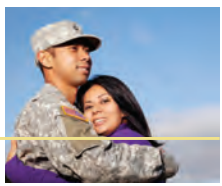
A GEORGIA COLLABORATIVE MEETING • JUNE 17, 2009

HOW DO WE



Pave the Way Home?

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At the time of publication, Pamela Hyde, J.D., served as the SAMHSA Administrator. H. Westley Clark, MD, JD, MPH, served as CSAT Director, Anne M. Herron, MA, served as Director of CSAT's Division of Services Improvement, Catherine D. Nugent, LCPC, served as the Quality Improvement and Branch Chief, and Donna Doolin, LSCSW, served as the CSAT Project Officer.

HOW DO WE

Pave the Way Home?

". . . continue the mission you helped launch."

This report of the Georgia Veteran Initiative Statewide Meeting in Forsyth, Georgia is dedicated to the memory of one of the founding collaborators, Paula Crane, who was the CEO and Executive Director of Clayton Community Service Board.

Paula passed away October 18, 2009, but her vision for serving service members, veterans, and their families remains. Her passing has left a gap in our Steering Committee and in our hearts.

Paula, we will not forget your efforts, and we will continue the mission you helped launch.

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Veteran Support Day

BY THE GOVERNOR OF THE STATE OF GEORGIA

A PROCLAMATION
VETERANS SUPPORT DAY

WHEREAS: There is an increasing number of veterans of the armed forces returning from Operation Enduring Freedom and Operation Iraqi Freedom who are facing behavioral health and addictive disease issues; and

WHEREAS: Up to 30 percent of the veterans from Operation Enduring Freedom and Operation Iraqi Freedom have stated they have experienced some type of mental or cognitive dysfunction; and

WHEREAS: In 2007, an average of 9.3 percent of the veteran population reported experiencing a major depressive episode, and even higher rates were found in veterans ages 21 to 29; and

WHEREAS: Of those veterans that have reported a major depressive episode, a majority of these veterans indicated experiencing complications in their daily living; and

WHEREAS: Research findings indicate that untreated mental illness impairs the functioning of that individual and could influence the quality of their relationships with family, friends and others; and

WHEREAS: Behavioral health resources are available in the state of Georgia, and can be instrumental in improving the lives of veterans and their families. Therefore, Veterans Support Day is an opportunity to raise awareness about the needs of the men and women in Georgia who have valiantly defended our country; now

THEREFORE: I, SONNY PERDUE, Governor of the state of Georgia, do hereby proclaim June 17, 2009, as VETERANS SUPPORT DAY in Georgia.

In witness thereof, I have hereunto set my hand and caused the Seal of the Executive Department to be affixed this 9th day of June in the year of our Lord two thousand nine.

Sonny Perdue
GOVERNOR

ATTEST
Ed F. Holcombe
CHIEF OF STAFF

CHAPTER 1

Introduction

On June 17, 2009, 150 civilian and military service providers, community stakeholders, service members, veterans, and family members gathered in Forsyth, Georgia. They were brought together by their love, gratitude, and concern for:

- The men and women who have left the safety and comfort of their homes to endure extreme hardship, danger, injury, and loss in the war zone
- The service members and veterans who have brought pieces of these wars back in their bodies, minds, and spirits
- The families who have waited, worried, wept, and kept on loving and caring, no matter what

This Georgia Collaborative Meeting was the first step in a year-long process designed to find a definitive answer to the question: *How do we pave the way home?* The meeting was sponsored by the Georgia Department of Behavioral Health and Developmental Disabilities, and organized by the Division of Addictive Diseases, in partnership with the Southeast Addiction Technology Transfer Center.

How Do We Pave the Way Home brought together mental health and addictive disease service providers; members and veterans of the Armed Forces; representatives of the Departments of Veterans Services, Veterans Affairs (VA), Labor, Criminal Justice, and Family and Children Services; and constituents from a wide variety of community-based organizations.

With more than 4,000 Army National Guardsmen due to return soon from Iraq and Afghanistan, the many stakeholders shared a significant concern. An estimated one third of veterans of these wars seeking VA health care are being diagnosed with mental health conditions—most often posttraumatic stress disorder (PTSD) or depression. However, it is also estimated that only half of those who warrant these diagnoses have sought help or been evaluated, and only half of those who have sought help have received adequate care.

The process begun at this meeting has one overarching goal, the creation of a seamless system of care and support for service members, veterans, and their families. To that end, this process is designed to:

> Build a statewide interagency coalition of military and civilian stakeholders dedicated to finding collaborative ways of addressing the challenges facing Georgia's returning and transitioning service members and veterans and their families

> Draft a State Action Plan to support the mental health and addictive disease-related needs of veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF, the war in Afghanistan)

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[1] Seal, K.H., Metzler, T.J., Gima, K.S., Bertenthal, D., Maguen, S. and Marmar, C.R. (2009). Trends and risk factors for mental health diagnoses among Iraq and Afghanistan veterans using Department of Veterans Affairs health care, 2002-2008. Am J Public Health, 2009 Sep;99(9):1651-8. Epub 2009 Jul 16.
[2] Tanielian and Jaycox (2009). Tanielian, T. and Jaycox, L.H., Eds. (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery.* Santa Monica, CA: The Rand Corporation.

