment is a war environment. We are trying to categorize that risk and develop a matrix so that we can predict risk and do interventions that target the highest risk categories. We are yards away from that goal.

The available data, while abundant in some areas, does not give us that much knowledge. We need much better data and an entire research component around this issue. But one could make much of this data, and I am going to suggest some things to consider.

Demographics

There are over 1 million workers in the seven categories of Guards and Reserves (Army National Guard, Army Reserve, Coast Guard Reserve, Air National Guard, Air Force Reserve, Marine Corps Reserve, and Navy Reserve). Considering basic demographic data, 48 percent are under 31 years old; 52 percent are above the age of 31. These are not people who are deploying at age 19 or 20 with their whole life ahead of them; that age group may not have invested in any career, may not be married, and maybe there is not much going on in their life to disrupt, especially their work environment.

Most of them are male; 38 percent have at least some college education, and 51 percent are married. Does that mean they have less social

support? Does it mean that, in their work environment, they are more alone and less likely to rely, or have to rely, on extended family? Seventeen percent are officers, and their ethnicity is 76 percent Caucasian non-Hispanic.

Other data reveal possible risk issues based on discrepancies among the seven components, such as: age, gender, and race proportionality; education levels; marital status; and length of deployment. The impact of some of this data is examined below.

We are seeing a substantial increase in the number of days of deployment. More frequent and longer

deployments, and with less advance notification, suggests real disruption in one's life. For the most part, these service members are above 19 years old; they

may be working, and they may have substantial careers that they have invested in over many years. This is a real psychological stressor.

For the most part, these service members are above 19 years old; they may be working, and they may have substantial careers that they have invested in over many years. This is a real psychological stressor.

Employer's Perspective

When service members return home, there are resulting changes in their health status and in functionality. Attitudes about work may have changed; they may look at something they did previously as trivial. Their worldview and their psychological status have definitely changed and may impact their job.

Employers are worried about productivity. They do not look at the removal of a valuable employee as a positive thing. Certainly, they are dedicated to the mission of the country and to their workers who are also in Reserves and Guard. Nevertheless, you have to replace workers. Sometimes, you have to retrain workers when they return, or provide reasonable accommodations for them.

Employers have not done a good job in providing reasonable accommodations. Just look at the Americans with Disabilities Act of 2008—Congress has expressly overturned two Supreme Court decisions that make it easier for plaintiffs to provide reasonable accommodations. The

more complicated question is, as difficult as it is to provide reasonable physical accommodations,

Some employers may not hold jobs open; they may refill them immediately. We need to ferret them out, and not to be Pollyanna about it.

how much more difficult would it be to provide accommodations for psychological functionality

issues? Some employers may not hold jobs open; they may refill them immediately. We need to ferret them out, and not be Pollyanna about it.

Veterans' Perspective

Returning veterans may not be able to walk right into that job. They are coming back for the second or third time, and their performance level may be very different. Everyone else they have worked with has been there every day. They are in an environment where there is high productivity, and all of the sudden, they are there with psychological and functionality issues, and their performance may not be up to what it had been. They may internalize this, as well as have it externalized on their performance appraisal.

People in their 30s or 40s are progressing in their careers. It is difficult enough not to be deployed and have your career interrupted. How do you come back from deployment and get it started again? How do you get back on the ladder? Those are stressors that we have not characterized well. They have a life of their own while the person is back at their job. The worker may have an acute flare-up; they may be seeing a cumulative pattern or cascading upward so they have an event, a suicidal gesture, or worse.

Effects

Do we know exactly what particular type of mental health effect is really going on by virtue of risk categories that we have yet to construct? Because of their risk, Marine Reserves will have more PTSD and more depression. Tailoring our treatment becomes an issue of how we correlate that with work performance issues so that we can do an intervention at work.

Employers and EAP programs will be able to be informed about whether this person really has an impulse control problem. They may also be

informed about whether we can predict if, because of the particular work that he did in the war theater, that returning veteran will have more problems with impulse control or will be flat and unable to think well, to take initiative, or to problem solve.

The difference in safety compliance socialization may be different for someone who has been in a war theater. He or she may not be impressed by an unguarded machine, or a cord strung across the hallway. And writing a memo back and forth, trying to get it right, may seem to be an entirely trivial activity, which may add more stress. You can be present, and the lights are on, but nobody is "home" because you cannot focus, you cannot concentrate.

There also is the disruptive nature of deployments. In one of the components, data show that of 100,000 service members, 72,000 are called up involuntarily. Maybe they are prepared; maybe they are packed and have handed their work off to someone else; and maybe they have talked to their employer, who has said, "No problem, we are going to save your job." Service members who volunteer are probably more prepared than those who are called up involuntarily. Again, it is evidence of the destructive nature of deployments.

There have been a substantial number of non-hostile deaths—the enemy did not kill the individual. These could be accidents in the war theater, or they could be friendly fire; the number for self-inflicted deaths on the battlefield is 285. This may be the tip of the iceberg of the problem occurring in the war theater. It is a DOD issue about what is really going on here and whether we can pre-identify service members who are coming out of one employment setting into another knowing they need specialized interventions.

Almost 61 percent of the selected reserve units are working fulltime. Some are students, some part-time workers; only a very small percentage would come under the non-employed status. So, again, what is the effect on them, and what is the effect on the workplace?

Most Reserves work for large employers. But if you are 25 percent of the workforce in a place that has four employees, deployment becomes disruptive for the work, the worker, and the

employer. And what if you are the CEO of that little company, what happens to the company when you are gone?

The majority of people work in the private sector; they do not all come from government, which has fabulous programs for employees. Private sector employees are spread out in places that vary in terms of their policy orientation about reintegration and deployment. A substantial majority of selected Reserves work fulltime and are in management. They run things, so their absence may be even more disruptive. Not surprisingly, many of them are in protective services: security, police, fire.

Four percent of selected Reservists are self-employed, and most of them are in the chief executive category. Their business, their world, their livelihood, their family's livelihood may depend solely on them. Dentists usually are solo proprietorships; lawyers may be sole practitioners.

Larger employers have more workers. But 23 percent of the employers with selected Reservists are in business services, such as the restaurant business and bars.

All of this data suggests that we really do not know as much as we probably should. For example:

- Do we really understand what all the issues are about risk?
- Have we categorized risk?
- Have we segmented risk so we can begin to predict where problems can occur? Can we start orienting needs and resources to that?
- Do we perceive people's correct needs?
- Are these resources well targeted to the wonderful things that folks are doing?
- Are the people who need these services really available to receive them?
- Are we timing interventions well, and do we know how to time them?

Lastly, I want to mention that the Center for the Study of Traumatic Stress, Uniformed Services University is conducting two significant studies: a longitudinal study of Guard and Reserve to look at mental health outcomes, exposures, and work organization; and the Army Study to Assess Risk and Resilience in Service members (Army STARRS). We hope to be able to have a summit focused on findings from this research in the next year.

RESPONDENTS

William C. Bonk, M.B.A.

Director, Health and Wellness, Lockheed Martin

Lockheed Martin is a large employer with 140,000 employees. The financial and other organizational resources that we can bring to the table to help support the transition of service personnel must be balanced between the veterans' and the community's needs.

We are not really sure if the resources that we have the capability to bring to bear are necessarily the right ones, at the right time, at the right place. And some of the laws that we have to abide by—affirmative action, equal employment opportunities—at times place restrictions on what we are able to accomplish.

I want to share a brief narrative involving a young man. In 1999, he had been accepted to Morehouse College, but was hungry for new experiences. He decided to join the Army, serve his four years, and then pursue his degree. But something happened: he fell in love with the Army and decided to make it his career. He had the next 20 years of his life planned.

My name is Patrick. My Humvee was hit by a roadside bomb on a night patrol. An IED blast entered my Humvee on the right side and shattered my right knee.

The Sergeant's career was over. The date was Sept. 11, 2005.

It changes your life. You get depressed, down on yourself, you start to lose yourself to a certain extent. But somewhere along the line you remember that you are a soldier, that you can do this. You don't know the meaning of quit.

The Army told me they were going to have to medically retire me. It was devastating at first, but I knew that I could land on my feet and start over and start a new chapter in my life.

His new chapter began as a Lockheed Martin employee where the Focus on Ability Team is at work to make the corporation a more inclusive workplace for people with disabilities. Today, Patrick is managing business contracts as a member of the Seamless Transition Apprenticeship Program, which provides opportunities for wounded warriors.

The program's slogan is "from service to serving," because we have already given our service. Now it is time for us to start serving our country again. That is the foundation that the program is built on.

At Lockheed Martin, we never forget for whom we are working. Servicemen and women need to be reminded that the home fires are continually lit for them and burn brightly. While Lockheed Martin provides critical technologies that they use, we are equally dedicated to supporting service members and programs, improving their lives, and doing what we can to honor their selfless service to the country. We make philanthropic contributions, conduct fundraising efforts, and offer employment opportunities and volunteer activities.

Lockheed Martin Initiatives

In terms of active and deployed service members, we are committed to providing the moral support that boosts the spirits of these individuals and reminds them of our gratitude. One of our biggest efforts is the Operation USO Care Package. We have had to turn people away on the weekends, we have so many employees showing up to volunteer to stuff packages!

The Wounded Warrior Transitional Housing Initiative provides free housing to military families making a transition back to civilian



life after their injuries. The Wounded Warrior Project, which is several creative programs, is designed to enhance the wounded soldier's recovery. We put together backpacks, comfort packages, for their arrival at military trauma centers. We also have initiated disabled sports programs, like kayaking and skiing, and outdoor activities such as hunting, fishing, boating, and camping for severely wounded service members.

Lockheed Martin also supports the entrepreneurial boot camp for veterans with disabilities at Syracuse University. This program offers cutting-edge experiential training, entrepreneurship, and small-business management.

We have more than 28,000 employees with prior military service, and those are just the ones who have identified themselves. Data is difficult for us to get because it is all self-reported. But Lockheed Martin is number 20 on the G.I. Jobs list of 50 military employers. We recognize that employment is one of the keys to helping veterans reestablish themselves in civilian life, so these programs target the returning veteran population.

Our military relations staffing team is unique within the industry. We have three veterans, one of whom is still in the Navy Reserve, and they guide the corporation's veteran recruiting efforts, which include more than 160 military career events each year. We participate in the Hiring for Heroes series of job fairs co-sponsored by the Secretary of Defense, and the Seamless Transition Apprenticeship Program.

While military service members make many sacrifices in the fight for freedom, their families give up a lot too. In recognition of this, our employees support numerous projects that make life a little easier. Operation Home Front Family Hub enables military families to set up free personal websites and allows them to communicate with deployed loved ones, no matter where they are. Deployed soldiers and their families share emails, pictures, and videos at any time of the day or night.

The Service Aid Organizations provide a range of programs and assistance to service members. We support fundraising activities through direct contributions to support a specific program. Many Lockheed Martin companies have signed statements of employer support for the Guard, the Reserve, and the Department of Defense organizations that encourage employers to support employee participation.

Lockheed Martin has funded a major upgrade to the Veterans of Foreign Wars computer system. The upgrade makes this system compatible with the newly upgraded Department of Veteran Affairs system and will enable the two to talk to each other in a more integrated fashion when members file for benefits. We also support the Congressional Medal of Honor Foundation, which provides values and qualities of courage, sacrifice, and patriotism through increased awareness, education, and behavior.

Balancing the Workforce

My responsibility in the corporation is on workforce balance. We have been building this 30- or 40-year-old program, but a large part of our workforce is starting to exit with retiring baby boomers. So we face severe hiring shortages in the future. Our current crop of students is not studying the math and sciences that will be required, but our programs need to be U.S.-based.

We have a difficult time hiring non-U.S. citizens, and that golden ticket for the clearance requirement is critical for our continued success. Therefore, we have a vested interest in tapping any labor pool that we can get our arms around and embrace. Veterans clearly fall into that category.

Our expertise includes special military relations managers who understand veterans' needs. We are trying to stretch the envelope on gaining access to this labor pool. We make regular visits to military bases and participate in fairs, and we have a relationship with service academies and their alumni.

Once employed, veterans have access to the full complement of benefit programs offered to all Lockheed Martin employees and their families. No Lockheed Martin coverage has exclusions for any injuries or illnesses received while a member of the armed service. As a matter of fact, we tried to integrate the care our company offers through the employee benefit programs with VA benefits.

In particular, our Employee Assistance Program works to place resources specific to the needs of the veteran community and to situations unique to them and their families. These include training staff for specific situations that may arise 24/7; access to counselors and programs; and developing a network of experienced counselors who are veterans themselves and who specialize in issues that are unique to their community.

The organization NAAS provides consultation and materials for managers on how to integrate the returning soldier successfully, how to identify early warning signs, and on addressing performance and other issues that may arise. We have targeted education materials for veterans, spouses, and their children, as well as co-workers and managers on common issues that are unique to them.

While military service members make many sacrifices in the fight for freedom, their families give up a lot too.

No Lockheed Martin coverage has exclusions for any injuries or illnesses received while a member of the armed service.

In 2009, our military relations team hired more than 1,800 veterans, including 990 who came directly from military service.

According to the U.S. Department of Veterans Affairs, of the private sector employees in 2010, we are the employer of the year.

We moved the percentage of exempt transition military hires from 1 percent to over 65 percent.

According to the U.S. Department of Veterans Affairs, of the private sector employees in 2010, we are the employer of the year. We achieved the

We need veterans' skills, and we need the characteristics, leadership, and management experience many of these individuals bring to the table.

role of a primary sponsor of the Service Academy Career Conference; we are the first in the industry to have a dedicated

transitioning military recruitment website, the first to hold webinars, and the first with a YouTube job fair video.

We are G.I. Jobs' Top Military-Friendly Company, a list we have been on for five consecutive years for best practices methodology on our subject-matter-expert teams. We brand all of our activities and have high customer satisfaction per our enterprise-wide surveys.

We need veterans' skills, and we need the characteristics, leadership, and management experience many of these individuals bring to the table. The challenges are to align these resources to meet veterans' real needs. Sometimes, we will hit it right on, and sometimes we won't. And sometimes, operating a business in this industry and in this economic environment is challenging.

I have spoken with military recruiters and many others who are involved behind the scenes in making all of this happen. As they see it, the challenge is preparing service men and women to transition from military life into industry. But no matter how many accommodations you try to make, you cannot always account for all of the challenges that these individuals face when they come out of the military.

Daniel J. Conti, Ph.D.

Managing Director, Employee Assistance and WorkLife Program, JP Morgan Chase

Manufacturing has been the leading recruiter and the leading employer of veterans, Guards, and Reservists, particularly for Defense Department-affiliated occupations: aeronautics, aircraft manufacturing, weapon systems, and the like. For the most part, the financial industry has not been a large recruiter of servicemen and women. We are out to change that at JP Morgan Chase.

For the longest time, when we thought about Guards, Reservists, and our veterans, we thought about them as customers. Our focus was on giving them special products that would help them or their families, whether it was a special credit card that enabled them to defray interest charges or to put off other kinds of special fees, or whether it was special ATM privileges around bases while the service member was deployed. That is the way we reached out to veterans, Guards, and Reservists.

JP Morgan Chase Programs

What you are seeing now at JP Morgan Chase is a business that is very young with respect to building the kind of robust programs like those of Lockheed Martin. I represent our Employee Assistance Program and WorkLife Program, so my perspective probably is based much more on the psychological situations for which we are preparing.

We have accomplished some good things already to make ourselves an employer of choice among service members. Like other companies right now, we are providing full pay and benefits to our deployed Guards and Reservists while they are away from the workplace, for up to a year. We are also providing full pay and benefits for a graduated period of time post-deployment before they return to work, so that they can get their

affairs in order at home before they have to return to the workplace. That is based on how long that they have been deployed.

At this time, we are working on increasing the childcare benefits for our military families. We already have a pretty robust backup childcare program for the bulk of our employees. We are putting in special provisions to give our returning veterans, Guards, and Reservists extra childcare benefits that will aid them through the transition when they are trying to get things sorted out to return to work.

Our Career Services Department is very much interested in providing transitional services for our veterans when they return to work. To that end, we are providing training for them before they get there, and once they get there. Then, we want to continue providing career-progression training for them as they remain at our worksite.

We estimate veterans, Guards, and Reservists to be about 3.5 percent of our workforce. I say “estimate” because this is a self-reported demographic; we cannot make anyone tell us whether they are a veteran before we hire them. Our chairman’s mission is to double that. Manufacturing has long held a stranglehold on our servicemen and women because it fits very well with their previous duties, but we know we have to get these people into our company.

There are good and bad points about that. On one hand, physical disabilities in a financial industry really do not make that much difference. The majority of our jobs are sedentary, involving IT knowledge and some interpersonal skills. It does not matter if you are in a wheelchair or have limited use of your arms and legs.

The skills that our company needs are largely interpersonal and cognitive. So we have an interesting interplay coming up in the near future, given that the higher number of casualties we will be seeing from these last two conflicts are going to be concerned with psychological and neurological competencies. We are trying to prepare by providing the right kind of training for our managers and for our employee assistance program so they can meet these challenges head on.

Accommodations in the workplace around physical disabilities are much easier. It is easier to build a desk than to figure out how to stagger

training requirements and work hours; how to change reporting contingencies; and how to change the nature of customer interactions to work around factors like memory loss, fatigue, exhaustion, concentration difficulties, and emotional volatility.

Those are going to be the very competencies that we depend on in an industry like ours. Yet, we are told that those are the very competencies that we may be seeing the greatest impairment in for the relatively small number of casualties that come back.

In that vein, we are trying to provide an employee assistance program with a dedicated intake team that has been trained on veterans’ issues. We are doing our best to identify providers and an ER counseling program that understands veterans’ issues and language. We are also making sure that we have trained professionals who have some exposure to the military and the military way of life so they do not have to spend the first three visits trying to understand what it was like or what it meant to be a soldier.

We are walking a very fine line here. How do we provide training for our managers and our workplace that provides compassion and help for servicemen and women without building in automatic stigmatization? Whenever we start training managers about the special needs of any group, there is almost an implication that this group needs to be looked at differently.

One of the real challenges is in preparing a workplace for returning veterans who may have special needs, particularly in the cognitive and interpersonal areas. How do we train those managers without automatically sticking a red label on people to say they are dangerous, or unusual, or eccentric, or to be watched out for? That is an incredible balancing act that we have to work on when providing psychological outreach programs to returning veterans.

Recruitment

We are increasing our recruitment. Not only is it a patriotic thing to do, but it is the smart thing to do. Wall Street would not be making millions of dollars—with the protection and the freedom to do so—if it were not for those people who are carrying weapons and protecting us. There is also a selfish piece: we know these people have

management skills and “under pressure” skills and can really make our workplace better. We also believe that they increase the morale and the productivity of the work teams in which they are placed.

Future Plans

We are planning to do a lot more in terms of partnerships and philanthropy, and we are very

Wall Street would not be making millions of dollars—with the protection and the freedom to do so—if it were not for those people who are carrying weapons and protecting us.

active with a group called the Wall Street

War Fighters. This fantastic group out of Philadelphia retrains obviously well-qualified veterans to become Wall Street traders. We also are providing special help in training around

Ronald Drach

President, Drach Consulting

I recently retired from the U.S. Department of Labor, which has several programs. One program is called the Disabled Veteran Outreach Program Specialist, and approximately 1,000 of them are based in the states that work day-to-day with returning disabled and wounded

economic issues that are facing our returning veterans, Guards, and Reservists, particularly around the housing and mortgage crisis.

One last piece: We are putting together employee networking groups. Our company has had employee networking groups that, originally, were based largely on race and culture. We had an African American networking group called Ujima and an Asian American networking group called Aspire. Now, we are building a veterans networking group, whether it is for peer-to-peer support or peer-to-peer counseling.

We want these people in our workforce, and we are going to do our damndest to bring them in and accommodate their needs. We all know the resiliency of soldiers and naval personnel is incredible. But for that small proportion of people that will need the kinds of accommodations that we can deliver and the kinds of accommodations that will be most sensitive to us, that is where the great work will be.

service members. However, they serve all veterans who have a disability and some barrier to employment. Commonly called DVOP, the program is about 34 years old.

President Jimmy Carter established this program in response to the employment needs of returning Vietnam veterans, particularly those with disabilities. Originally, it was an administrative initiative. When President Carter was leaving office, he sent a proposal to Congress where it was established successfully in law. The program has made a real difference in Veterans' lives, particularly those of Vietnam veterans. Now, this generation of veterans are coming back and working with DVOP to gain employment.

The Office of Disability Employment Policy (ODEP), an agency in the Department of Labor, conceived the program America's Heroes at Work. A small agency,



ODEP was established in 2008 and morphed as a result of two pre-existing programs. One was the President's Committee on Employment of People with Disabilities, which was established back in 1949. The other was a taskforce on the employment of adults with disabilities established by President Clinton. Those two programs merged and became the Office of Disability Employment Policy.

We had been hearing this from employers: "We want to hire wounded warriors; give us someone who has a gunshot wound; give us someone who is an amputee, or who has some other physical wound." We never heard from an employer who said, "I want to hire someone who has PTSD; I want to hire somebody who has traumatic brain injury."

America's Heroes at Work

America's Heroes at Work evolved as a result of employers asking for, recruiting, and looking for wounded warriors. We told them there is a need to educate employers on the issues of returning service members and veterans who are living with traumatic brain injury and/or PTSD. I emphasize "living with."

When we first started this initiative, we made a conscious decision that returning service members and veterans are not "suffering from," they are "living with." To me, "suffering from" is a debilitating term. It implies they are not doing well; "living with" means a person is getting on with life, coping with the stresses, whether it is PTSD or some other issue.

We created an employment pilot through America's Heroes. One participant said, and I paraphrase:

"Thank God for this program because, otherwise, I would be sitting at home thinking about the war. Guess what happens when you sit home thinking about the war? You sit home thinking about the war. You get up in the morning, saying, "What am I going to do now?" Around 2 or 3 o'clock in the afternoon, you go have a beer. Then it spirals, cascades down, and the next thing you know you are having that beer at noon, then a six-pack at noon. Next, you get up in the morning and you are drinking, and then taking harder drugs. The next thing you know, you have really hit the bottom."

Part of the problem started with the media depiction of Vietnam veterans as drug-crazed, baby-killers, walking time bombs ready to explode. In some of the TV shows of the '70s, like "Streets of San Francisco," who was the bad guy? Not just someone who shot someone else.

It was the crazed Vietnam veteran, and more often than not, it was the crazed Vietnam veteran that the media depicted that helped to stereotype veterans with PTSD. To

some extent, that stereotype still exists today. Part of what we are trying to do with America's Heroes at Work is to mitigate the stigma that is associated with PTSD.

One documentary closed with this individual seeming to be getting along okay. But if after I see this and then go to my office, and I am an HR person, and I see that individual in line to apply for a job, I am not too sure I will be interested in talking to him because of the stigma attached and because of what I saw in the documentary. We have to try to educate the media on the issues so that the media depicts the positive. We know what the problem is: We need to identify and publicize the solutions and the services that are available so that these individuals can continue living with these conditions and moving on with their lives.

We started America's Heroes at Work based on employers', and part of the public's, lack of knowledge. It was never intended to be an employment placement effort; it was intended to be an education and outreach effort to educate employers on issues related to TBI and/or PTSD in the workplace. We knew what we did not know. We knew employment and employment resources. We knew job accommodations. What we did not know was the mental health aspect of it. So we reached out to DOD and VA and said, "We need your help; we cannot do this alone."

We want to complement what they are doing. They provide quality medical and mental healthcare. They do not provide employment.

***We know what the problem is:
We need to identify and publicize the solutions and the services that are available so that these individuals can continue living with these conditions and moving on with their lives.***

You can provide the best mental health, best rehab, best services. But at the end of the day, if employment is not provided, then we have failed.

We have failed because, without a job, anything can happen to you. How do we define ourselves?

You can provide the best mental health, best rehab, best services. But at the end of the day, if employment is not provided, then we have failed.

When we are just talking to one another, we say, "Hi, what do you do? Who do you

work for?" These common questions are almost always asked; they are a type of icebreaker. America is about working and making a life for ourselves and taking care of our families. We need to provide those opportunities.

We populated our website with resources, information for employers and others. Although it is directed specifically at wounded warriors and returning service members and veterans, anyone who has PTSD can benefit from our resources.

Everything that we developed, we vetted through DOD's Defense Centers of Excellence for Psychological Health and Traumatic Brain

Injury, VA's mental health, and SAMHSA. We could not have done it without those three agencies.

We announced the program in a very small room, too small to invite the public, at the National Press Club on Aug. 20, 2008. The room was filled with media people. General Laurie Sutton, two assistant secretaries, and a veteran were there also. The veteran is living with TBI and PTSD.

The veteran stood and said, "I am Mike, and I have PTSD and TBI." Then, he paused for a second and said, "You know, I'm very nervous about being up here. I was so nervous that, when I left this morning, I left my notes on the table." He paused, and then said, "You know, that is a symptom of PTSD."

There was a collective sigh of relief: "Oh my God, he is normal, we are okay, and we are going to get through this." At the end of the session, Mike was the person the media wanted to interview. They did not talk to the assistant secretaries or the others. They talked to Mike.

Online Resources

For a lot of good information, go to the website, AmericasHeroesAtWork.gov. If you are involved in your own organizations, link that website to your own. If you think your site would be valuable to America's Heroes, contact them about getting your link as a resource. There are veterans' and employers' success stories. If you are an employer that has successfully employed a veteran who has TBI or PTSD, let them know, and we will post that.

I will close with a quote from Vince Lombardi: "It is time for us to stand and cheer for the doer, the achiever, the one who recognizes the challenge and does something about it."

The screenshot shows the homepage of the America's Heroes at Work website. At the top, there is a navigation bar with links for Home, For Employers, Success Stories, and Helpful Links. Below this, the main content area is divided into several sections. On the left, there is a 'What's New' section featuring two articles: 'Veterans Hiring Toolkit' and 'TBI, PTSD & Employment Training Tool'. On the right, there is a 'Stay Connected' section with links to join the LinkedIn group, subscribe to the newsletter, and bookmark/share the page. The website also features a search bar and a text size adjustment tool.

PANEL III: REINTEGRATION INTO THE COMMUNITY

Brian Flynn, Ed.D., Moderator

Associate Director, Center for the Study of Traumatic Stress, Uniformed Services, University of the Health Sciences

Many of us began our mental health careers in the era of community mental health back in the '60s and early '70s. The concept appears to have taken a backseat from time to time and now, seems to be reemerging as something of value. Nowhere is this more evident than the realization that communities play a significant role in promoting healthy lives for our veterans.

I want to make a couple of contextual comments and identify a few things about which I hope we might think a little bit more. I think the language, the words we use, are really important. What does reintegration really mean? There are assumptions implicit in that word, and we need to look at and examine those assumptions, and complicate our thinking a little bit.

When we talk about reintegration into communities for veterans, one challenge and complicating factor is, while we have reintegration in the community, we also have simultaneous disintegration of a community for those veterans. The military, especially the combat community, forges bonds among people that few of us can fully understand unless we have experienced it. This may be one complicating factor: we have reintegration but also dissolution and a mourning of a loss of community.

Community means different things. It can be a geographic place. But we have also heard of the veteran's community. When we hear about different definitions of community, we ought to keep in mind that we are not always talking about the same thing. Again, there is an implicit assumption that reintegration into a community is something to be sought after and desired. But we also need to acknowledge that people may not be a community to which the veteran can go. In addition, communities may be dysfunctional or isolated and may not have welcomed or supported these veterans before they left it. All of this makes reintegration a complicated paradigm.

When we hear about so many of the programs that are available for veterans, their families, communities, and workplaces, we need to think about who owns these kinds of issues. It is a wonderful thing when we have huge numbers of well-motivated, disparate kinds of programs. At the same time, who is responsible for looking for where the gaps and duplications are, which ones work, and how we will establish quality control to ensure that what we are providing has an evidence base to it and actually makes a difference?

Several of my friends are fishermen on an island in Canada on the Bay of Fundy. By our traditional definitions, these fishermen are mostly uneducated, yet they are extremely wise. They have a saying: "There are a lot of things you might want to bring alongside, but you have got to be real careful what you haul onboard." I think we need to have criteria and give serious thought to how we decide what we are going to bring alongside and what we are going to haul onboard.

Finally, as we think about community issues, I would like to encourage us to rediscover history. PTSD and other war related stress is not new.

We need to look back to see what we have done in the past to help.

My dad was a World War II veteran. He spent four continuous years in the Army as an officer serving in the South Pacific. One challenge in the current wars is *repeated* deployments; a major challenge then was *duration* of deployment. When he came home, he married his fiancé, my mother, but his service was not over. Immediately, he was sent to Asheville, N.C., where the Army had a two-week program both for the soldier and for the soldier's spouse on how to reintegrate into society after having spent four years living in the jungle. When I see what happened 60 years ago and what happens now, I wonder how it is that we forget so quickly the lessons of history and our former strategies.

"There are a lot of things you might want to bring alongside, but you have got to be real careful what you haul onboard."

Barbara Van Dahlen, Ph.D., Main Presenter

President and Founder, Give an Hour

I am a big believer in storytelling. So I will say a little about my own story, and that of Give an Hour, to give a context for my comments about the challenges of reintegration into community for service members and their families.

My father was a World War II veteran. He served in the Navy long before I was born, and he never talked about his experience. He only shared funny, anecdotal stories about being in the brig because he was rowdy, or about when he was injured. My brothers and I never knew the details of his service. The message coming to us was not to ask; this was not a place he wanted to go.

One of the saddest memories of my childhood was during the Vietnam war. Like many men of his era, my father got tattoos during his time in the service. But when the Vietnam war broke out, he rolled down his shirt sleeves, and from that point on, when we would go out into the community, he would leave them rolled down, even if it was hot, and it got hot in rural California's San Joaquin Valley.

It was clear that he felt bad about what was happening to Vietnam veterans and about the anger in our country—at the warriors not just the war. This man who had taught me about pride

and integrity and honor felt ashamed of his service and concerned about the impact that his service might have on his family.

We have learned much from Vietnam-era veterans. We learned about post-traumatic stress and that it is a natural consequence of war. Practicing outside the Washington, D.C., area as the Iraq war began to unfold, I was optimistic. I thought, because we know what war does, we are going to have this population of warriors and their families covered. We know the long-term consequences. Then, I began to hear the coming-home stories of the men and women who had been serving in Iraq, stories of people living out of their cars and losing their families. We would not be able to get in front of this quickly enough.

The Beginnings of Give an Hour

As a mental health professional, I would be willing to donate time to help. I have a skill, an area of expertise. As a child psychologist, I was concerned about the children of our servicemen and women because I knew from training in community mental health centers, and from hearing stories of Vietnam veterans' children, that we needed to get in there early; otherwise, we would have a whole generational issue and transmission of symptoms.

One day, I was driving through Bethesda with my daughters. My very verbal and precocious 9 year-old, who is an advocate at heart, saw a homeless veteran on the street. This man had a sign saying, "Vietnam Veteran. Please help. God bless." She looked at me with outrage and said, "Mom, how can we let this happen to these men who served our country?"

There you go, I thought, we cannot. And I could not. I could not go home saying I had this idea, but I do not know how to implement it. I wanted my children to learn the power of one, that if you



have an idea and a conviction, and you get a lot of smart people to help you, you can make something big happen.

Her challenge launched Give an Hour, and the idea is very simple. We ask licensed mental health professionals throughout our country—social workers, psychologists, and psychiatrists—to give an hour of their time each week and to stay in the network for a year or more. We now have more than 5,000 who have stepped up to provide services to those who serve and to their family members. We define family as anyone who loves someone who has served since 9/11, or who is currently serving.

Give an Hour provides services for active duty, Guard, Reserve, veterans, parents, siblings, cousins, aunts, and uncles. We have a great relationship with them and with DOD. Wonderful things are happening at DOD and the VA. But we are a different option, and we try to complement and add to what they offer.

Training Mental Health Professionals

Give an Hour looks for many ways to provide training to mental health professionals so they are knowledgeable about military culture and the issues that affect our military families. Staff has grown from all volunteers to 10 paid staff, hundreds of volunteers throughout the country, and 5,000 plus mental health professionals. But my team is always talking about needing training, because that is what our mental health professionals say they want. They do not want to be paid; they do not want to be part of any bureaucracy. They want to do their work, and they want training.

We also need to work on our training programs because our up-and-coming mental health professionals will face military mental health issues for decades to come. I was not a trained military mental health professional; but I understood there was pain. I have learned, and now I have become expert in this arena. Many military visitors to our site will tell us the mental health professional did not really know about the military culture, but was willing to listen and be taught, which made the military visitor feel he or she had something to share. We have heard from our mental health people, too, that they are so impressed with the men and women who serve,

that even if they do not know the culture, as long as they are willing to ask and learn, it is a wonderful two-way street.

What we need to do is teach both sides how to share stories and how to learn from each other. Then we are on the journey together. I would tell people that I am just the tour guide, I know some things, I can point out some things, but they did it. Mental health professionals can learn how to be good tour guides as we continue to get additional training.

About two years into it, we realized we had harnessed a huge network of knowledge, wisdom, and compassion. So in addition to providing the direct service most people wanted to give, we asked them to consult with schools, employers, and first responders in their communities. Now, we partner with several organizations, and we provide the mental health piece of the equation.

Challenge of Reintegration

I travel a lot, spreading the word about Give an Hour. I was having great conversations with community leaders and hearing the same thing repeatedly: we want to help. Often though, they did not know other people in the community were doing things, what those things were, and how they could collaborate and coordinate. Nor did they have many resources.

Wouldn't it be wonderful, I thought, if we could create guidance for communities to help them develop a comprehensive, coordinated plan for how to connect with each other? That idea percolated over the last few years as I continued to see the desire and the need, but also duplication of services and confusion about how best to do this.

Recently, I was asked by the head of a foundation, "Why are so many still falling through the cracks?" More veterans are entering the homeless population from this current generation than at the rate of the Vietnam veterans. Why are we unable to harness what Admiral Mike Mullen so eloquently has called the "Sea of Goodwill"?

Let's think about a concept that we take for granted when we use the term "reintegration." It suggests that this military community was integrated into the larger community before they



deployed. In most communities, I would say that is not the case. We have had a huge culture gap since the Vietnam era. Civilians do not know much about the military culture; and for very good reasons, the military community does not always feel comfortable with people who do not understand them.

I conducted a workshop with several military mental health professionals, and we were talking about the need to have a little primer on military culture and acronyms.

If we do not recognize and identify what the issues are that prevent successful reintegration, we cannot do much about it.

In the military, there are so many! The civilian community is not used to this, and it creates an immediate culture barrier in language. If we do not recognize and identify what the issues are that prevent successful reintegration, we cannot do much about it.

This culture gap creates misunderstanding. There is a lack of trust and a lack of communication. It is difficult to imagine that we can reintegrate families into communities where there had been no integration. My daughter's freshman high school classmates could not name the different branches in the military. They certainly would not understand the individual augmentees, and they would have no concept of the structure. Why not do presentations in schools to help our children understand basic things like the branches of the military? Often, children in military families feel as if people do not understand their experience. The Blue Star Families organization conducted a study in 2009, and 94 percent of military families felt the general public did not understand or appreciate their sacrifices.

Those of us who want to do this work have to get very clear on what our goal is here. If it is to create a comprehensive, integrated system of care, we have a lot of hard work to do. We need to recognize that and roll up our sleeves. It is not like Vietnam, where we did not understand what was happening when people went to war. We have the wisdom, the knowledge, the expertise, and the resources. Certainly, we have enough to connect the dots and start helping service members and their families.

Built into the concept of Give an Hour is the notion of offering service members and their families the opportunity to give back if they want to. Many of them thank us and then ask, "How can I help you?" Young men and women at Walter Reed or Bethesda Naval, invariably, come up to me and say, "Ma'am, what can we do for you?" Providing opportunities in our communities for them to continue to serve when they come home is critical. We need to open doors to allow them to continue to care and serve because that was why they went into the military.

Obstacles

We are confronted with big obstacles, but I am an optimist; otherwise, I would not have started this organization. I am also a realist and very action-oriented. This is an incredibly complex issue, but we need to face some things we are avoiding. Military and civilians alike have trouble absorbing the pain of others. Many of us who are familiar with this population see this pain day in and day out, and our hearts are opened. But it is difficult not to turn away and change the subject. It is not that we are not compassionate; it is the "shutdown phenomenon," where someone will change the subject or act as if they did not hear what you just said about this trauma, this pain. People do it without even knowing they do it. We have to do a better job of educating our larger community so that they know it is okay not to shut down. One thing we can do is just hear the stories and be open.

Often, a lot of rage comes out of people who are suffering and in pain. When people experience trauma, there is a lot of unfocused and misdirected anger that emerges, and you can

feel it. Mental health professionals have been trained to know what those feelings are and what to do with it.

Veterans do not always make it easy for us to help them because they are hurting and they are not trusting; they are not sure how to proceed or who is safe. So you get a pushback: "I do not need the help," or "I'm okay," or some other, choice words. It is not always easy to push through. How can we address that in our communities? We have to tell stories of the pain and suffering, of the successes, and about who the military population is. They are just like me; we have more in common than not, and that is the bridge that we need to make.

Growing up in rural California I was pretty naïve. I thought, "I have a pretty good idea, I'll start talking to people, and they are going to want to help." That is not the way it works.

There is a struggle for organizations to get out of their silos, open the doors, and talk to each other, to say what they have to offer. Silos get in the way of making changes. We may think

There are many great programs doing their own thing, but there is very little overall coordination and a lack of comprehensive systems of care.

we do a good job parking our ego at the door, but we do not. There are many great programs doing their own thing, but there is very little overall coordination and a lack of comprehensive systems of care.

Community Blueprint

We set a goal to assist communities to come together. For those of us who want to step up and overcome these obstacles—individual obstacles, obstacles with the cultural barrier, and obstacles with organizations that are afraid to share resources, afraid to share power, afraid to share limelight, afraid to share foundation sponsors—we have to be honest about the issues. Leaders have to get out in front and show their organizations how to partner, how to collaborate.

We need to educate ourselves and others, and we need to take action, to call someone in our community to start the ball rolling. I also believe we should give everything away. Everything that

you have learned, give it to everyone, because it really is true, that lovely saying, "a high tide raises all boats."

Leaders have to get out in front and show their organizations how to partner, how to collaborate.

I began to be aware that communities were struggling, trying to determine what to do. I talked to my friends in other organizations about creating a blueprint, a guide to aid organizations to work together, and I presented this notion to a great gathering of about 50 organizations. Four organizations in the room stepped up and said we will make it happen with you. That was the beginning. Many organizations have now joined. The White House has been phenomenal in supporting the concept, as have DOD and VA. I have never seen anything like it.

Now, we are in the process of organizing what is coming to be called the Community Blueprint. Basically, it is a very simple concept. It is a series of questions across eight areas:

- behavioral health
- employment
- education
- homelessness
- financial and legal
- family strength
- reintegration
- volunteerism

In each area, there are five or six questions community leaders are asked. For example, in the behavioral health area, we ask, "Do you provide military cultural sensitivity training to your civilian mental health professionals? Do you have a meeting in your community to bring together stakeholders of these different areas so that they can talk to each other?"