The Day's Events

After the morning welcome, participants heard presentations about programs and priorities, facts and figures, but the speakers never strayed far from their stories of the strength, courage, and intelligence of the men and women of the American Armed Forces, and of their families. Their words are presented in full in Chapter Two.

Both the speakers and the group discussions that followed them portrayed many layers of challenges and solutions:

- The experience of war brings with it a great vulnerability to injuries visible and invisible, from burns and lost limbs to the often long-lasting and sometimes fatal effects of combat and operational stress, including posttraumatic stress disorder (PTSD), traumatic brain injury, substance use disorders, and anxiety and depressive disorders.

- The families at home are far too often overwhelmed and underserved—while their loved ones are deployed in harm's way; when they return and struggle to bring their changed lives back together; and when the effects of post-deployment stress threaten their loved ones' lives, marriages, careers, dreams, and sense of purpose.

- While a wealth of resources exists—in service members, veterans, families, support networks, communities, the Military, the Department of Veterans Affairs, the State, and the nation—there are also many barriers to seeking, finding, securing, and using these resources. Not least among these barriers is a deeply held sense of stigma and shame concerning symptoms and disorders that are in fact common and normal reactions to the experience of war.

- The type of collaborative effort initiated at this Meeting provides the best chance possible for planning initiatives that will help service members, veterans, and families overcome these barriers.

After the plenary presentations, participants were divided into Breakout Groups, focused on key areas of need:

- Wounded Warrior Care
- Family Support/Transition Back into Family Life
- Continuum of Care/Service Coordination/Access to Care
- Public and Military Awareness of Mental Health and Addictive Disease Issues/Stigma Reduction
- Workforce Development

Each group was asked to bring to the final session a set of recommendations for overcoming the many barriers and addressing the needs of service members, veterans, and their families.

These recommendations (included in full in Chapter Three) fell into six broad categories, areas in which collaborative action is needed:

1. **Increasing Access to Services,** including measures focused on planning and policy development, collaboration and networking, referral information and procedures, improved service coordination and navigation, planning for pre-deployment support, preparation for delayed onset of symptoms, and planning to address barriers to access

2. **Training and Education for Service Providers,** including dissemination of information about training opportunities, training based on model community service boards, training on the military culture and experience, training and recruitment of new counselors, training of Navigators (outreach and employment counselors), and training of broader community partners

3. **Outreach and Stigma Reduction,** including training in effective outreach, general outreach to military families, outreach directed toward stigma reduction (within the military culture and within the community), and dissemination of information (electronic and non-electronic) about available services

4. **Peer Support and Training,** including peer education and training, peer support programs, peer support for families, peer-based housing, and ongoing recovery support

5. **Expansion and Improvement of Services,** including pre-treatment; treatment; aftercare; and advocacy for individual service members, veterans, and families

6. **Veteran Workforce Development,** including the development of model programs, employer education, outreach to veterans and families, removing barriers to employment, and employment training and education

Acknowledgments

This process was the work of the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). Primary responsibility for its success lies with Frank E. Shelp, MD, MPH, Commissioner; Onaje Salim, LPC, MAC, CCS, Director, Division of Addictive Diseases; and Vonshurii S. Wrighten, M.Div., MAC, CCS, SAP, Adult Program Specialist, Division of Addictive Diseases and facilitator of the Statewide Meeting and the State Action Plan development process. Other significant partners within the Department include Qwynn Galloway, MA, Jail Diversion and Trauma Recovery Project Director Department of Behavioral Health and Developmental Disabilities; and Brenda J. Davis Rowe, PhD, Director of Prevention Services and Programs, Division of Public Health. As a group, we extend our gratitude to all who have contributed to this dynamic process, with special thanks to the Southeast Addiction Technology Transfer Center, Dawn Tyus, MEd, Director, for partnership in planning and executing the June 17th event.

Our deep gratitude goes to Georgia Governor Sonny Perdue for his strong support, given concrete form in the Veterans Support Day Proclamation that he issued in honor of the June 17th event (Page 2). Special thanks also to our two partners who contributed brief Welcome remarks at the beginning of the day: Colonel Tom Carden, Director of Military Personnel, Georgia Army National Guard; and Thomas E. Cook, Jr., Assistant Commissioner, Georgia Department of Veterans Services.