This will take shape over the next few months across the country. We are also collecting best practices. It is not the only tool, but we are excited that it could become a way, at least, for all of the great efforts and organizations that we see to latch on to and share with each other.

RESPONDENTS

Linda Rosenberg, M.S.W.

President and CEO, National Council for Community Behavioral Healthcare

The National Council and about 1,780 of its organizational members, in looking at the issue of reintegration, have tried to take every critical issue and work on it in two ways: in the policy arena with the administration and Congress, and in the practice field. How can we help our members and their quarter of a million staff really practice standards of excellence? This issue is no different.

Many people never come for services, and many never go to primary care if they can avoid it.

One of the first things we did was to get involved with the leadership on Capitol Hill, working around policies that would support reintegration. We began talking with our grassroots members about what they were doing in their communities to serve veterans and their

families, and we began to compile that information to make sure we could support and encourage that work. We also began to look at staff competencies, not only for people who deliver mental health and addiction services, but competencies in primary care also, where many problems get identified.

Many people never come for services, and many never go to primary care if they can avoid it. Instead, they talk to family and friends and colleagues. So we have rolled out an initiative for the military through the Department of Defense.

Policy Arena

We partnered with Mental Health America on two veterans bills. Their policy person at that time, Ralph Ibson, worked with us to ensure that, in the 2008 bill, there was a piece that had the

VA begin a pilot project that contracted with community providers. Those contracts have since been announced.

In 2009, we talked about peers with Mental Health America. Those of us who have seen the power the peer movement has in working with people with serious mental illnesses know how important that is in terms of the array of services and supports. The VA is one of the best supporters of the use of peers.

Right now with SAMHSA's leadership, we are working with the military health care program Tricare. We know that having a benefit does not mean real access to services. Our executive vice president, Jeannie Campbell, is serious about making sure there is access to community services that are seamless and smooth for all people entitled to that benefit.

We try to stay in touch with our members in every possible way, by phone, video conferencing, webinars, and by travel on the road. We also survey members with quick questions, which we have done repeatedly around veteran services. About one-third of our members responded to our last survey, and 90 percent of those responding are more likely to be people who are serving veterans. There is also much interest in the children of veterans and the children of service members who have been deployed. I found this interesting: two-thirds of the responders have peers on their staff or are planning to hire peers in the work that they do.

Many of the treatment providers offer services free to veterans and their families. Philanthropy has really stepped up—foundations, private donors—we have been very fortunate.

Centerstone, an organization that works in Indiana and Tennessee, not only provides face-to-face support, but also the use of telemedicine for



treatment. They also are creating online social networks for support, and other organizations are following suit. We are seeing that more and more across the country.

Housing is something else again. Those of us who have worked with people with serious mental illnesses for many years have been very involved in the development of housing. Everything from congregate living in the past and now, to really supporting people in their own homes and including them in the fabric of their communities—these are just some of the programs that have been funded through the VA, SAMHSA, the Department of Defense, as well as through the Department of Justice.

The peer-to-peer movement has certainly grown in importance. Aspen Pointe, Colorado, probably has the first peer-to-peer program. In their Peer Navigator program, they help veterans and their families with day-to-day living issues. It has been quite successful, and now serves as a model for other member organizations across the country.

From the beginning, National Council members have been involved with Minnesota's Beyond the Yellow Ribbon, which offers soldiers support. We are involved now in other communities as well, as that program has spread

to Virginia where they are working with families to teach them relationship skills out of the school of social work.

Practice Field

In the area of staff competencies, one of the things we have done with our online learning partner, Central Learning, is to put together an array of courses that staff in member organizations across the country can take online. We developed these courses with DOD, using their materials. Now we are creating a certification program for people working with veterans and

We have political will, we have resources, and still we cannot solve all the problems.

their families. Standards are important to us, and we want to make this available to anyone who is working through one of our member organizations or who is working with any other group that serves veterans and their families.

We also try to get the word out. We have political will, we have resources, and still we cannot solve all the problems. It makes one realize how complicated human beings and human systems are, and how much work goes into tackling important issues. One of the things we know is that we are not going to do this alone. But in addition to that, we have to begin to think about what we can do for people who are in training.

We have a new partnership at the National Council. It is with the University of Southern

California School of Social Work, which has started the first concentration in military social work. We are helping them promote that program because they also are the first university to offer an online M.S.W. degree. People still do practicums in their own communities, but all the classes are done online. With a technology partner, avatars have been created on which students practice social work services, and they have recruited retired military leaders to be part of their faculty.

Through our network of state and local associations, we also are trying to help connect people with what is available in communities across the country. We are doing that through our website network and through Trilogy Veterans Network of Care, which are online resources for veterans based in all communities. It talks about what is available, not only in benefits, but also in treatment and services to families.

About Mental Health First Aid: Mental Health First Aid is in 10 countries. It is an evidence-based intervention and a 12-hour certification, just like CPR. You are far more likely to see someone having an anxiety attack or suffering with depression than you are to see someone having a heart attack in front of you. This is a literacy program that teaches about mental illnesses. It also teaches what a person can do in an emergency and how that person can be helpful to someone in crisis. People are becoming instructors or taking the training from faith-based communities, law enforcement, schools, and some are just concerned citizens.

Rev. Thomas B. Carter

Partners in Care, Maryland National Guard

I am not a mental health professional. I am part of Partners in Care in the Maryland National Guard, and I am a chaplain in the Guard Unit through the Maryland Defense Force. My son is in Afghanistan now, and he has completed two tours of duty in Iraq, one through the Maryland National Guard.

About five and a half years ago, my son was preparing to deploy with the National Guard to Iraq. I went to a family readiness meeting where we were told what our loved ones would be going

through, what they would experience, and how we might be able to help at home. Chaplain William Sean Lee, who is Joint Force Headquarters Chaplain for the Maryland National Guard spoke. Later, he talked with some of the other people who were there. Among other things, he said the following:

“If you are a car mechanic or if you are a plumber, and you can offer your services to family members while their service member is gone, do that. Whatever it is that you have to offer, offer

it to help these families while their service members are deployed.”

After the meeting, I went up to him. “I am not a mechanic, and I am not a plumber, and I cannot do some of these other things. I am an Episcopal priest. What can I do?”

He just about jumped out of his skin because he said, “I have this idea, this thing I have been working on. I am going to call it Partners in Care where we match up service members, veterans, Reservists, and Guard members with faith-based communities. And I do not have any communities yet.”

And so, about five and a half years ago my church, the Church of the Nativity in Baltimore, became one of the first Partners in Care congregations. There now are Partners in Care congregations in all 70 counties in the state of Maryland.

Partners in Care is a faith-based initiative, and referrals are made in conjunction with readiness groups and various armories, as well as with the Joint Force Headquarters Chaplain’s Office. Each congregation signs a memorandum of understanding that they will not discriminate on the basis of religion or display discrimination of any other type. They will help anyone who comes to them regardless of their faith tradition, or lack of faith tradition. It is not about proselytizing or bringing people into my church. There are Christian, Jewish, and Muslim congregations involved in the Partners in Care program. All of us agree that we will offer our services, regardless of the religious affiliation of those who seek us out.

The Joint Force Headquarters Chaplain’s Office provided each congregation with a comprehensive manual of all the service agencies, veterans groups, as well as other types of mental health providers and providers of



assistance for legal problems, and any other kinds of problems. Sometimes the needs are around homelessness; sometimes service members just need to figure out how they can feed their family for another week or so. The problems are across a wide spectrum of issues. But I can say that, in the last five and a half years, I have had the opportunity to assist many returning Guards or their families in any number of ways.

Whatever it is that you have to offer, offer it to help these families while their service members are deployed.

One thing we all need to remember is all crises have a spiritual dimension. The idea of having faith-based communities help to deal with the needs of our veterans, National Guard, and Reservists is a natural thing. Every community has faith communities: churches, synagogues, and mosques. The first place many people go to look for assistance is to clergy. These people are referred to a Partners in Care organization in the community where they live.

Citizen soldiers live in communities, and they search for services where they live. Partners in Care is not the answer, certainly, to all the problems that our returning soldiers and their families face. But it is an answer and a solution to help in the local community to direct them to the services they may need.

Liisa Hyvarinen Temple, M.S.

Freelance Journalist; Military Spouse; Adjunct Faculty, University of South Florida; Rosalynn Carter Fellow for Mental Health Journalism, 1999–2000

I want to tell you how our story went viral on the Internet. And I am going to tell you how you can tell your own story and not rely on other people telling it.

My husband, Rex Temple, is a senior master sergeant in the Air Force. He had deployed three times prior to his last deployment and completed 10 other overseas tours. My background is in journalism, 15 years in television, print, and online. When we married, I started teaching because it allowed me to spend more time with my husband; with broadcast work I was always on the road or staying late due to breaking news. So in 2006, I began teaching multimedia journalism, which means doing all the traditional platforms of print, TV, and online social media.

Afghanistan—My Last Tour

One day, my husband came home and said, “Honey, I have volunteered for an assignment in Afghanistan as an adviser on loan to the Army.” He would be embedded with the Afghan National Army, not at a big base, but in the middle of everything that he has never experienced before as an Airman, such as incoming enemy fire and frontline combat.

He knew that traveling through six different provinces for the next year or so meant he would not have a way to communicate with the family. Since I was the social media maven in the family, he asked me to help him create a blog. He did not want to have to write the same email to individual family members, and he certainly did not want to upload photos, because we all know how long that takes.

He started his blog *Afghanistan—My Last Tour* (<http://Afghanistanmylasttour.com>) in February 2009. He wanted me to show him how to do it, and he promised me that he would learn the tagging and how to embed keywords—and all the technical things that go into uploading a blog entry correctly. And he wrote almost daily until April 23, 2010, the day he came home.

Rex had started writing during his training at Fort Riley, Kan, before he left for Afghanistan. We already had a following on the blog, mostly family, extended family, and friends. But the second he got to Afghanistan in early May 2009 and started writing about his daily activities, the readership went up. Because he had a horrible Internet connection at Camp Blackhorse, which is located almost at the Pakistan border in Eastern Afghanistan, he would be lucky if he could send me an email and attach the blog entry. And he would spend hours trying to upload one or two photos. So due to the bad Internet access, I quickly became the manager of the blog.

Looking at the blog's infrastructure every day, I started noticing that we were getting a lot of foot traffic from military blogs and Twitter. The busiest day of Rex's personal blog was when his unit had come under fire. They had lost 12 Afghan soldiers, six Frenchmen, and one Marine captain. Rex's little brother, a Georgia National Guard member, had been shot in the leg and almost died. Rex's account of that particular mission has had to date 5,038 views, and so far as of today Rex's blog has had 340,087 all-time views.

Military Blogs (<http://milblogging.com>)

There are many different people who decide to write a military blog as a communication tool, and there are many blogs. They reach tens of thousands, if not millions, of people.

The first link we received came from Milblogging, which is an index of military blogs. All members are military, former military retired, people connected to the military, writing about military. Mostly it is unedited copy, people writing their own personal opinions about whatever subject they choose. Recently, Milblogging promoted a military wife. Her husband had died and she wanted to write his story because she was not happy with the way traditional media was covering his death.

J.P. Borda started Milblogging in 2005. JP is a Virginia Tech grad who joined the National Guard after 9/11. He completed multiple tours of duty and then decided to create Milblogging as a resource, a place for everyone to gather and link their military blogs. Almost 3,000 accounts are already indexed on it; many of them are also Twitter accounts, which are micro blogging.

Think of the Milblogging community as a way to get your message out. These people care about military issues and write eloquently about these topics. Some of them take outside content, and all of them take story ideas. This is another venue to tell your story and not necessarily have to go through the same filtering processes as you would if you were going through a regular journalist or news organization.

J.P. only covers military and social media. If you pitch him a mental health story, he is not going to do it. But if it has a mental health aspect and a social media aspect together, he might put it on his blog, and he has a huge reach. He was the first to promote Rex's blog, featuring him five or six different times in the course of his deployment; that is how we ended up with a massive number of people finding Rex's blog.

Blackfive (www.blackfive.net)

Blackfive is another extremely well-respected military blog. Started by former Paratrooper and Army Officer, Matthew "Blackfive" Burden, this blog receives thousands of unique visitors per day, based on his public sitemeter statistics. Its mission: "Supporting the Military, Caring for the Wounded, Remembering the Fallen & Honoring the Sacrifices." They will take outside content, but they will edit and write his own content from it.

You Served

(www.vamortgagecenter.com/blog)

You Served is a leading blog and podcast focused on the military and veterans communities. Its bloggers take the pulse of every branch of the U.S. military, as well as of all those who have served our nation. It features frequent posts from some of the most recognized Milbloggers, including C.J. Grisham from A

Soldier's Perspective and Troy Steward from Bouhammer.com. It also features other popular guests from the Milblogging community and now allows all U.S. veterans to submit material for publication.

They are on Twitter and Facebook, where you can find occasional exclusives like listening in live to guest interviews being recorded for playback on You Served Radio, which airs live each Tuesday at 1900 Central on BlogTalkRadio.com.

Military.com (editor@military-inc.com)

Military.com has 10 million members, and you will need a password to gain access. Send submissions to editor Ward Carroll. Articles are posted based on the relevant content for Military.com's membership, type of information that fits in its information categories, and space provisions. Mr. Carroll determines how the content is posted, either submitted wholly by the author, or rewritten by a Military.com associate editor.

SpouseBUZZ.com (www.spousebuzz.com)

SpouseBUZZ was absolutely wonderful for me while Rex was gone. This Virtual Spouse Support Group, a connection for thousands of "mil spouses," is written by 17 military spouses from all branches, who write about spousal and family issues.

If you want to connect with military spouses through SpouseBUZZ, you must contact one of the individual bloggers and pitch your story. They write a lot, and they write about very interesting and on-point issues. They can also be accessed on Facebook (<http://www.facebook.com/spousebuzz>) and on Twitter (<http://twitter.com/spousebuzz>).

Soldiers' Angels (<http://soldiersangels.org>)

Soldiers' Angels, a nonprofit, serves service members and their families during deployment and beyond and has a special emphasis on the wounded. The group is extremely active on Twitter and Facebook. The group's national communications chief is Shelle Michaels, whose

handle is @publicrelations on Twitter; you can also find her on Facebook at <http://www.facebook.com/shellemichaelsfanpage>.

Create Your Own Blog

If you think you cannot get your message out, why not create your own blog? You can replicate what we did. We expected to have maybe 100 people reading it, not hundreds of thousands. My favorite two sites to use are www.blogger.com or www.wordpress.com. This is the key: if you are going to work on a blog, or if you are a big organization, make sure your Web expert knows what he or she is doing with their tagging. If your entries have the right tagging, people will find your blog in the right Google searches and search engine searches. And look for micro communities, people who are invested in this topic. My particular favorite is enlisted spouses clubs. Every base has them.

Facebook is very effective also. If you can, make your own public page, make your own group, and post your messages on other people's pages, on your own page, and on any place where you think family members and military service personnel are likely to visit. A page allows you to see who is visiting, how they are finding you, and how they are being linked into your page. And it is easy to use. If you choose to be on Facebook, make sure that you respond to people in a timely manner when they send you a request, because the Internet generation wants instant feedback.

We have a school supply drive on our blog, and we also use Rex's Facebook page for the blog to help this drive. My husband's service in Afghanistan may be over physically, but he started his school supply drive while he was there, and we are still sending hundreds of boxes of school supplies to Afghan children. We use the Facebook page to communicate with people who want to help us with this drive, and it is absolutely amazing how quickly people find you.

We have an active drive right now at Purdue University. They don't know us; they found us on Facebook. Little elementary school kids in New Hampshire have sent 30 boxes already, and they also raised the money to ship the boxes. The power of the Internet is truly amazing.

Twitter

Twitter is micro blogging with 140 characters. The key is to put up links to good content, preferably multiple times a day. If you have good content, other users will RT (reTweet, or repeat) it. When you RT a Twitter status update, you are sending someone else's message to all of your followers, so more people will see your original message. For example, Milblogging has 107,000 plus followers on Twitter; Shelle Michaels has 6,000 plus.

Mondays are #MilitaryMon on Twitter (online movement by mil spouse/milblogger Greta Perry and TV host Carson Daly). To get military-related Twitter users to notice your tweets, use #sot and #military hashtags (keywords or topics) in your tweets.

YouTube

Those who study social media say 2011 is the year of the Internet video. If you have the budget to produce effective videos, make sure they are short segments: no longer than two minutes. Upload them on every possible video-sharing site, starting with Vimeo.com and Youtube.com. Make sure you write a good keyword-rich description and include proper tags to help your video to be found in searches. If possible, seek advice from a search engine optimization expert so that your videos and online content get maximum exposure.

DISCUSSION TOPICS

EDUCATION

Jarrett Blake

Associate Director, Veterans Division of the Veteran, Immigrant, and Refugee Trauma Institute of Sacramento

I got out of the Marine Corps in July 2010, and I am trying to go to college. I am also an associate director for the Veterans Division of VIRTIS (Veteran, Immigrant, and Refugee Trauma Institute of Sacramento). The Veterans Division's goal is to develop psychosocial reintegration programs for veterans and their families.

Why would a veterans organization link up with the Immigrant and Refugee Trauma Institute of Sacramento? The common denominator is trauma. Veterans, refugees, and immigrants in this country all have suffered trauma, and I am one of them. VIRTIS provides psychosocial reintegration because immigrants need to be integrated into our country, and veterans need to be reintegrated into our society, into our culture.

A separation occurs when you go to war, a separation from the community that is not just physical but also emotional and spiritual. It is as if, when we deployed, we left people standing in one place, and when we came back, we thought they were going to be right there. But life happens. Things change, and it is not easy to come back.

What I did was life-changing, and what everybody else at the college did was normal, day-to-day life. It created a gap, so reintegrating was the piece. That is why we partnered with VIRTIS, because trauma is that common denominator, and our symptoms are similar. VIRTIS is a large organization with a lot of good resources, including a global health institute. Because of our partnership, we have an opportunity to get with doctors, certain technologies, and psychology modalities.

We provide psychosocial integration by offering camaraderie, recreational activities, assistance with education, financial aid, employment, housing, and local resources. Vets are not going to be too worried about their grades if they are also worried about where their next

meal is coming from, or if they have a wife and children, or if they are a single parent. There is no way college is going to be a priority in their life.

We give them an opportunity to get connected with these various resources, and we support the whole person. We can give them a tutor and buy their books. Does that mean they are going to be successful in college?

No. You have to support the entire person, whether it is the housing issues, local resources, employment, financial aid, and so on. We have to start from the bottom and work our way up, and that is really all that it comes down to.

In Sacramento, we are going to develop a hub that will have all of these resources. We are not only going to be networking with the VA but also with the housing and the financial aid people in the area, and all these other resources within our communities. That is the most important thing, I think, that resources are embedded within our communities. Because I can't do it in Denver or in New York, but I can do it in Sacramento, because I know them, and I have been there and networked that community.

If you want to talk about policy, the government needs to start supporting people at the community level, at the very bottom—the people who know the VA guy in their neighborhood, the people who know the college counselor in their area, and who know them by name. That is the policy that needs to change. We need to start supporting the people at the community or grassroots level.

We are going to develop this hub and then a satellite, because rural California is a lot more rural than a lot of people know. Many veterans are way out in towns I don't even know, but they

A separation occurs when you go to war, a separation from the community that is not just physical but also emotional and spiritual.

call up and say, "I want to go to college. I want to do this; I want to do that." This is a model that we all can work with. In fact, people are already doing this in their communities. When a vet comes to a satellite, if there is no resource for a service that they need there, the hub will make sure that it gets to them. And it provides all those different services right there.

This is where I come in. I manage likeminded veterans who want to reach out to help people. I identify their skill-set, whatever it may be. We have a guy right now who is going through audiovisual training, and he will be making videos for us. But more importantly, we train people on how to do the GI Bill. The reality is the GI Bill is different for every single person. It is not "cut and paste," and you have to learn the intricacies of the GI Bill and the VA in general. Once you do that, then you can try to pass on that knowledge.

I have applied for and gotten a GI Bill, but that does not necessarily mean that I can help another guy do it. There are different things that may qualify him or disqualify him for various benefits. And so we educate people about that, and then, when they come in, our group can fill out that paperwork and do it appropriately and correctly.

In Northern California, a gentleman with the Wilderness Institute in the Tahoe area took part in Road Courses, which is comprised of different activities. It is mostly physical, but they have a learning element to them, whether it be

partnership, teamwork, or leadership skills. It is an event where we get together and do these various activities. You create an environment that is difficult and challenging, but people have to work together to accomplish the task, whatever it may be. Not one of these tasks can be accomplished individually. You have to work with someone else.

You would be surprised at the bonds and the friendships and the relationships that are built in a single day. At the end of every event, we process; and in the evening, we have a larger processing group. It takes trust-building among all of us, something that maybe would have taken five or six months, we build in a weekend's time. They redevelop a relationship with a group of likeminded people that they felt they had lost.

It is our opinion that the policy needs to change to fund and maybe support community-level outreach. It is programs like this where we were lucky enough to be in an academic environment where veterans can come. We have access to them, but the policy needs to change to directly fund and support them. What we have shown here is proof that this works. These guys are building relationships, they are networking, and they know other veterans in their community. And they network with the different resources available to them because of likeminded people who want to network in the communities as well. That is where the policy needs to change. That is where the funding needs to go.

Catherine Morris, M.S.

Veterans Counselor and Professor, Sierra College

I work at Sierra College as a counselor, and I have been doing that since 2001. When I started, I think my population was probably around 180 veterans. Currently, I have over 500 veterans, approximately 85 percent of whom have served in combat. So, I work with the veterans, the Guard and Reserve, and their dependants.

Although I am a faculty member for Sierra College, my primary position is as able counselor for the 500 veterans. I meet with every single one

of them when they come on campus, and I wanted to share some of my observations over the past year, including the stress injuries and, more importantly, the readjustment issues, solutions, and recommendations.

California leads the nation in the number of veterans—2.2 million veterans, Guard, and Reserve. At the community college level, we have approximately 17,000 out of the 22,000 veterans, Reservists, and Guards who are using the GI bill. Typically, when they come out of high school, they are not necessarily college-

bound. When they get out of the military, usually they will start at a community college so that they can do their preparatory work and then, hopefully, transfer to a university. For the majority of the veterans, this is their first college experience, a totally foreign experience for them. And as we know, every soldier's journey is a long process, and it varies from soldier to soldier.

The Issues

Many colleges want to house the veterans' programs within disabled student services. The majority of the veterans do have some type of combat stress injury, whether it is depression, anxiety, PTSD, or traumatic brain injury. But when they hear about disabled student services, the usual comment I get is, "I am not disabled, I am not going to use those services." One guy whose leg was blown off and who had a metal leg said, "This new leg is stronger than my first leg. There's nothing wrong with me." So again, I think it is really important to be aware of how often and how easy it is to assume that because they are veterans they are disabled, so let's just house them with the disabled student services. That is an obstacle.

There is a misconception that the colleges should eagerly embrace the veterans because of a new GI bill. Community colleges are the least expensive when compared with a private school, university, or a state college. But at the same time, at community colleges, we usually see the least amount of funding to educate our student population. Now, we have all of these veterans, Guard, and Reservists all coming to community colleges with a lot of different issues, such as no available funding, and there are no extra services. The college gets the same amount from any student, so there is benefit to a college when a veteran has a GI bill. Most community colleges are turning students away for lack of funding.

About 80 percent of my veterans, Guards, and Reservists have to take assessments to give us an idea of their reading and math skills for a proper placement. The majority of the veterans test into what are referred to as remedial classes. These classes have to be taken before they get up to the college level. That becomes an issue when veterans come in and find out that, to get into

a college-level math course, they have to complete five semesters before they can even get to that level.

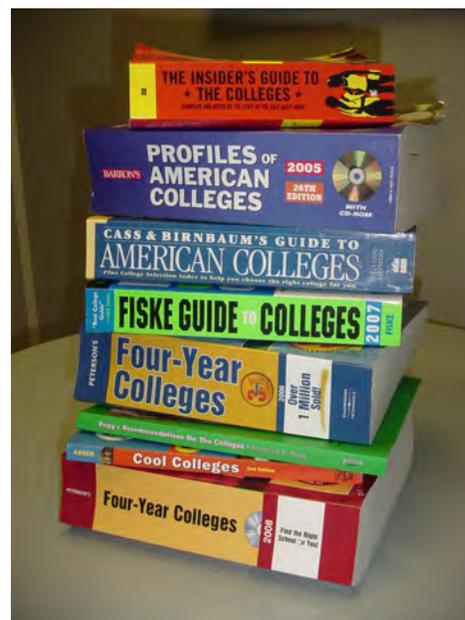
In most community colleges, you test into these remedial courses. It costs money to take that course, yet it does not count for college credit. Vets have to take these remedial courses to get caught up, but they only get 36 months on the GI bill. If you have to take a year or maybe even two years of remedial courses just to get to college level, then veterans are not going to get college educated.

That is very discouraging for them. They may have taken trigonometry in high school, but it has been six years or longer since they have taken math, and they have to start back with arithmetic or pre-algebra. That is a major issue with them, trying to be able to move ahead with their education so that they can get a career and be able to be self-supporting.

The other issue is so many of the veterans are much older than the students in their classroom, so there is also that stigma. I have about 50 Guard and Reserve, and I am constantly on the phone with a faculty member because Guard or Reserve drill may conflict with a person's classes.

Now their issues start being compounded. Add the process of getting the GI bill and being able to get into needed courses, and being able to get your paycheck on time so that you can buy food and pay your rent is definitely difficult; it is right up there with filing a VA disability claim. You get stacks of papers, and if you do not do things right, you will not get that paycheck. Our nearest VA is about an hour away from our campus. When you get a VA apartment, you take what you can get because you know it may be several weeks or a month longer. So you start adding that onto the stress issue.

My entire population is unaware of financial aid



services, which is a huge issue. They also experience a loss of camaraderie, that sense that you are not alone in this. When they come back home, they are so isolated; a huge issue for these guys is that sense of isolation.

Many of my students are using and misusing alcohol and drugs as a coping mechanism. One of the guys knew he had a drinking problem, and I knew he had a drinking problem. But, he told me, "At least the alcohol gets rid of the nightmares. Until somebody can convince me that if I stop drinking I won't have to live with these nightmares, I'm going to keep on drinking."

They are more afraid of attending college than they were serving in combat.

I teach a class to 30 vets, National Guard, and Reservists. Out of that number, I think 15 of them are single parents. Before they can focus on their academics, they are dealing with a crisis at home: they are trying to find a babysitter; they are trying to find a place to live because no one considers the GI Bill as income; they are trying to figure out how they are going to pay for their books and apply for financial aid. These are veterans, Reserve, and Guard going to college, but they are not completing their goal. These different issues are major factors impacting their success.

I kept hearing from my student population that they are more afraid of attending college than they were serving in combat. I have heard that 1,000 times, without any exaggeration. I thought, "This is something I can do, I can make a difference for them." If over the last years I hear 1,000 times that these men and women are more intimidated by attending college than they were fighting for our country in combat, then something needs to change.

Action Steps

Michelle Johnson, an English professor, and I created the Boots to Books Learning Community. For 16 weeks, the veterans take my class on how to be successful in college, and we look at the different issues. The same group of veterans takes the remedial English class because that is where the majority of my veterans are. We combine the college learning community, so I sit in on the English class, and the English teacher sits in on

my class. We are all together as a family unit for 16 weeks, and that connection and rapport is phenomenal and loads of fun.

Registration for spring is occurring now. The guys who are in our Boots to Books class are teaming up for the next semester because they want to continue the relationship they are building in this class. Peer support is phenomenal. We have mentors who are vets, and we were fortunate enough to have an English tutor who was also a combat vet.

I kept hearing about the fear in college, and so we had a roundtable conversation about it. I asked if they had ever experienced fear, and I knew the answer—fear in combat. Then I asked how did you deal with that? It was really interesting because the guys were saying that after awhile, when you start seeing arms and legs being blow off and dead bodies, you have to have some humor about it. Then they started sharing, talking about how they have been dealing with it.

I have found that you do not have to bring up mental health as an issue, or PTSD, or mild TBI; that all that comes naturally. All of a sudden, they are talking to each other and sharing experiences: fear in college; the fact that they are 26 years old and the majority of students in the class are 18; that they are not sure they will be able to make it. And then, one of the other guys says, "Dude, I'm 36, you think you are old? I have four kids." When you bring these men and women into a safe, loving, nurturing environment, the things that need to happen do, once you build the safety net.

Another issue is that every college has a VA rep, but a VA rep is not someone who works for the VA. In most situations, a VA rep is a clerical or staff person who works in the financial aid office or works in records, and they process the paperwork. That is all they are suppose to do, process the paperwork because colleges receive \$7 per vet, once a year from the VA to take on the GI Bill process. I think we get \$3,000–\$4,000 a year to run the veterans program. Typically, colleges will put their least expensive person in that position because they have to come up with the salary.

Vets have to go through a lot of red tape to be able to receive their benefit. If things are done incorrectly, the veteran has to pay back the money. To avoid that, my colleagues decided it was a much better idea to have one of their counselors trained on working with veterans. It is critical for counselors to have that competency, but there is no funding. Counselors need to receive training on the GI Bill process; if the paperwork is not done right, service members will not receive a paycheck. Then, they cannot buy food or pay rent, and the cycle begins. If the first person veterans, Guards, and Reservists come to actually has some knowledge and can help them cut through the red tape, a relationship begins from that point.

There are resources on the campus, and we have created a special veterans-specific orientation. Every Tuesday, for an hour and a half, we bring in between three to 10 veterans who want to receive their benefits. Then we start walking them through the red tape and connecting them to the people.

We also did a lot of hard work, a lot of fighting, to get a veterans resource center on the campus. One of the deans at the library had an extra room that was not in use Monday through Thursday afternoons. A local group donated a refrigerator, microwave, and a coffee pot, and there are also computers in there. Vets start helping each other with homework, meeting each other, and talking—again, that sense of community.

In addition to having a resource center, a safe environment, there is a multidisciplinary veterans support team on the campus, where one individual from every area of the college is ready to address specific needs. Ideally, that would be to have someone from faculty, financial aid, admissions, and records, and also a community VA advocate so that we can deal with the whole person and not just help them find a house or a counselor.

I am one of the advisers for a veteran's student alliance, and I am a counselor. I could not provide all these services for 500 veterans. So over the years, I have been finding out who in my community does this. Now, a VA service rep comes on campus every Thursday, helps with VA claims, and informs them of their benefits. And a pending nonprofit organization is looking at what outside resources are available that we can use to help the men and women beyond what an education can do.



CRIMINAL JUSTICE

Hon. Robert T. Russell Jr., J.D.

Associate Judge, Buffalo City Court

Often, we observe individuals who are participating in our program with writings on their shirts. One man wore a shirt with this message: “The only thing worse than losing is quitting.” We want to instill in the veterans we see in our justice system a sense that there is an avenue for hope, where people can receive some degree of stability and healing.

We have to ask ourselves this question when we talk about the veterans seen in our justice system: Do we know who they are? Many times we do not know a veteran is appearing in our court system because that question is not asked. It is not ingrained in our systems to ask the question, “Have you served, and when did you serve?”

Typically, we may not learn veterans are in our justice system until a veteran stands before the court awaiting sentencing. Then, a brief sentence

report raises the fact that a vet is before the court—or, if during the course of trial, their defense counsel raises it as an issue. Otherwise, not until someone is serving a state or federal prison sentence is that type of information collected. But in local law enforcement and in our court systems, typically that is not done.

For those who work in criminal justice, or would like to explore how we can assist veterans seen in our criminal justice system, what more can we do to begin to ask critical questions to see what type of services may be needed to help that veteran move forward with their life? We could ask:

- Are you a veteran?
- When have you served? In what branch of service?
- Have you been deployed?



Background

I have presided over a drug treatment court since 1995 and a mental health treatment court since 2002. I would see veterans in those courts, but typically, it was because a veteran may have disclosed that information.

In 2006, a veteran who was in my mental health treatment court, and with whom I had been working for eight or nine months, was not doing well. An imposing figure, he was around 6'6" tall, but he would stand before the court with slumped shoulders. We had him engaged with one of our civilian community treatment providers, and this veteran would not smile. He would always come to court, stand there with slumped shoulders, and just would not smile.

My project director was a Marine veteran who had served during the Vietnam era. I asked him and another Vietnam veteran who had served in the army and was working with the county at that time, if they would speak to this gentleman who was not doing well in my mental health treatment court. They spoke with him in the hallway, and after that brief conversation, when he returned to court, he smiled and stood erect.

I began to ask, is there something more that we can do to identify veterans who are coming through our justice system? If so, we might be able to provide better, culturally sensitive, and more uplifting services to help our veterans have better outcomes in our justice system.

Of course, we also wanted to ask the question how many veterans are we really seeing? In 2006, from what we were able to identify, we knew at least 300 veterans during that year had self-identified themselves in our justice system. The RAND report had come out during that time period. That report and a number of others indicated that of those service members who were serving in the most recent conflict in Iraq and Afghanistan, an estimated one in five was displaying some mental illness symptoms on their return home. We also knew that some might not display symptoms until six months after their return home.

Part of the question was "What could we do, and what would it look like?" The first part of the process was to meet with our local VA Healthcare Administration. In that discussion, I was invited to meet not only with the director

but with the VA Hospital Advisory Board, which is comprised of veterans active in the community in western New York. We started talking about this concept: "What do you think about us setting aside a day in court for nothing but just veterans?" The volunteers, the advisory board, and all the veterans raised their hand and said, "We want to volunteer, we want this to happen."

In 2007, we began a year of planning. We met with our community health providers, those who worked in the areas of mental health treatment and substance abuse services. We began to have a series of community meetings with respect to the concept of starting up a veterans treatment court. There was no other model then; we were working to create one and to get the best idea on how we could make it work and be successful at it.

Veterans Treatment Court

The Veterans treatment court has a specialized, separate criminal court docket. Imagine that everyone sitting next to you in court is a veteran. And imagine the potential of a support network in and of itself for other veterans who are realizing that they are not going through this alone.

We also wanted to move past the paradigm that treatment is for the weak. It takes strength and courage to ask for help. In addition to that, we addressed both substance use and mental health. For the last 20 years or so, drug treatment court had worked exclusively with individuals who had a clinical diagnosis of dependency on substances as the primary diagnosis.

It takes strength and courage to ask for help.

We handle both felony and misdemeanor cases and substitute the traditional criminal case process with the problem-solving process. In years past, criminal justice, working with the VA healthcare delivery system, may have been challenged regarding receiving communications on how a person was doing in that treatment program. The treatment court program relies on up-to-date information on how someone is progressing in the program, and to have that information lacking made for a very strained relationship.

We were able to transcend this in setting up a Veterans Treatment Court. I commend actions of the previous secretary and of Secretary General Shinseki, who has been awesome in his support of working closely with Buffalo Veterans Treatment Court and veterans treatment courts throughout the country.

Staff members from a federal agency and the state court sit in state court for Veterans

Treatment Court. Not only are they physically present in court, but they have with them a computer that is linked directly to the VA Hospital Healthcare Network. They are able

to continually access a veteran's healthcare records and immediately work to schedule an appointment for veterans. We get it done right then and there.

There is a concern with respect to veterans' healthcare records and whether a veteran is eligible for VA healthcare services. There is also a concern with regard to veterans' discharge status and the benefits they have earned through their service. The VA has also had the Veteran Affairs Benefit Officers sitting in court with a separate computer linked directly to the Benefit Affairs Office. They are able to access the veteran's discharge status and work on upgrades for veterans who may have been discharged less than honorably. At the same time, there may be questions about the nature of their discharge and whether that discharge is related to post-traumatic stress disorder or TBI.

In addition, we bring in our community healthcare providers. They are in court, along with our homeless providers, our shelters, our housing providers, and employers who are willing to hire veterans. This is an array of services that exist in a one-stop environment.

The word started getting around about the resources that were available. We have had veterans who have not been charged with a crime come in and say, "Judge, do I need to get arrested in order to get some help?" And of course, our response is that we are going to get them help and services. Not only is it becoming

more than just a court that is processing and working through cases, but it is also becoming a resource for the community.

Goal

We want to successfully rehabilitate the veterans and reduce the behavior that brought them into the court. We will do everything we can to make sure that they have the treatment-related services. For a veteran who is homeless, or is in a home that is not good, we will work to make sure that they have habitable housing. We want to make sure unemployed veterans are employed during or by the time they complete the course. For a veteran who would like to go back to school, we will do all we can to get that veteran into school. For those who are underemployed, we work to bring them to the appropriate employment level.

Families also go through a period of service as the veteran does. So we have agreed that a family member of the veteran is also allowed to be in the Veterans Treatment Courtroom.

We started the program without any new or additional funding. My coordinator on my mental health side is my coordinator for my mental health treatment court. My coordinator on the substance abuse side was my coordinator for my drug treatment court. The VA provides everything else to the staffing with regard to the VA Healthcare Network and the VA Benefit Affairs. We received one grant from the State of New York, through the Department of Justice, and we were able to hire one case manager.

We have participation in the program for spouses of veterans who were deployed in either Iraq or Afghanistan. Because of depression and anxiety, the at-home spouse began self-medicating and came through the criminal justice system. We worked with them and the children to get things stable in the home.

Part of the challenge is in overcoming that warrior mentality. Right now we have more than 40 volunteer veteran mentors, veterans from our community who give freely of themselves. They are not on the court payroll. They come to court, sit on the side, and work as a mentor, as a coach, as a resource. Several mentors are from different professions. Some are schoolteachers, some nurses.

We have had veterans who have not been charged with a crime come in and say, "Judge, do I need to get arrested in order to get some help?"

We have seven attorneys who have volunteered, not to represent someone in their capacity as a lawyer, but as a veteran, where they will work on other issues for them also. The attorneys do their own fundraising. They will pay if a veteran's lights were cut off, and they spend close to \$2,000 a month on bus passes and train tokens to make sure veterans can get to counseling and to their treatment program.

One Vietnam veteran who appeared before me had retired from his job at age 63 and had been sitting at home for two years. This is what he said to me: "Judge, when I returned home from Vietnam, I would drink a bottle of vodka a day, and I was functional. I would go to work, I worked, and I retired. But one day, I went to my closet where we kept a rifle. I had not picked up a weapon in over 30 some-odd years. I picked up the rifle, and you know what happened? I went back."

He thought he was back in Vietnam. He had undiagnosed post-traumatic stress disorder, had self-medicated all those years, and eventually it surfaced to the extent that it alarmed the family. Fortunately, the police entered and used their de-escalation skills, and no one was physically harmed or injured. This gentleman participated in a residential post-traumatic stress disorder facility at the VA. He became exceptionally well and graduated from our veterans treatment program.

National Perspective

A couple of bills have passed in Texas, Illinois, and Colorado for the establishment of a veterans treatment court. These are some of the cities or counties and states where treatment courts have been set up:

City/County	State
Montgomery	Alabama
Anchorage	Alaska
Tucson	Arizona
Lonoke County	Arkansas
Orange County	California
San Bernardino	California
Santa Clara	California
Tulare County	California
Colorado Springs	Colorado
Okaloosa	Florida
Forsyth	Georgia
Cook County	Illinois
Madison County	Illinois
Ingham County	Michigan
Ionia	Michigan
Oakland County	Michigan
Kansas City	Missouri
Washoe County	Nevada

A couple of bills have been stuck in committee nationally for the funding and support of veterans treatment courts. However, there are probably close to 45 that have been set up throughout the country, and at least 20 to 30 more are in the planning stages. Anyone can access current information on the National Clearinghouse for Veterans Treatment Courts (NADCP) website (www.nadcp.org).

Sean Clark, J.D.

National Coordinator, Veterans Justice Outreach

The Veterans Administration (VA) has a couple of different programs for justice-involved veterans, although there are other programs that we partner with at the federal agencies and with communities around the country. I coordinate the Veterans Justice

Outreach (VJO) program in its central office in Washington, D.C. I use the phrase justice-involved, which I blatantly, openly, and proudly stole from the GAINS Center, to define anyone who is in contact with any stage of the criminal justice system.

Justice involvement includes contact with law enforcement, whether or not as a result of a mental illness or substance use. That is the population we target: those under supervision by a treatment court—drug court, mental health court, or court of general jurisdiction. We also target veterans in jail, as opposed to prison, who are either serving a sentence or who were detained until trial.

1.1 million veterans are arrested every year.

The Veterans Benefits Administration is a separate system that deals primarily with monetary benefits—post 9/11 GI Bill, home loans—benefits for non-healthcare needs. Our sister program, Healthcare for Re-Entry Veterans (HCRV), provides outreach to veterans coming out of state and federal prisons.

All of our numbers are estimates, which will give you a sense of the scope of the problem. This is a question not asked nearly often enough by law enforcement, by jail administrators, or the courts: “Have you served in the U.S. military?” Until fairly recently, there has been no perceived incentive to ask:

- How would that information change the way police officers handle an encounter?
- How would it change how a judge would structure a sentence, whether involving treatment or otherwise?
- How would it change jail administrators’ decisions in terms of placement or for re-entry planning?

Some of our estimates from the Bureau of Justice Statistics at the Department of Justice (DOJ) are the best available numbers:

- 1.1 million veterans are arrested every year.
- 72,600 are in local jails.
- About 170,000 are in state and federal prisons.
- About 400,000 are on probation or on parole.

Across the board, these numbers represent about 10 percent of the criminal justice population. Veterans are not overrepresented as a whole, but their numbers are significant, and there is plenty of work for us to do.

Homeless Prevention Initiatives

The VA’s five-year plan to end homelessness among veterans was launched about a year ago. It represents the expansion of some of our existing homeless programs and the creation of some new ones. When the five-year plan was launched, Veterans Justice Outreach (VJO) was in existence.

Healthcare for Re-Entry Veterans is also considering a homelessness prevention initiative. About 10 years ago, Martha Burt and her colleagues found that incarceration is the most powerful predictor of future homelessness in this population.

We link veterans to many of these services. They will be contacted in the justice system with case management services. Our partnership with the Department of Housing and Urban Development (HUD) is an important resource for transitional housing for homeless veterans that we fund through grants by community providers.

Also, the Compensated Work Therapy (CWT) Program provides a sheltered work experience for veterans. It is a clinical program, and they are not VA employees, but often they may work at jobs in the VA facilities. That is expanding rapidly. This program is going to be hiring 400 peer specialists, formerly homeless veterans, to work with the CWT Program and help veterans develop skills and secure employment.

Services for Veteran Families will be a \$50 million grant program to community agencies to provide support to homeless veterans and veterans at risk for homelessness that we had never been able before to provide. This program will provide for the needs that can be a proximate cause for someone falling into



homelessness, such as a late rent payment. We can provide emergency rental assistance, and the grantees provide funding for security and utility deposits, the kinds of things needed to get into housing, if that is the only thing holding them back.

The grantees also will be able to provide for childcare services. Obviously, you cannot look for a job if you do not have your childcare situation settled. In recognition of that, we are expanding the categories of assistance that we can provide. If you are in a community that does not have great public transportation, and much of the country falls into this category, you cannot look for a job or seek other resources if your car does not work. These are simple but critical things to be able to provide.

Veterans Administration Limitations

There are certain well-defined things that we are prohibited by our regulations from being able to do. A vet may be on probation or parole, or have a criminal history, or was arrested the night before and we are seeing that individual in the morning—as long as the vet is in the community and has charges pending, none of that matters to our ability to provide services.

But if the veteran is incarcerated, whoever did the incarceration has the constitutional duty to provide for healthcare and other needs. Other than that, we can provide outreach, an initial clinical assessment, a linkage to VA services, and other kinds of services at the time of a veteran's release.

That is how Healthcare for Re-Entry Veterans got started several years ago in the state and federal prisons. Now we are serving up to 1,300 plus state and federal prisons around the country and have seen over 25,000 veterans.

With the help of the prison administration, we identify the veterans, explain to them the benefits they may be eligible for, and do an initial clinical assessment. We ask them about their needs, what their life was like before prison, and whether they had a substance abuse disorder that had not been treated. We know what the options are for treatment for mental health issues and substance abuse disorder in U.S. jails and prisons. These folks may not be treated while they are incarcerated, and those needs must be addressed

quickly once they are released. That is the basic model there for Healthcare for Re-Entry Veterans, the predecessor and sibling program to Veterans Justice Outreach (VJO).

In the film “War Torn,” a veteran was preparing to report to serve a state prison sentence several years in length. I thought about what we are able to do and not do for him. Once he is in, we cannot treat him, but we can see him in the facility, do that initial clinical assessment, and start on the re-entry planning process. How can we help him the day he walks out? That is what Healthcare for Re-Entry Veterans is about.

Progress

One of the curious and sad things that we found, and that became, in part, the impetus for Veterans Justice Outreach, is that, of the 25,000 veterans in these prisons, their average number of arrests prior to the charge for which they are serving their prison sentence is eight. Opportunities were missed if there had been a mental health problem or a substance use issue that we could have connected to services at one of those earlier arrests.

We have 153 medical centers, and there are more than 800 community-based outreach clinics and veteran centers in a separate system. However, it is in the medical centers that our justice outreach specialists are based, and their main function is as links to our clinical services. One of the struggles that we have had in the rollout of this program is the funding for these positions. It was one thing to get recognition for the role that veterans' justice involvement plays in homelessness and the need to connect with clinical services. It was quite another thing to get this initiative resourced.

As of Oct. 1, 2010, we have been able to fund 120 of these positions full-time. Many of the medical centers have been able to kick in funding on their own, but we think it is important that our community partners—judges, community treatment providers—have a consistent point of contact with the medical center. That is also important for the development of some expertise in our system.

Mr. William Feeley is the former deputy undersecretary for Operations in the VA. This was his charge to the field when he mandated this activity at each one of our hospitals:

“In communities where justice programs relevant for veterans exist... the VA will take the initiative in building working relationships to see that eligible justice-involved veterans get needed care. In communities where no such programs exist, if this conversation is not taking place, the VA will reach out with its justice system partners to connect eligible justice-involved veterans to VA services.”

It worked with community planning efforts to get a seat at that table where they are going on, and start the conversation where they are not. The whole charge was certainly necessary if we are going to accomplish the very ambitious mission of ending homelessness for veterans in five years.

The National Association of Drug Court Professionals is a tremendous resource on this issue, and not just in terms of expertise and technical assistance. They are the umbrella organization that provides training and a kind of repository of best practices for the drug courts and the mental health courts. They have now adopted the Veterans Treatment Courts and are taking a key role in their development. With the help of money from the Department of Justice, by the end of 2010, they will have trained community treatment teams for 40 cities around the country.

The drug courts have a rich literature about their effectiveness. That has been less so for mental health courts. There is a lot of idiosyncrasy in the way they operate. But there is a multi-site, very controlled study published by Hank Stedman in “Archives of General Psychiatry.” We have a foundation nationally of definite improvements in recidivism for participants in mental health courts.

Priorities

Building awareness of veterans in the justice system and building awareness of VA among justice system practitioners are ongoing issues and priorities for VJO. For too many years, we have been viewed as that hospital on the other side of town, where they do something or other

with veterans and it does not have anything to do with me. I have never met anybody who works there; they have never contacted me and explained their services; they have never expressed interest in partnering with us community service providers. This has to change, and we have a clear mandate from the secretary and from the entire system that those days are over.

We are never going to accomplish ambitious goals, such as ending homelessness among this population, with resources inside the four walls of VA medical centers. And so I think the VJO is a key example of community outreach. Obviously, we cannot operate a diversion program or a treatment court on our own. We cannot prevent veterans who have been arrested from serving a jail sentence and all those negative collateral consequences.

We have a crucial role to play, and we have treatment resources that veterans earn and are available to them that can help them in their recovery and from being involved again in the criminal justice system. We need to get outside, start that conversation, and make sure that we are involved as they go forward.

The treatment courts are dealing with some of the clinical issues veterans present, and we have good centers of expertise on these. Obviously, we have had good experience dealing with PTSD in the VA system, as well as traumatic brain injury, the other signature injury among veterans of the current wars. There is also the rich array of benefits and other services beyond direct treatment for these veterans.

Next Steps

We hope for continued expansion of the funding resources to the VA. The shift from prison back to the court system is a necessary step. But let's take it one step further back and catch a veteran right at the point where he enters the criminal justice system, where we can work with law enforcement, educating them about mental health issues particular to veterans.

Fortunately, there is no wheel to be reinvented here. The Crisis Intervention team, which started with the VA in Memphis, evolved at the beginning of that effort. It is transformative in

the way that law enforcement works with the mental health treatment system, its community, and with other resources throughout.

We are also working with the VA police. Many people do not know about the VA police force. There are about 2,500 officers who provide law enforcement services to our medical facilities. We have worked with their training academy, our National Center for PTSD, and CIT center in Memphis to expand their curriculum to give much better information about PTSD, TBI, and other mental health issues, as well as suicide prevention.

A larger vision for that is the stated intent of the VA police. In the communities we serve, they are going to be leaders on the law enforcement response to individuals with mental health issues. At this point, it is unclear exactly

what shape that will take, but it is as simple as sharing the expertise that they are able to build up.

There is a plethora of efforts going on right now that are focused on justice-involved veterans. The Department of Labor's Incarcerated Veterans Transition Program grants have just been revived, and 16 of those are focused on jobs. In addition to the work it is doing with Veterans Treatment Courts, the American Bar Association is encouraging pro bono legal services for veterans with child support issues and the wide array of unmet civil legal needs. We cannot provide a veteran with an attorney to serve their legal needs, but through these partnerships with community providers—lawyers working pro bono in these communities with the encouragement of the ABA—we hope to cover more than that.

RURAL ISSUES

Dennis Mohatt, M.A., Moderator

Vice President for Behavioral Health, Western Interstate Commission on Higher Education

There are many different special populations in rural America. Whenever you specialize something within rural, whether it is rural kids, rural African Americans, rural Asians, or rural veterans, it becomes very complex.

First, let us start with the notion that when we talk about rural, there is not one "rural" America. The rural South is very different from Alaska. Rural places in Hawaii are different from rural places in Iowa, which are very different from rural places in Vermont. And so, rural American is diverse. People who have lived there, and live there now, have always been diverse.

When I grew up in rural Iowa in the late 1950s and 1960s, it was routine for me to hear older people speaking German. It is still routine to hear people in North Dakota speaking Norwegian. It is routine now in Nebraska, Iowa,

and probably most rural places where there is food industry to hear people speaking

Sixty percent of rural Americans live in mental health professional shortage areas. That has not changed since the 1950s.

Spanish, Somali, and any number of other international languages. So rural America is diverse in culture and ethnicity and in everything that goes with that.

Culture is always influenced by place. An urban Indian and a reservation Indian experience two different kinds of cultures. They share a lot, but it is a very different kind of experience. An African American raised in the Tidewater area has a different cultural perspective than that of an African American raised in the inner city. Research has yet to capture that diversity. Ninety percent of the United States landmass is rural, and about 25 percent of our residents live there.

So what is different about the country? Rural and urban rates of mental illnesses are pretty much the same. There are little spikes here and there, but for the most part, there is agreement, after having spent so much time in rural research

in the last couple of decades looking for urban and rural differences.

To a significant level, differences are not there. This leads us to believe that mental illnesses are pretty evenly distributed in our society. But there are things that will cause spikes, and poverty is certainly one of the biggest. If you put an urban population under that same stressor, they will hit the same spike. There are significantly higher rates of suicide in rural, mostly among white men over the age of 55. And, there are some very significant differences in substance abuse and the substances that are used.

What is different is the experience of having a mental illness and living in a rural place. It is about accessibility, getting the services and paying for them, both as a provider and as a consumer. When you do arrive, will there be a mental health professional available to you? Sixty percent of rural Americans live in mental health professional shortage areas. That has not changed since the 1950s.

In most rural places, you do not have a choice about which Wal-Mart you are going to drive to and get your groceries, or about where you gas up your vehicle. And you do not have much choice about where you will have available mental health services.

So what about rural veterans? The Department of Defense does not report rural versus urban rates of deployment, so we do not know exactly how many of the people who were deployed are from rural versus urban. But the DOD reports that approximately 40 percent of all enlistments come from residences of non-metropolitan areas. And that is a disparity: about 25 percent of the U.S. population is rural, but 40 percent of enlistments come from non-metropolitan areas.

Many rural veterans must travel extensive distances to access the VA and military healthcare, just like most rural Americans have to travel great distances to access healthcare. Many rural Guard and Reserve personnel do not reside in the same community, or even the same

state, as their assigned unit. This is especially so with the National Guard because the Guard is difficult to move from state to state. But people do not always live anywhere near the unit from where they are deploying, and thus, when they come home, they go home somewhere else.

Since 9/11, 3.3 million Americans, including 700,000 Reserve personnel, have been deployed. I think there is only one county in the United States that does not have a resident who has not been deployed.

That is the magnitude of this. Reserve personnel deploy from everywhere in the United States, and not all VA facilities or military healthcare facilities are near where any of them live.

Every state has a mental health professional shortage area. There are roughly 3,000 counties in the United States. Sixty-one percent of rural residents live in a mental health professional shortage area—1,680 counties. There is not a single mental health professional living in those counties, but Guard and Reserve personnel live there. In comparison, there are fewer than 300 counties in the United States that do not have primary care services available.

In Kansas, with the exception of the Kansas City area, the Wichita area, and the Manhattan and Lawrence areas, every armory in the state of Kansas is in a mental health professional shortage area. You would see the same sort of thing in Nebraska and Montana.

Often, the Guard and Reserve seek care outside the DOD or VA healthcare system. During the Vietnam Post-Traumatic Stress Disorder Study, of those people identified with post-traumatic stress disorder, 60 percent sought care outside of the



VA or healthcare system. That is a significant portion of service members going somewhere else. When you go to rural, it is not surprising that people seek care elsewhere because it is hard to get to distant providers.

Family members are also dealing with deployment, and we need to strengthen systems to work with the community. The rural community-based providers are probably not prepared to serve this population. They have not received the training, they do not understand it, and right now, they are probably not asking about it.

Working with the Citizen Soldier Support Program and with community providers, we discovered people are not routinely asking their patients whether they have been deployed or had been next to someone who was blown up. They do not know the questions to ask to identify those things. This is not going away; this will be with us for a long time. The VA still provides excellent care to people who served in World War II. We are going to be serving this population and their families for another 70 years.

James (Jay) Shore, M.D., M.P.H.

Center for American Indian and Alaska Native Health, University of Colorado-Denver

I am based out of the Center for American Indian and Alaska Native Health. I work in a rural native veteran domain, mainly for the Office of Rural Health, which was established three years ago to address rural veterans issues within the VA. My work with the psychological health portfolio is focused around the use of technology to get care into the communities.

Background

The VA's Office of Rural Health is a large, new national office established through an act of Congress. As part of that, they established three rural veterans resource centers, dividing the country into regions: eastern, mid, and western. Two years ago, we established the

There are more than 4 million American and Alaskan Native identified peoples and almost a million of Native Hawaiian and Pacific Islander descent.

Veterans Rural Health Resource Center Western Region, which is based out of Salt Lake City. I am based out of Denver at the University's Center for American Indian and Alaska Native Health, which has been around for a quarter of a century. The Center does a variety of health promotions, innovations, and research for Native populations.

For more than two decades, they have been working with rural Native veterans populations. An outgrowth of our partnership with the VA's Office of Rural Health was the establishment of the Native domain for the rural health in the VA, which is really intended to be a resource on Native veterans issues. We define Native veterans as American Indian, Alaskan Native, Native Hawaiian, and the Pacific Islander populations. We are a point of contact for the VA, Congress, and the public to facilitate Native veteran information.

We are building partnerships with existing agencies in communities growing out of the Center's partnership, which has worked with over 100 different Native communities from Florida to Alaska, Hawaii to Maine. We also have a strong partnership in communities with several VAs, from the local level, to regional, and national organizations.

The diversity of rural communities is extreme. When you add in the Native populations with the different language groups and tribal groups—more than 464 recognized federal tribes—you have an incredible diversity of cultures, approaches, and locations.

Within the Native domain, we struggle with the concept of how to have programs that have a national scope and can impact communities, when every program needs some component of local focus and adaptation to make it relevant and meaningful for those populations. There is very little science to fall back on to try to understand where and how that adaptation gets made, and where it is appropriate.



There are more than 4 million American and Alaskan Native identified peoples and almost a million of Native Hawaiian and Pacific Islander descent. Also, there are more than 560 federally recognized American Indian and Alaskan Native tribes. That does not include the Native populations in Hawaii. Several tribes are not federally recognized but may be recognized by their states and are seeking federal recognition.

Although native communities are concerned about losing some of their traditional culture, up to 30 percent of American Indian and Alaskan Natives still speak a language other than English at home. If you are using language as a mark of traditional cultural identity, that still is very much present. Native populations are all around the country, but particularly in the rural west and other more rural areas.

Native American Veterans

Why focus on Native American veterans? Native American veterans enroll and serve at a higher rate per capita than any other population. They represent 1.5 percent of the general United States population. But depending on how you slice it in the military, they represent 2 to 3 percent of the active duty population. This may be an underestimate, but there may be from 300,000 to 500,000 Native veterans. They are the most rural of any veteran population. Again, there are different datasets, but using the common American household survey dataset, 38 percent of Native veterans are highly rural. The highest group of vets is Caucasian, and of that group, 25 percent are rural.

We also know from the limited scientific literature and studies that they are disproportionately impacted by their military service. Native veterans have higher rates of PTSD due largely to higher trauma exposure. This comes out of a study that replicated the National Vietnam Veterans Readjustment Study, which Congress conducted in the late 1980s. In the 1990s, in partnership with the National Centers for PTSD, our program completed an epidemiological study focused on the American Indian veterans population. We found that the rates of lifetime and concurrent PTSD were almost twice that of the Caucasian veteran population, which

was about 20 percent. In some communities in the Northern Plains, it was as high as 50 percent of those who had served.

People began hypothesizing why this is. Are there cultural issues, location issues? If you control for combat exposure, there are some cultural issues and location issues that do account for why Native veterans have higher rates of trauma exposure. But if you have more exposure to trauma, you will be at greater risk for developing PTSD and the other consequence of that, namely depression and substance use.

Again, we mentioned the rural location, and we have talked about the barriers that all rural veterans face. In addition to that, rural Native veterans also face some cultural access barriers that some studies have documented well, including system prejudice in accessing VA and other services. The choice of providers is very limited, and then trying to find a provider who understands both veteran issues and Native and cultural issues that are specific to that community can be extremely challenging.

Native American veterans enroll and serve at a higher rate per capita than any other population.

Telemental Health Clinics

These clinics began in our program in 2001 to address these challenges. We formed a multi-organizational collaboration between the VA and the University of Colorado, which is still continuing. At each site, we have mixes of partners from the Indian Health Services to tribal partners, tribal governments, and the community partners. The numbers keep changing, but currently, we are at eight clinics with 14 tribes. We are hoping to go to nine clinic sites serving 15 tribes.

It gets a little complicated because many of the communities we work with have multiple, independent, sovereign nations. I am still the clinician on the Wind River Clinic, which has the Eastern Shoshone Tribe and the Northern Arapaho Tribe. The U.S. government put these two traditional enemies together for the last 100 years, so you have two separate tribal governments and a joint tribal council that try to work together.

These are weekly clinics, and usually they involve an individual therapist who is located in Denver. Our team of providers expressed an interest in working in this population, have previous cultural experience, and do not believe that they know everything about these communities and are willing to continue to learn and educate themselves.

The provider is in Denver, and we have a VA electronic medical record. The key to the success of this clinic is to have these providers available in Denver. In many states, like Montana, it is very challenging for the VA even in Helena to get a psychiatrist who will stay for more than a couple of years, let alone some place like Fort Peck on the Montana-North Dakota border where there are not many VA services, or any other services by urban standards.

More important than the psychiatrist and the technology has been what we call the telehealth tribal outreach worker. We started the first clinic in Rosebud, S.D., in 2001. We talked to the tribal community and said, "Look, we have veterans in need." We also talked to Hot Springs Va. and some of the Vet centers. They said, "We have heard this; our services are available, but they are not coming in."

So we hired our first outreach worker, a tour combat veteran of the Rosebud Sioux tribe, who had served in Vietnam. He knew every veteran in the community, and he also knew their mental health status. He was not professionally trained, but he could tell you who was out drinking and who was arguing with their family. This clinic is still running.

It took us six months to get some veterans in. We worked on one patient for seven or eight years. Our motto: Try to leave no man behind. If we know they are out there in the community, we just keep knocking on the door. That is how that partnership works.

The other very important component of this has been in a parallel process as these clinics expanded. A VA in Montana started the Tribal Veteran Representative (TVR) program. The VA says to the tribes, "You choose a tribal member." The government does not select, the community does. Once they have selected their TVR, we tell

them to send that person to us, and we will give them intensive training on how to navigate the VA system.

The TVR helps with benefits, appointments, and with educating both the veteran and the community about the VA. When many of these vets come in, their first desire is not to learn about anger management. They are struggling with PTSD and cannot sustain employment. We get them service-connected and an income started. Then they can settle down and begin to listen to you about other things that can help them.

Native populations have had a history of people saying, "I am from the government; I am here to help." Those are deadly words. It is all about that individual trust and engagement, and it is also about that trust and engagement with the community. Our most important relationship is not with the individual veteran, which is critical to do the work, it is with the community. If they do not think we are trustworthy, no one is coming into our clinics.

We have been wildly successful in some communities. In others, we are still struggling to establish our credibility, which in part goes into the politics and the history. Many of these communities are used to outsiders or government agencies building up expectations and not delivering, so they do not really care what you say when you come in; they are just going to watch you. It is your behavior not your words that are judged, and that takes time. Sometimes that is a challenge because local VAs can be under pressure in terms of producing numbers or getting patients. The community has to be about the VA and the VA about the community.

We do not want to run all the Native clinics that we could have in the country. What we are trying to set up is a national consultative service so we can go to other VAs and educate, mentor, and coach them in how to talk and work with tribal communities to begin disseminating and adapting this model in a way that will work for them.

We try to link as many programs as we can into the mental health and medical services that we provide, communicating back and forth. We also have either formal or informal relationships with the traditional communities at all our sites.

For instance, in one of our sites we have the VA reimbursing for sweats (traditional Native American ceremonial sweat lodges) for veterans who follow traditional ways. Not all Native veterans will, but for those who do, it can be a very powerful healing component for dealing with trauma. We will collaborate with the healers, and that goes a long way toward engaging the community and showing them that we are listening to how they feel.

People often ask about telehealth, which is what I do. For seven or eight years, I have been treating some patients I have never met. I have a weekly PTSD group that has been running for six years—five guys and me. Occasionally, we will have some food together and do a live group, but most of our groups—it is a dynamics-supported group—are all on the video conferencing system.

There is always the question, “Is it as good as face-to-face?” We have six or seven randomized control trials right now with specific behavioral health treatments that demonstrate there is an equivalency between face-to-face and the video. In my clinical experience, it is different.

I have had many Native veterans tell me things in the first interview that they have never said to anyone else. Now, I would love to think that is because I am a great clinician. But when I ask them why, the unifying reason is because of

the feeling of distance and space they get with my not being in the room and in their face. They feel safer opening up. On the other hand, I have had problems with patients who have been slightly intoxicated, and it is harder for me to pick up on that. So there are strengths and weaknesses to each modality.

Challenges

There are specific challenges for Native communities in particular, but also for rural veterans. For instance, family is a very complicated issue in rural and Native communities. It can be a tremendous place for support, but it can also be a tremendous place for stressors and aggravation, and we do not talk about both sides of that. I am for family engagement, and I am for community support. But I also think it needs to be nuanced, because sometimes, the therapist wants to get the family out of the treatment and the patient out of the community because of what is going on.

Technology is an extremely powerful tool. But it is just that, a tool. It is the bridge. Just because a technology is there does not mean you should use it. It is important to be very critical and cautious moving forward, but there are some wonderful opportunities there.

Anthony Mohatt

Lieutenant Colonel, Kansas National Guard; Assistant Special Agent-in-Charge,
U.S. Department of Agriculture, Office of Inspector General

Seventeen hundred soldiers work for me in the Kansas National Guard. I have been fortunate to stay in the Guard for 25 years. And despite the fact that I have lived in Arkansas, Washington, D.C., South Dakota, and now Illinois, I have always stayed in the Kansas Guard. For some people, that is unusual. But, I am a military officer with a traditional background in the Guard; and once soldiers get to a certain rank and experience level, other states do not want to bring them in without their first proving themselves.

So I have stayed with Kansas because I already have a proven record with them and have had a great opportunity to lead soldiers during a time of

war. That has been worth the sacrifice to be able to travel back and continue to be an active member in that Guard community and, more importantly, in the Kansas community that I still call home. My mom and dad, my sister, and my in-laws still live in Kansas City.

When 9/11 occurred, we started working in airports. In some cases, the Guard in states other than Kansas supported different areas with 9/11 disasters. Obviously, the active-duty force deployed heavily shortly after 9/11 in 2002, as they started operations in Afghanistan. My Guard unit was asked to provide security missions in Germany while the active-duty forces took the

fight to Afghanistan. We deployed to Iraq in 2005; obviously, that was very different because of the combat aspects of that deployment.

Since that time, I have had individual soldiers in my command who have deployed seven and eight times. They are doing that because many of them are unemployed, which gets down to the nuts and bolts of it: a soldier has a family and needs to continue fulltime employment. They get paid better in the Guard as a deploying active-duty member than they do working whatever job they had back in Kansas prior to their Guard affiliation. They get used to that income and keep volunteering.

The Guard was lucky because the DOD started the 12-Plus-1 Policy: 12 months of deployment time and one month leave. Before that, with Iraq deployment we had soldiers who were away from their families, communities, and their jobs for about 18 months to train for deployment and post-deployment activities.

Currently, this infantry battalion is in the Horn of Africa, not something that is talked about in the media. Most Americans probably do not know that we have a strong military presence there. But 550 soldiers deployed there in April 2010, and another 550 will be leaving in April 2011 to backfill those soldiers there. We began with secure missions here in the United States and in Germany, then to combat action deployment in Iraq, with soldiers sent to Afghanistan throughout that time.

When a soldier comes to me to talk, it does not matter if it was a combat deployment or a peacekeeping deployment; many of the issues are similar. The long-term effects of many of the previous deployments are now just emerging with their last deployment, and that one might have been a peacekeeping deployment.

The different experiences, combat stress, long deployments, and too much communication—I will tell you, there can be too much communication. Husbands and wives and families talking back and forth help a commander greatly in dealing with the separation. But at some point, there are things that soldiers are told right before they go out on a mission that will distract them from what they are doing, that could potentially put them and their team in harm's way. Social

media is something I think we all need to take advantage of, but we also have to be very aware there are operational risks with that.

When soldiers come home, they are not the same; the family unit is not the same; the job is not the same, and they are looking for answers. I think many of the resources are getting out there. I am hearing it, and the soldiers are hearing it. I just do not know how to get them to use them. We have had soldiers commit suicide in my unit in the last couple of months. Some of them were very involved in some of the systems that are set up to handle those issues, and still, they took their life.

Remember, these are soldiers one weekend a month after they return from deployment. They are members of your community. Except for a few of the leaders, for the most part, they are thinking about their families, their jobs, and about what they are doing in the community. They are not Guardsmen 24/7. They will talk about it, but their true desire is to be productive, whatever that means, in life, in their community, with their family, or in their spiritual lives.

If I can get a soldier right when he comes back, and I identify him as high risk because he has no job, that is what I need an answer for right away. He wants something to move into right away that can help him. I had some men living under the bridges in Kansas City, Kan., and Kansas City, Mo. They just want a job so they can take care of the family.

Even the best situation is a challenge. I use my situation as an ideal: great family, great kids, great job. Yet it was still challenging for me to reintegrate, let alone the soldier who has any of those difficulties that I just mentioned. Deployment is not normal. When you throw the Reserve and Guard piece and the rural piece into it, it is even more challenging.

The bottom line is that rural America adds that extra degree of challenges to the situation. It is already a tough situation to redeploy a National Guard or Reserve soldier and integrate them back into their family unit or community. Then add a rural dynamic to it, where the resources are limited and the distances between care are so far. We have set up crisis management teams in Kansas, and they are on the road constantly, if somebody calls to ask for it. But how do you get them to ask?

RESEARCH

Dori Reissman, M.D., M.P.H., Moderator

Senior Medical Adviser, National Institute for Occupational Safety and Health, U.S. Centers for Disease Control and Prevention

Looking at research on a very basic level, we ask the following questions:

- Do people keep their jobs? Do people stay at a job very long?
- Do people remain on their career track?
- What is happening to people when they leave military service, and when they go back and forth between military and civilian service?
- What is going on with job satisfaction, the organization of their work life, the organizations in which they work, and what happens to them when they leave and when they come back?

There are so many questions and so few answers. All we have is a very basic, descriptive epidemiology, which from our perspective, shows there is a huge research gap.

Michael Schoenbaum, Ph.D.

Senior Adviser for Mental Health Services, Epidemiology, and Economics, Office of the Director, National Institute of Mental Health

I am a researcher who spends a lot of time among non-researchers, so I am fluent in both languages, except I still think like a researcher. When I am among researchers, I tend to be on the pragmatic end of “Come on, let’s not be so egg-heady.” When I am among non-researchers, I try not to be totally egg-heady and obtuse. We do not have to think of it as research with a capital R necessarily; we can think of it as research with a lowercase r, or we can scrap the word research and use a different language when talking to different audiences.

I am going to talk a little about what the National Institute of Mental Health (NIMH) is already doing in this space. Then, I will state my personal views of things I think should be

My colleagues in the Center for the Study of Traumatic Stress at Uniformed Services University of the Health Sciences have been doing several environmental scannings, trying to understand the number of programs that are available to veterans and to returning Guard and Reservists after military service in terms of benefits and services. We found that there are a huge number of programs, but very little program evaluation. So you have a thousand seeds and questionable blooming flowers. We do not know if there will be a flower, a forest, or no growth at all.

Below are questions for research:

- What should we be doing about that?
- How should we be measuring that?

What should we be learning, aside from the basic clinical science around whether the interventions that have been developed are really efficacious?

happening. I would love to be persuaded they are happening, but maybe I am not entirely convinced of that at the moment.

NIMH is undertaking and sponsoring a study in partnership with the Department of the Army and with the consortium of academic grantees called the Army STARRS Study. STARRS is an acronym for a study to assess risk and resilience of service members. This is the biggest study ever of risk and protective factors for suicide and associated adverse mental health outcomes in U.S. Army soldiers. In short, we are looking at the entire active-duty Army five years backward and five years forward.

We are looking at Guard and Reserve only to the extent they are activated, and we follow them after activation. That was a limitation in the scope of the work that we negotiated with

the Army. We are looking to see what is different between those who have good outcomes versus those who have adverse outcomes, with an emphasis on risk and protective factors. The objective is to help the Army develop target-applied intervention strategies and change who they recruit and how; how they assign and train them; how they deploy them; and how they screen and treat them medically.

We are a year into a five-plus-year study: \$50 million from the Army, another \$10 million from NIMH and counting, plus an enormous and unquantified in-kind contribution from the Army, the Department of Defense, and from NIMH.

In a variety of our grant programs, NIMH also

We do not know the suicide rate for the 80 percent who separate from military service but do not enroll in services at the VA.

supports a whole range of other research initiatives relating to mental health needs, service use, and the underlying etiology

of service members and veterans. Other components of NIH are very active in this space: National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse (NIDA), and the National Institute of Neurological Disorders and Stroke are very active in the neurological consequences of combat, trauma, and stress.

In cooperation with the National Business Group on Health, NIMH has been working to engage larger employers on evidence-based behavioral health practices. The National Business Group on Health has placed on their website for large employers a toolkit that embeds practical detail on a whole range of insurance benefits and clinical services best practices. These are as follows:

- what your health plan should be doing
- how your benefit management should work with employers
- how you should write RFAs for insurance company bids

We are trying to make the body of literature about what we know how to do more accessible to the various players whose actions ultimately

determine whether people, particularly those in the private sector, get anything approaching evidence-based practice.

The Gaps

Some chunk of the particular problems facing returning service members and veterans could be addressed, at least in part, if we were able to improve quality of care for behavioral health problems in ways worked on by the Business Group and other entities. That is the rising tide, for it floats all boats. We need to raise the rate of minimally appropriate care provided to people with common mental disorders in the community from the currently dismal rate of 20 percent. Only half receive those services at all, while the rest receive sub-threshold or sub-therapeutic or even contraindicative care. If we were better at that, we would probably have a better net for capturing and addressing the particular things that the veterans are returning with, although not all of it.

We are focusing on suicide in active-duty service members. The Department of Defense and the various services actually know a lot about the suicide rate in active-duty service members. Many other people are engaged in trying to figure out what underlies the suicide rate and what to do about it. The Pentagon does not know what the suicide rate is in service members the year or two or five after they separate from service. Not because it is not knowable—it is knowable—but at the moment, no one knows it. The VA knows it for cohorts of separated veterans, but only for those who have enrolled for services at the VA, which I believe is one in five separated service members.

We do not know the suicide rate for the 80 percent who separate from military service but do not enroll in services at the VA. There are two groups working on this now. One is the Army Public Health Command based at Edgewood Arsenal at Aberdeen Proving Ground; the other is a team at Fort Lewis that is responsible for the Department of Defense Suicide Registry. Eventually, we will know this; but 10 years into the war and five or six years into knowing that this is a real crisis, we do not know that statistic.

Similarly, I do not know anyone at the Pentagon who knows what the suicide rate in the family members of current active duty personnel is. That is actually harder to answer, but it is feasible to get a ballpark estimate. That is shocking to me.

We do not know very much of anything about the employment and earnings of returning service members. If you think about people's lifetime economic trajectories attached to the labor force, you might have periods of unemployment; you work in different jobs and know what your economic trajectory looks like. We do not know how that trajectory is influenced by a period of military service. This is particularly focused on Guard and Reserve who leave a non-service-member job to be deployed for a period of time and return.



In the general case, we do not know how this changes their economic trajectory, and so we don't know if we are coming close to compensating them for the service to the nation in any empirical sense. Then there are the ones who come back with physical, psychological, or neurological injuries. Again, we have no empirical basis for knowing how close we are to making them whole in a purely economic sense. There are longitudinal studies of it. People focus most commonly on the Millennium Cohort, but it does not measure economic outcomes and is not constructed in a way that allows anyone to answer these questions.

We also do not know very much about the geographic distribution of health needs, the population prevalence, and the characteristics of health needs of returning service members outside the DOD or Army system. For example:

- Where do these people live?
- Where do they go back to, and what services are available?
- What problems do these people have?
- How do we direct them to care?

A year or two ago, the Department of Health and Human Services tried to undertake a study of how much spillover there was into other

public services from this population who return into Medicare, Medicaid, HRSA services, and SAMHSA-funded services. Unfortunately, the methodology available to them to answer that question was wholly inadequate to the task because all they managed to do, in practice, was to look at the accounting systems of where the money is currently being spent in these different public systems. None of those public systems is set up to account for whether someone is actually a veteran.

It is only ad hoc that they are denominated as veterans in the records of these different populations and service programs. We are guaranteed to vastly undercount the spillover into these other public programs because only by chance do we know they are veterans.

What Works

SAMHSA underwrites the suicide lifeline and a pilot relating to the National Guard service members returning to Kansas City. The Department of Labor pilot program also is focusing on employment. As a researcher among non-researchers, I would ask, "Are these things being evaluated? What is the basis for determining whether a pilot should be proliferated?"

The Department of Labor and SAMHSA, the Department of the Army, and the Department of Defense are undertaking model initiatives. Not only are they not being evaluated systematically, but they are not designed to enable evaluations should a research entity like NIH be willing to fund research on top of what are otherwise intended to be service delivery programs.

It is not the mandate of the delivery people to do the evaluating. Their charter from Congress is to provide services, and they set up these programs to do so. I would say, design it so the evaluation can be funded. I do not believe that that is happening in general, and that is

both regrettable and probably fixable.

One of the things that evidence-based care focuses on is routine screening, case

identification, and then intervention and follow-up. You start someone on something and see how it is going for them or if they are following through. Very little of that is happening in the military delivery system.

One exception is the National Guard's version called the Post Deployment Health Reassessment. Deployed service members get a pre-deployment health assessment, which includes behavioral health screens. Immediately after they return, they get a post-deployment health assessment. Sometime afterward, they get reassessed.

The National Guard's implementation of the post-deployment health reassessment not only screens people for whether they have a behavioral health problem, but if they do, the National Guard system facilitates a referral. There is the only implementation of this system that follows up with the person to see if they completed the referral. In the active-duty delivery system Tri-Care, you send someone for a referral, and no one follows up. You write a prescription, and no one follows up to fill it. But the National Guard is doing this.

That is a chunk of federal activities. There also are nonfederal activities and state initiatives. Give an Hour is the one that comes readily to mind, but there are several. And I will cite our own failure.

A couple of years ago, these issues became publicly more prominent. We became aware of an increasing number of community organizations focused on addressing the mental health needs of returning combat vets in community settings. So we proposed and got approval for a request for applications, which means earmarked research money.

This money does not go into the same pool as every other investigator-initiated grant proposal. We set aside millions of dollars and issued a request for applications. Specifically, we invited partnerships between community-based delivery organizations aimed at addressing the behavioral health needs of returning combat vets and the research partners, where we would be funding evaluation on top of program-service delivery efforts.

We did not expect them to have the expertise or to spend their budget to do the evaluation. We just hoped that, if we made the money available, they would partner with academic institutions, and the academic institutions would work with them to do the evaluation for their own quality assurance purposes, but also, to tell the rest of the world what is working.

Well, we failed completely. We published this thing and got zero fundable applications. I do not think we have ever done what the Army

The part that matters most is the legal polices that bar employers from firing these people.



calls an after-action review to figure out where we failed. I do not think it is because there were not enough such organizations, that there were not enough potential academic partners, or that none of them were open to doing this kind of thing. Maybe we did not market it right. Whatever it was, we failed.

Employer's Role

As people separate from service, there is an effort now to get the DOD and the VA Health System to coordinate with each other better. What about coordination with private insurance plans? I do not know how much is happening, but it seems important to me. My guess is it has fallen through the cracks.

James P. Kelly, M.D.

Director, National Intrepid Center of Excellence, Department of Defense

My topic, traumatic brain injury (TBI) research, blends with psychological health concerns, especially within the Defense Centers of Excellence for Psychological Health and TBI. We know the dollar figures for what has been spent from 2007 to 2009, at least in the field of traumatic brain injury and psychological health research, and it is a fair bit of change. One lump sum, \$255 million, went through Fort Detrick, and some smaller chunks are not insubstantial as well.

The congressionally directed medical research program (and many other ways that money has gone out) has brought the academic community's attention into this world and offered an opportunity for us to work together. DOD, academia, and the VA have their own separate processes for research, which have always been very vigorous in this area of psychological health, although less so in traumatic brain injury.

But one of the things this project does not buy is expedited dissemination of findings. The four-star generals to whom I answer when they call say, "What's new out there that we can roll out now? We do not want to wait anymore. We do not want to wait for the grant process and all of the chewing-on that academics need to do and the peer review publication processes."

Some companies' programs look exemplary, but they are outlier companies. Their firms have a commercial interest to do good. They are trying to recruit military populations and, in some cases, are selling to military populations. They have PR and social marketing interests of their own, and they live off making serious investments in human capital and keeping those people attached to their firms.

But that is not the way most of the workforce works and is not the model for the jobs returning combat veterans come back to in the community. The part that matters most is the legal policies that bar employers from firing these people. How well is that working out? I do not think we know, and it seems to me that we should.

We are learning as we go, especially in the National Intrepid Center of Excellence (NICOE). We take little chunks of things that we learn and get it out there quicker, recognizing full well it has not been vetted properly through all the different paths. But when we think we are onto something, we want it out there as quickly as possible, and this process will continue and inform us in a much bigger way.

Common Data Elements Project

The Common Data Elements Project has bridged DOD, NIH, NINDS, the VA, and the Department of Education. It is looking at traumatic brain injury outcome measures for detection early in the post-deployment health assessment questions. It also measures that part of neurological, brain-related assessments and neurological tests that we can use to create a menu from which people can choose and then talk to each other, whether they are at UCLA or Fort Benning, and have some idea of what it is they are talking about. Our shop, the NICOE, has been very involved in this right from the beginning.

We also are the data repository for the upcoming hyperbaric oxygen treatment study. There has been controversy about that as to

whether it is potentially useful. Some people are absolutely convinced that it is a miracle approach in terms of treatment, and some say there is absolutely no scientific basis for it and that it is all placebo effect.

The DOD is trying to figure that out and is taking a very diligent approach to looking at a controlled study with one outcomes assessment center for the entire national project. This project has five centers around the country where the hyperbaric protocol will go on. Then they will come to Fort Carson for outcome measures to compare what was shown before they entered

the study. In order to have a measurable effect, which you anticipate being small, you need

However, the problem to be addressed is the mixture of psychological health issues with TBI and the idea that this may be that individual's sixth deployment.

many subjects to know whether it is real or not. Therefore, 200 soldiers and Marines with traumatic brain injury will be coming through that project.

Other than the extremity injury, what the blast does to the body is understood fairly well. What it is doing to the brain is not as well understood. There are elaborate projects involved in injury prevention, and the whole downstream reset and reconfiguration of tissue engineering can be a part of this.

But we also need to determine what was a concussion and what was the psychological distress reaction to a horrific event. There is so much overlap in those two human issues in the same person at the same time that we have a lot of work to do to figure that out. Does it really matter? You still end up with a person with a problem that has to be addressed. The more academic neuroscience piece of it may not be as productive as simply taking care of these people.

We have a couple of projects looking at handheld, ruggedized, war-durable PDAs where you can do neuropsychological assessments remotely and then download them or beam them elsewhere. This is actually stateside, but they have been done in a couple of locations in theater.

I was in Afghanistan last November to look at the traumatic brain injury process—what happens when someone has a concussion. The severe TBI piece of it has never been better. The acute care received all the way back to the United States and into care and rehabilitation is absolutely stellar. Yet the milder injuries are often dismissed and misunderstood, and we need to get a handle on that.

In terms of early detection and the need for screening for traumatic brain injury, multiple studies in the peer-reviewed literature have looked at post-deployment health screening and other ways of looking at individuals returning from in-theater experiences as to whether they had a traumatic brain injury or not. I am most impressed with one study also out of Fort Carson. Twenty-three percent of the returning combat soldiers had had a concussion during one major deployment; 3,900 soldiers returned to Fort Carson within a week, and all had to go through this screening process. Fort Carson has an elaborate, very well-staffed process for getting this information. These numbers are believable because of redundancy in the assessment. A clinician verifies that yes, that is a concussion, and now we understand what really happened back in theater.

On the other hand, most of these people resolve spontaneously. Of those reporting a concussion, less than half have symptoms that need to be addressed, and less than half require specialist care. Usually, they are cared for successfully by primary care, and then they go about their routines. However, the problem to be addressed is the mixture of psychological health issues with TBI and the idea that this may be that individual's sixth deployment. We were not gathering information from the very beginning back then, so this is a whole new kettle of fish. We have never done this to human beings before, and we need to learn the impact of multiple deployments.

One of the things that we learned in Colonel Heidi Terrio's study at Fort Carson is that when people had what they thought was a concussion, they described it as an alteration in consciousness or loss of consciousness or a gap in memory. The symptoms actually are very much the same as, if not identical to, the civilian experience in concussion. Headache always tops the list, then

dizziness, or balance or equilibrium problems, and some irritability, memory, and sleep problems.

The non-medical leadership of the Army and Marines began a recent initiative that screens individuals who have experienced any event that may have caused a concussion. Many months ago, a conversation between two Generals and the medical people in our groups and in the uniformed services went like this:

“We don’t want to have to wait for the service member to say, ‘I think I’ve got a problem.’ We want them all screened in-theater.”

Then they looked at me and said, “You are going there to figure this kind of thing out?”

“In all honesty, Generals,” I said, “I do not think I can because they said do it like you do in the NFL, and I cannot run out in the war zone and say, ‘Time out, I’m taking GI Joe to the locker room.’”

One General said, “You let me worry about that. You tell us how to do it.”

I think the seriousness with which they are taking this will turn this around. We are going to understand the nature of the problem, get people to come forward and say, “Yes, I do have an issue here.” We are going to be able to measure it better. We are going to know the natural course of recovery as a result, much like we do in the sports community. Because the non-medical people took control and said you are going to do it, everyone will do it. Oftentimes in the military system, the healthcare providers have a more passive role. This is a much more active way of going about it. We do not have data to share just yet, but it is being gathered now in theater.

NICOE

The NICOE is a two-story, 72,000 square-foot research and clinical care facility with robust training and education features as well as telehealth and telemedicine reach. It has elaborate research instruments, like a 3 Tesla MRI scanner, a PET-CT scanner, a magneto-encephalography machine, and very elaborate virtual reality capabilities.

We can actually look at the corpus callosum and other parts of the brain’s anatomy with standard anatomical approaches or with various functional testing. But now, we can dive deep

down, look at specific tracks in the brain, and find the lesions in the wiring. And we can superimpose the functional imaging, so I can have people engage in some cognitive task or wiggle a finger, and the part of the brain responsible for that function actually enhances with specific approaches. Then, we can superimpose that on the anatomical fiber tracks scans and see where the wiring from those areas of the brain goes. We can also see if other parts of the brain actually take over functions if there have been injuries deep within the brain’s tissue and its pathways. Only a handful of places on the globe are doing this right now.

Our colleagues at T2, Telehealth Technology, and others engaged at Fort Detrick, are bringing in theater virtual reality equipment. They are using it to test individuals right there in the front lines to see if we can use projects and programs that are undergoing current testing. If you engage individuals much more proximately to the event itself, does the treatment help the way forward, rather than have it reverberate, take on a life of its own, and be more intractable over time?

We also have studies by Dr. Albert Skip Rizzo and his team, that are looking at a part of the brain called the amygdala. We will be collaborating with this team when we look at pre-engagement and post-engagement in terms of this virtual reality treatment. We will be looking for actual reductions in the fear center of the brain, which revs up and becomes so metabolically active pathologically in post-traumatic stress disorder. With proper treatment, we can see a reduction in that metabolism over time.

Dissemination

In terms of getting this information out into small-town America, our approach started with a meeting of all of the organizations—federal agencies, private sector entities, and academic communities. The idea was to have these people meet and talk to each other about projects and programs and share information, and then learn to collaborate and make commitments to each other.

We also are focusing on the nation’s Area Health Education Centers. Back in the 1970s, federal legislation established Area Health Education Centers in underserved areas to help



with the maldistribution of healthcare providers, primarily physicians. They still exist, are fairly elaborate in about 47 states, and are mostly in small- town America.

This is what the DOD is about now: getting people together and making federal-private bridges happen.

The infrastructure and the health educators in those areas already are waiting for information to disseminate to the primary care teams, the physicians, and the

physician extenders. We had the VA at the table with us, and this is just the first effort that we have made to try to bring this together to export programs like the Citizen Soldier Program in North Carolina. This is what the DOD is about now: getting people together and making federal-private bridges happen.

SUMMATION

Terri Tanielian, M.A., Moderator

Co-director, RAND Corp.'s Center for Military Health Policy Research

We have been moved by striking images. Our heartstrings have been tugged on, and we have been called to action. We know that, since September 2001, we have deployed over 2 million service members to support operations in Iraq and Afghanistan; 40 percent of those are still on active duty. As service members come home, they are being redeployed multiple times, and traumatic exposures are very common. Coming home, they are sleep deprived and inundated with information, and they just want to see their families.

We know there are groups that struggle more than others. Those who have been severely wounded and are very ill have a difficult time getting their care coordinated and getting the care that they need in their home communities. Those who are in the Guard and Reserve are breaking up some of their social support systems and going back into communities. Almost every single county in the United States has had a member of its community deploy. These are our neighbors.

People with mental health problems struggle. Depending upon which group you look at and what you define as a population, about 20 percent of all of those who have ever been in time for PTSD or depression, and that is a significant number of individuals.

We hear from them that they are challenged, not just by issues of stress and mental health problems, but also by feelings of social isolation. This is true for those who go to college campuses where they feel very different from their peers. They are not the average 19-year-old college student. They have been walking the streets of Baghdad and carrying with them very heavy psychological backpacks for quite some time.

Service members are amazed and confused about the number of benefits for which they may be eligible. They are overwhelmed by the amount of paperwork they may need to complete to gain

access to those benefits, and they have difficulty getting an appropriate evaluation. They are figuring out where to go.

I had a team of Ph.D.-level individuals try to figure out how to navigate the systems of care. It is pretty overwhelming even for those of us who think we know how healthcare systems work, so it is quite overwhelming to the individuals and their families.

They also worry about their families. We already have data that the children of military service personnel are affected by these deployments. It is not just the stress associated with deployment while their parents are gone; it is also when their parents come home and are reintegrated into their families. We need more research to understand what is going on within these families and over time.

There are many barriers to getting veterans the help they need. We have heard a lot about stigma, the culture, the institutional barriers that are in place, all of which make it very difficult for veterans to get help. And there are barriers at the individual level, the provider level, and the system level that need to be attended to if we are going to solve some of these issues. Veterans themselves have a lot of great ideas.

What We Need to Do

This is going to take new partnerships. People are very good about staying in their lanes; it is going to take people being a little more willing to take risks and get out of their lanes. It was very difficult even to get partners from across the two federal agencies—both of which are working on these issues—in the same room together about five or six years ago. Now, we are getting nongovernmental entities, state governments, and other local partners engaged in thinking about this in a more comprehensive, cohesive way, and that is important.

There are many challenges to our ability to be successful in this regard, and again, we need to be creative and innovative. But we also need to be strategic. We need to think about strategic coordination and what we need to do to make sure that stakeholders are working together.

We also need sustainable commitment, not just in the resources and the funding, but in the partnerships. There is a lot of money now; there may not be a lot of money in four or five years. But we know these problems are going to be around for quite a long time.

We need to integrate within and across service sectors. We are getting a little better, but there is a lot of room to grow. This is not just between the government and non-government—this is between primary care and specialty care. We need to rethink the way we deliver behavioral health services, and not just for our veterans but for all Americans, because the civilian healthcare sector is a major player in serving those who have served us.

We need to make sure that data is available and accessible and that we share it for planning purposes. As a researcher, I can tell you it is not easy to get data on who these veterans are, where they live, and what they need.

We need accountability, transparency, and quality control. We need to make sure that we are demonstrating that what we are doing is having an effect and making things better, a continuous quality improvement model so that we can make sure we are on the right track.

If we are going to move forward, we have to think about eliminating barriers and embracing a comprehensive, integrated approach that brings all stakeholders to the table. We need to close the knowledge gap. We need to make sure that we are investing in research that not only includes the groundbreaking science that is going to happen as we unlock the brain, but also the etiology and phenomenology of PTSD and other mental health challenges. We must do this, not just for our veterans but also for their family members, as they will be the next generation of our warriors that we need to think about. By doing so, we really are challenged to promote a message of hope, recovery, and successful reintegration. We need to think about how we can use messages of strength and recovery as we reach out to serve those who have served us so well.

CLOSING MESSAGE

Rosalynn Carter

Chair, Carter Center Mental Health Task Force

Well, I have a story, and since everybody else was telling their story I figured I would tell mine, too. Jimmy's uncle Tom is the reason he went into the Navy. He was Jimmy's mother's brother, and when he was in the Navy he used to send Jimmy gifts, little souvenirs from all over the world. So Jimmy wanted to be in the Navy too, and then he realized that it would be the best way he could get a free education, because they didn't have very much money. Uncle Tom, who was very close to Jimmy and the family, was captured in Guam in the first week of the war in the Pacific, during World War II. We didn't hear from him; he had a wife, Dorothy, and three little children, and after he had been gone for awhile, she received a telegram saying he was missing in action. And when we still didn't hear from him for a few years, I don't know how long it was, she received a telegram saying he had been killed in action. Well, about a year after that, she was having so much trouble with the children, trying to raise them by herself, that she married a family friend. And then when the war was over, Uncle Tom came home. It was a tragedy, because Dorothy wanted to annul her second marriage and be with Tom. But in his weakened condition — he weighed about 87 pounds — Jimmy's mother and her sister talked Tom into not having Dorothy annul the marriage. He stayed in the hospital for a very long time; he was in terrible shape physically and mentally. The end of the story is, after a good many years, he remarried and had some good years, I think. They gave the impression that they were getting along fine. I think with most of the people that come home from war, you don't ever know how they are affected for the rest of their lives. That is my story—talk about psychological damage, it was just an awful situation.

This was a great symposium, and nothing could be more timely. We all have learned a lot about the special issues facing veterans from the National Guard and Reserves as they reintegrate into their families, communities, and the workplace; I certainly have. We all go home with so much more knowledge about what is available in our communities and where to go for more information. I know my head is spinning with ideas and things to follow up on. But it is important not to spend too much time emphasizing the existing handicaps of these veterans. Their dedication and sacrifices for our country need always to be properly acknowledged. We want to be sure we provide them with the services and supports they need to minimize their injuries and concentrate on living successful, fulfilling lives in their communities. It is very important that we don't just treat them as a group and forget what they have done for our country.

Biographies

Nina Berman, M.S.

Nina Berman is a documentary photographer with a primary interest in the American political and social landscape. She is the author of two monographs, “Purple Hearts—Back From Iraq” and “Homeland,” both examining war and militarism. Her work has been recognized with awards in art and journalism from the New York Foundation for the Arts, the World Press Photo Foundation, and the Open Society Institute Documentary Fund, among others. Her work is widely exhibited and was featured at the Whitney Museum of American Art 2010 Biennial. She is a member of the NOOR photo collective and lives in her hometown of New York City.

Jarrett Blake

Jarrett Blake is an 11-year Marines veteran and associate director for the Veterans Division of Veteran, Immigrant, Refugee Trauma Institute of Sacramento, known as VIRTIS. The Veterans Division’s goal is to develop psychosocial reintegration programs for veterans and their families. VIRTIS is a partner of the University of California Global Health Institute’s Center of Expertise on Migration and Health and of the Migration Health Research Center, a joint UC Berkeley and UC Davis initiative. Blake has served two tours in Iraq, and he assisted with humanitarian aid on the ground after the tsunami devastated Southeast Asia. As a company gunnery sergeant with over 200 Marines in his charge, Blake practices and teaches the Marines principle “to exhaust the body, quiet the mind.” To this end, he has developed combat-conditioning drills and built obstacle courses for training under the most extreme circumstances. Currently attending Sierra College, he understands the transitional challenges of returning to community college and is committed to continue serving fellow veterans in civilian life.

Major Mara Boggs, M.S.

Mara Boggs enlisted in the Army Reserves in 1994 and commissioned as an active duty officer in 1998. She has served in leadership positions in the 82nd Airborne Division, 1st Cavalry Division, and the XVIII Airborne Corps, has deployed to Iraq twice and has traveled to Afghanistan. During the 2006 2007 Iraq surge, she was the first female company commander of an airborne engineer unit, which won an award for being the best engineer unit in the Army and performed over 800 combat missions without a single fatality. Mara was selected as a congressional fellow for the Department of Defense and served as a military legislative assistant to a U.S. senator for nearly two years. While in this position, she was the staff lead for forming the Senate Military Family Caucus, a bipartisan group of 26 senators devoted to working on military family issues.

William C. Bonk, M.B.A.

William C. Bonk is director of Health and Wellness at the Lockheed Martin Corporation. He leads the organization that manages the company’s benefit plans, internal medical operations, participant engagement and education strategies, data analytics, and leave administration in support of the mission to improve employee health, enhance productivity, and reduce the acceleration of costs to the employees and the company. He also manages the administrative operations and performance monitoring of Lockheed Martin Corporation’s group insurance plans for all active and retired participants, valued at over \$1.2 billion annually. Bonk received an M.B.A. in finance from Johns Hopkins University.

Thomas H. Bornemann, Ed.D.

Thomas H. Bornemann has been the director of the Carter Center Mental Health Program since Aug. 1, 2002. Prior to that, he served as senior adviser for mental health in the World Health Organization’s Department of Mental Health and Substance Dependence, where he worked on the

development of the World Health Report, focusing on mental health. A career public health officer, he has spent his professional life working in all aspects of public mental health, including clinical practice, research and research management, policy development, and administration at the national level. He received his doctorate in counseling from the University of San Francisco and served in a psychiatric emergency clinic in San Francisco. He has been deputy director of the Federal Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration and has held an academic appointment in the Department of International Health, Division of Health Systems in the Bloomberg School of Public Health at Johns Hopkins University. He has interest and expertise in humanitarian assistance in refugee and disaster situations, has published and lectured extensively in these areas, and has consulted domestically and internationally. He was chief of refugee health programs in the Office of International Health at the U.S. Department of Health and Human Services, and at the National Institute of Mental Health, he designed and developed a series of inpatient and outpatient services for a variety of populations, including a national mental health program for refugees. During his tenure at The Carter Center, Bornemann has provided leadership in the development of the first ever Surgeon General's Report on Mental Health.

Ron Capps

Ron Capps is retired from 25 years of service in the U.S. Army and Army Reserve, with overseas tours in Germany, Korea, Afghanistan, Uganda, Ethiopia, Mauritania, and Chad, and as a member of the African Union's Cease-Fire Commission in Darfur. He also is a retired foreign service officer who served with the Department of State in Cameroon, the Central African Republic, Kosovo, Rwanda, Iraq, and Sudan. His commentary and analysis have been featured in *Foreign Policy*, *Monday Developments* (the journal of humanitarian assistance), *Health Affairs*, on NPR's "All Things Considered," the BBC World Service and Pacifica Radio. He has received two Bronze Star Medal awards and two Department of State Superior Honor Awards. In 2007, the American Foreign Service Association presented him with the William R. Rivkin Award for his creative dissent of U.S. policy in Darfur, and in 2008, the director of National Intelligence named him a Distinguished Analyst. He lives and works in Washington, D.C.

Rev. Thomas B. Carter

The Rev. Thomas B. Carter is an Episcopal priest and rector of the Church of the Nativity, Cedarcroft, in Baltimore, Md. Nativity is one of the first two Partners-in-Care congregations serving the Maryland National Guard. There are now Partners-in-Care congregations in every county in the state. Carter also serves as a chaplain in the Maryland Defense Force, a part of the Maryland Military Department that helps provide chaplain support and other professional services to Maryland National Guard units. His son currently is serving in Afghanistan with the 101st Airborne and has served two tours of duty in Iraq, one of which was with the National Guard. The issue of reintegration of our National Guard and Reserve troops is an issue that is near and dear to his heart.

Sean Clark, J.D.

Sean Clark is the national coordinator for Veterans Justice Outreach in the Office of Mental Health Services, U.S. Department of Veterans Affairs. Veterans Justice Outreach is a recently developed program that provides outreach and linkage to services for veterans involved with the front end of the criminal justice system (police, courts, and jails). He has served as a special assistant United States Attorney in Washington, DC, both as a line prosecutor for general misdemeanors and as the assistant assigned to the Mental Health Court calendar. He is a former Presidential Management Fellow and earned his J.D. from William & Mary Law School.

Daniel J. Conti, Ph.D.

Daniel J. Conti is managing director of the Employee Assistance and Work Life Programs at JPMorgan Chase, the parent company of the second largest bank in the United States. He has developed and implemented innovative programs that address the link between behavioral health status and corporate costs and has published significant research on this subject and other health economics topics. He currently serves on the board of directors of Mental

Health America of Illinois and is a member of the business advisory group for the Joint Commission on Accreditation of Healthcare Organizations. He was a former director on the board of the Depressive and Bipolar Support Alliance. Conti is an adjunct associate professor at DePaul University in Chicago where he received his Ph.D. in clinical psychology.

Ronald Finch, Ed.D.

As vice president of the National Business Group on Health (Business Group), Ronald Finch has responsibility for business development for the Business Group's Institute on Health, Productivity, and Human Capital; Pharmaceutical Council; and behavioral health projects. The Institute on Health, Productivity, and Human Capital develops and shares solutions aimed at improving employee health and productivity and works closely with EMPAQ®, a system of standardized data and metrics that employers can use to benchmark employee disability and productivity. The Pharmaceutical Council comprises Business Group corporate members, pharmaceutical companies, and pharmacy benefit management companies and functions to provide sophisticated tools and products for developing effective and efficient medications. The Business Group develops mental health and substance abuse tools and products for employer use in health plans, disability management, employee assistance programs, and health and productivity management programs. These products focus on the mental health needs of employees and their families. Finch received a B.S. from Memphis State University, an M.S. in counseling psychology from the University of Tennessee, and a Ph.D. in counseling and personnel services from Memphis State University.

Brian Flynn, Ed.D.

Brian Flynn is an associate director of the Center for the Study of Traumatic Stress and an adjunct professor in the Department of Psychiatry in the Uniformed Services University of the Health Sciences in Bethesda, Md. He is a retired Rear Admiral/Assistant Surgeon General in the U.S. Public Health Service. He is an internationally recognized expert on the individual, family, and community psychosocial factors in large-scale trauma, disasters, and emergencies. He has served as an adviser to numerous national and international organizations, states, and academic institutions, practitioners, and government officials in many nations.

John Howard, M.D.

John Howard is director of the National Institute for Occupational Safety and Health and coordinator of the World Trade Center Health Programs, both of which are initiatives of the U.S. Department of Health and Human Services. He also has worked as a consultant with the department's Afghanistan Health Initiative and with the Public Health Law Program in the U.S. Centers for Disease Control and Prevention. Previously, he served as chief of the Division of Occupational Safety and Health in the California Labor and Workforce Development Agency. Dr. Howard received a Doctor of Medicine degree from Loyola University of Chicago, a Master of Public Health degree from the Harvard School of Public Health, a Doctor of Law degree from the University of California at Los Angeles, and a Master of Law degree in administrative law and economic regulation from George Washington University in Washington, D.C. He is board-certified in internal and occupational medicine. He is admitted to the practice of medicine and law in the state of California and in the District of Columbia and is a member of the U.S. Supreme Court bar. He has written numerous articles on occupational health law and policy.

James P. Kelly, M.D.

James P. Kelly is a neurologist and one of America's top experts on treating concussions. He is director of the National Intrepid Center of Excellence at the National Naval Medical Center in Bethesda, Md. He has been professor of neurosurgery and physical medicine and rehabilitation and assistant dean for graduate medical education at the University of Colorado School of Medicine, as well as director of the neurology residency program at Northwestern University Feinberg School of Medicine. He was director of the brain injury program at the Rehabilitation Institute of Chicago and neurological consultant for the National Football League's Chicago Bears and is consulted frequently by professional, elite, amateur, and youth athletes who have sustained concussions. Dr. Kelly co-authored the sports concussion guidelines of the American Academy of Neurology and the "Standardized

Assessment of Concussion” that is widely used in athletic and military settings. He is consistently listed among America’s Top Doctors and in Who’s Who publications. He is a fellow of the American Academy of Neurology and a diplomat of the American Board of Psychiatry and Neurology; past president of the Colorado Society of Clinical Neurologists; and a consulting neurologist to the Defense and Veterans Brain Injury Center—a component center of the Defense Centers of Excellence. He was the first chairman of the Defense Health Board’s Traumatic Brain Injury External Advisory Subcommittee for Military Clinical Care, Research, and Education. He received a bachelor’s and a master’s degree in psychology from Western Michigan University, graduated from medical school at Northwestern University, and completed his neurology residency and behavioral neurology fellowship at the University of Colorado.

Kelly Kennedy, M.A.

Kelly Kennedy is a United States Army veteran who served tours in the Middle East during Desert Storm and in Mogadishu, Somalia. After earning her journalism degree at Colorado State University in 1997, she began her writing career as an education reporter for the Ogden Standard-Examiner in Utah, a criminal justice reporter at The Salt Lake Tribune, and a family and education reporter with the Oregonian in Portland. While earning a master’s degree in journalism at the University of Colorado, Kennedy taught journalism classes at both her alma mater and the University of Northern Colorado. After completing her master’s degree, she worked an internship at the Chicago Tribune before arriving in 2005 at Army Times, where she remains today as a medical reporter. In 2008, she was named a finalist for the Michael Kelly Award for a series about a unit in which she was embedded in Iraq. She is also a 2008 Ochberg Fellow, sponsored by the Dart Center for Journalism and Trauma. In her spare time, she dances ballet and completely loses her military bearing.

Lt. Col. Anthony Mohatt

Anthony Mohatt enlisted in the Kansas Army National Guard in 1986 as a tactical radio repairman in an armor battalion. He was promoted to sergeant, received his commission from Kansas Officer Candidate School, and has had numerous leadership assignments, including battalion commander. He deployed to Germany in support of Operation Enduring Freedom, to Iraq in support of Operation Iraqi Freedom, to Saudi Arabia in support of Operation Friendship 1, and to the Gulf Coast in the wake of Hurricane Gustav. His academic education includes a Master of Arts in criminal justice from Wichita State University, a Master of Military Science from the Command and General Staff College, and a double bachelor’s degree of general studies in political science and sociology from Kansas University. He has received extensive military education that includes officer training at the Resident Army Command and General Staff College. Among his many awards and decorations are the Bronze Star, Meritorious Service Medal, Army Commendation Medal, Army Achievement Medal, Global War on Terrorism Service and Expeditionary Medal, Iraqi Campaign Medal, Humanitarian Service Medal, and the Combat Action Badge. He is a senior special agent for the U.S. Department of Agriculture, Office of Inspector General.

Dennis Mohatt, M.A.

As vice president for Behavioral Health, Dennis F. Mohatt directs the Mental Health Program and Center for Rural Mental Health Research at the Western Interstate Commission for Higher Education. He received a master’s degree in rural community-clinical psychology from Mansfield University in Pennsylvania in 1984 and has had more than 25 years of experience and training in rural community mental health. As the executive director of the Menominee County Counseling and Mental Health Center in Michigan’s Upper Peninsula, Mohatt was responsible for the planning, operation, and evaluation of a successful rural ACT program and primary care integrated delivery system. During his tenure as the deputy director of Health and Human Services for Nebraska, where he served as the state’s commissioner of mental health, he was a member of the leadership team that established an integrated Health and Human Services Agency following the merger of five state agencies. Mohatt served as the chief consultant to the rural issues subcommittee of the President’s New Freedom Commission on Mental Health and authored the subcommittee report to the president and the nation. Mohatt also led the effort around rural behavioral health relating to the National Action Plan for Behavioral Health Workforce developed by the Annapolis Coalition.

He is in collaboration to take to national scale the Citizen Soldier Support Program, designed to enhance the capacity of community providers to meet the needs of returning military and their families. He also serves as the co-principal investigator for a Department of the Army research study to develop and test the efficacy of military Mental Health First Aid.

Catherine Morris, M.S.

Catherine Morris is a veterans counselor and professor at Sierra College in California. In addition to over 15 years of military service in the Marines and California Army and Air National Guard, Morris has spent a decade providing counseling, teaching, and advocacy for over 5,000 veterans, guard, and reservists. She developed and teaches College Success, part of the Boots to Books Learning Community, which is linked to an English course and designed to assist veterans in transitioning from military to college. Morris has presented dozens of workshops to colleges, military units, community, and veteran organizations on topics such as combat stress, educational benefits, creating veteran friendly campuses, and military competencies. Morris now serves as vice president and executive director of the Veterans Division under VIRTIS.

A. Kathryn Power, M.Ed.

Kathryn Power is director of the Center for Substance Abuse Prevention in the Substance Abuse and Mental Health Services Administration, an operating division of the U.S. Department of Health and Human Services. Prior to her current appointment, Power served as director of the Center for Mental Health Services from 2003 to 2010. Previously, she served for over 10 years as director of the Rhode Island Department of Mental Health, Retardation, and Hospitals, a Cabinet position responsible for four systems of care, including mental illnesses, substance abuse treatment, and prevention services.

Joyce Raezer

Joyce Raezer became executive director of the National Military Family Association in 2007 after serving at various staff positions in the Government Relations Department since 1995. She guides the management of the Association's programs and initiatives that serve the families of the seven uniformed services and that promote improvements in their quality of life. Raezer has represented military families on several committees and task forces for offices and agencies of the U.S. Department of Defense. She served on the first national board of directors for the Military Child Education Coalition. In 2004, she authored a chapter on transforming support to military families and communities in a book published by the MIT Press, "Filling the Ranks: Transforming the U.S. Military Personnel System." She has been a member of the TriWest Healthcare Alliance's Executive Advisory Board since 2007. A Maryland native, Raezer earned a B.A. in history from Gettysburg College and an M.A. in history from the University of Virginia. An Army spouse and mother of two children, she has lived in the Washington, D.C., area for four tours and in Virginia, Kentucky, and California. She is a former teacher and served on the Fort Knox Community Schools Board of Education.

Linda Rosenberg, M.S.W.

Linda Rosenberg is an expert in mental health policy and practice with more than 30 years of experience in the design, financing, and management of psychiatric treatment and rehabilitation programs. A certified social worker, family therapist, and psychiatric rehabilitation practitioner, Rosenberg has held faculty appointments at a number of schools of social work and serves on many agency and editorial boards. Since 2004, she has been president and chief executive officer of the National Council for Community Behavioral Healthcare, a nonprofit advocacy and educational association of more than 1,700 organizations that provide treatment and support services to 6 million adults and children with mental illnesses and addictions. Under Rosenberg's leadership, the National Council has more than doubled its membership, helped to secure the passage of the federal mental health and addiction parity

law, expanded financing for integrated behavioral health and primary care services, was instrumental in bringing behavioral health to the table in federal healthcare reform dialogue and initiatives, and played a key role in introducing the Mental Health First Aid public education program in the United States.

She previously was senior deputy commissioner for the New York State Office of Mental Health, where she strengthened the voice of consumers and families in the policymaking process; promoted the adoption of evidence-based practices—tripling New York’s assertive community treatment capacity; expanded children’s community-based services; developed housing options for people with mental illnesses and addictions; and implemented a network of jail diversion programs, including New York’s first mental health court.

Hon. Robert T. Russell Jr., J.D.

Judge Robert Russell is an associate judge for Buffalo City Court and serves by appointment as an acting Erie County Court judge. In January of 2008, he created and began presiding over the nation’s first Veterans Treatment Court, in collaboration with the Western New York Health Care Network, Western New York Veterans Project, and a host of volunteer veterans who serve as mentors. Previously, he created the Buffalo Drug Treatment Court, over which he remains presiding judge. He established and served in Buffalo’s Mental Health Treatment Court, which oversees treatment cases of those diagnosed as severely and persistently mentally ill. Russell has received numerous national awards, including the Veterans of Foreign Wars of the U.S.’s James E. Van Zandt Citizenship Award, Vietnam Veterans of America Inc.’s Vietnam Veterans of America Achievement Medal, and the National Alliance for the Mentally Ill’s Nancy D. Smith Memoriam Award. In addition, he is the recipient of the Mental Health Association of Erie County’s Professional Service Award, the Erie County Bar Association’s Award of Merit, the New York State Bar Association’s Award for Outstanding Judicial Contribution, and the American Bar Association’s Judicial Division 2010 Franklin N. Flaschner Award. He has been chairman of the board of directors of the National Association of Drug Court Professionals, Inc., located in Alexandria, Va., president of the New York State Association of Drug Treatment Court Professionals, Inc., and he is on the national advisory board of the Judges’ Criminal Justice/Mental Health Leadership Initiative. Russell is a graduate of Howard University School of Law in Washington, D.C.

Michael Schoenbaum, Ph.D.

Michael Schoenbaum is senior adviser for Mental Health Services, Epidemiology, and Economics in the Office of the Director at the National Institute of Mental Health (NIMH). He directs a unit charged with conducting analyses of mental health burden, service use and costs, intervention opportunities, and other policy-related issues, in support of the institute’s decision-making. His responsibilities include helping to strengthen relationships with outside stakeholders, both public and private, to increase the public health impact of institute-supported research. Schoenbaum’s research has focused particularly on the costs and benefits of interventions to improve health and health care, evaluated from the perspectives of patients, providers, payers and society. He is a scientific principal in NIMH’s Army Study to Assess Risk and Resilience in Servicemembers, a study of risk and protective factors for suicidality in the U.S. Army; and he is working on initiatives with the Social Security Administration, the Department of Justice’s Bureau of Justice Statistics, the Centers for Medicare and Medicaid Services, the National Business Group on Health, and WHO’s World Mental Health Survey Initiative, among others. He spent nine years at the RAND Corporation, where his work focused on the feasibility and consequences of care improvement for common mental disorders, particularly depression; the social epidemiology and economic consequences of chronic illness and disability; design and evaluation of decision-support tools to help consumers make health benefits choices; and international health sector development projects. He was a Robert Wood Johnson Scholar in health policy at the University of California, Berkeley.

James (Jay) Shore, M.D., M.P.H.

Jay H. Shore is an associate professor at the University of Colorado Denver’s Department of Psychiatry and the School of Public Health’s Centers for American Indian and Alaska Native Health. He is the psychological health portfolio manager for the U.S. Department of Defense’s Telemedicine and Advanced Technology Research Center,

and he leads the Native Veteran Domain for the U.S. Department of Veterans Affairs' Veterans Rural Health Resource Center Western Region. A former Fulbright fellow, Dr. Shore received his medical and public health degrees from Tulane University School of Medicine and Public Health. After completing residency in general psychiatry at the University of Colorado, he undertook an NIMH sponsored research fellowship examining the reliability and process of telepsychiatry with American Indian veterans. He is participating in multiple telehealth projects, which include ongoing development, implementation, and assessment of telehealth programs in Native American, rural, and military settings aimed at improving both quality and access to care. He has been involved in telehealth consultation for tribal, state, and federal agencies and has authored a number of published manuscripts focused on clinical and research topics in telehealth. Dr. Shore has been a member of the American Telemedicine Association since 2000 and serves on its board of directors, and he is an active member and chair of the Telemental Health Special Interest Group.

Terri Tanielian, M.A.

Terri Tanielian is a senior social research analyst at the RAND Corporation where she also serves as co-director of the Center for Military Health Policy Research. Her areas of interest include the psychological and behavioral impact of combat, terrorism, and disasters as well as access to high quality mental health care. She has worked on several studies on the behavioral health related needs of returning veterans and their families. She co-lead the landmark study "Invisible Wounds of War" and is currently leading or contributing to several other studies examining the effects of deployment on service members, veterans, and their families. Among these are a comprehensive needs assessment of veterans and their families residing in New York State and a longitudinal study of military families across the deployment cycle. She has published numerous peer-reviewed articles in mental health services research and has served on a number of working groups and panels related to the psychological aspects of terrorism, disasters, and public health emergencies, including pandemic influenza.

Liisa Hyvarinen Temple, M.S.

Liisa Hyvarinen Temple is a freelance multimedia journalist based in Tampa, Fla. From June 2009 to August 2010, she took a break from fulltime work to help support her husband, U.S. Air Force SMSgt. Rex Temple, during his yearlong combat duty assignment embedded with the Afghan National Army in Afghanistan. The couple documented Rex's deployment experience in a popular military blog "Afghanistan – My Last Tour" (<http://afghanistanmylasttour.com/>). She will return to teaching at the University of South Florida where she has taught multimedia journalism since 2002. Previously, Hyvarinen Temple worked in print and broadcast both in the U.S. and overseas. Her journalism work has been recognized with an Emmy Award and the Walter Cronkite Award for excellence in political coverage; her joint work with her husband won first place in the Air Force category in the fourth annual MILbloggies Milblog of the Year Awards. She served as a Rosalynn Carter Mental Health Journalism Fellow, 1999-2000.

Barbara Van Dahlen, Ph.D.

Barbara Van Dahlen, president of Give an Hour, is a licensed clinical psychologist practicing in the Washington, D.C., area for 20 years. A specialist in children's issues, she served as an adjunct faculty member at George Washington University. She received her Ph.D. in clinical psychology from the University of Maryland in 1991. Concerned about the mental health implications of the Iraq War, Van Dahlen founded Give an Hour™ in 2005. The organization has created a national network of mental health professionals who are providing free services to U.S. troops, veterans, and their loved ones. Currently, the network has over 5,000 providers, who have collectively given roughly \$3 million worth of services. She frequently participates in panels, conferences, and hearings on issues facing veterans; writes a monthly column for Veterans Advantage; and has contributed to a book on post-traumatic stress and traumatic brain injuries. She has become an expert on the psychological impact of war on troops and families.

Antonette Zeiss, Ph.D.

Antonette Zeiss became the acting deputy chief patient care services officer for mental health at the Central Office of the U.S. Department of Veterans Affairs in May 2010. She completed her Ph.D. in clinical psychology at the University of Oregon in 1977 and worked as a faculty member at Arizona State University and Stanford University, before going to work for VA with the Palo Alto Health Care System in 1982. Currently, one of her major responsibilities is to ensure effective implementation of the “Uniform Mental Health Services Handbook” in VA medical centers and clinics, thus enhancing and transforming VA mental health services. She has published extensively, particularly on mental health policy and training, on interdisciplinary teams and health care service delivery, and on depression treatment and risk factors. She has received numerous awards, including the M. Powell Lawton Distinguished Contribution Award for Applied Gerontology from Division 20 (Adult Development and Aging) of the American Psychological Association. In 2009, she was the first recipient of an award named for her: the Antonette Zeiss Award for an Outstanding Contribution to VA Psychology Training, given by the VA Psychology Training Council; and she received a United States Presidential Rank Award, Meritorious, for her service as a government senior executive.

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