Both the organizing team and the event participants are grateful to the four knowledgeable and dedicated plenary presenters who spoke at the Statewide Collaborative Meeting: Brenda J. Davis Rowe, PhD, Director of Prevention Services and Programs, Division of Public Health, DBHDD; Lee Stuart, Founder and Director, Warrior Family Program; Erika Elvander, Advocacy Program Analyst, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury; and Laurie Ott, Executive Director, Central Savannah River Area (CSRA) Wounded Warrior Care Project, Augusta, Georgia.

We also extend special thanks to the five panel members who managed to encapsulate their impressive work in short summary presentations: Paula Crane, CEO and Executive Director, Clayton Community Service Board; Senita Thorne, Vocational Rehabilitation Counselor, Georgia Department of Labor; Kerry Traviss, LMSW, CAAC, OEF/OIF Project

Manager, Atlanta VA Medical Center; George Langford, Director, Claims Division, Georgia Department of Veterans Services; and Amy Stevens, EdD, LPC, Director of Psychological Health, Georgia National Guard.

Without the work of the five Breakout Groups, the June 17th event would have been little more than an awareness-raising exercise, and without their leadership, those groups would not have been possible. So we wish to acknowledge and thank the many partners who contributed to been possible. So we wish to acknowledge and thank the many partners who contributed to this process, including Facilitators Timothy Johnson, PhD, Gloria Jones, PhD, Taunya Lowe, PhD, Diane Sherman, PhD, and Elaine Tophia, PhD; Reporters Jeanette Aymerich, Beth Upshaw, Ari Gosa, Beth Malone, and Melva Steps, MBA (also a Recorder); Recorders Paula Crane, Qwynn Galloway, MA, Angela Mooss, PhD, CPH, Ayanna Perkins, MA, and Jennifer Zorland, PhD, CPH; and Room Managers David Kanar, Bob Poston, Amy Stevens, EdD, LPC, Lee Stuart, and Rosemary Wachtel, LCSW.

Behind the Statewide Meeting and the larger plan-development process that surrounds it is a truly collaborative multidisciplinary Steering Committee. Our sincere thanks go to all members of that Committee, including Terri Abraham, MS, LPC, NCC, MAC, Licensed Professional Counselors Association of Georgia; Joelyn T. Alfred, MS, NCC, CMOTC, Opioid Treatment Providers of Georgia; Ron Bowen, Cobb, Douglas Community Service Board; Mike Boyce; Brenda Cibulas, DeKalb Community Service Board; R. Denice Colson, MS, LPC, MAC, Eagle's Landing Christian Counseling Center, Inc.; CH (COL) Bradford L. Fipps, Fort McPherson; Susan R. Fort, LCSW, National Association of Social Workers – Georgia; Ari Gosa, Opioid Treatment Providers of Georgia; Richard Hampson, Oxford House; John Harden, Oxford House; Melissa Hinton, Southeast Addiction Technology Transfer Center; David D. Kanar, Georgia Mental Health Consumer Network; George Langford, Georgia Department of Veterans Services; Dr. Janet H. Lenard, Army Substance Abuse Program, Fort Gordon; Taunya A. Lowe, PhD, The Resurgent Group of Metro Atlanta, LLC; Jane Martin, Georgia Administrative Office of Courts; Angela Mooss, PhD, CPH, Georgia State University Pathological Gambling Program; Laurie Ott, Wounded Warrior Care Project; Ayana Perkins, MA, MS, Georgia State University Pathological Gambling Intervention Project; Bob Poston, Good Shepherd; Venessa Stanley, Army Community Service; Melva Steps, MBA, Georgia Administrative Office of Courts; Amy Stevens, EdD, LPC, Georgia National Guard; Lee Stuart, Warrior Family Program; Senita Thorne, Georgia Department of Labor; Kerry Traviss LMSW, CAAC, Atlanta Veterans Affairs Medical Center; Rosemary Wachtel, LCSW, Families

Acknowledgments (Cont'd.)

First; and Jennifer Zorland, PhD, Georgia State University Pathological Gambling Project.

In recounting the names of those who have contributed to the statewide collaborative planning process, it is essential that we end with the most important: The men, women, and children who have inspired, and continue to inspire, all these efforts. To the service members, veterans, and families who have sacrificed so much for their country, their loved ones, and their principles, we extend our deepest gratitude and our highest respect. May your strength and courage infuse these efforts with new life, and may our work together make the road home easier, swifter, safer, and more fulfilling.

Thanks

This Document

This report was written by DBHDD partner and consultant Pamela Woll, MA, CADP, Director of the Chicago-based Human Priorities and a partner and consultant to the Great Lakes Addiction Technology Transfer Center.

In the following pages you will find:

- Transcripts of the Welcome addresses, plenary presentations, and panel discussion delivered at the Statewide Collaborative Meeting ("Plenary Presentations," Chapter Two)
- A discussion of the strengths, challenges, and barriers illuminated in the plenary and breakout sessions, and the recommendations presented by the five Breakout Groups ("Discussion and Recommendations," Chapter Three)
- A list of participants at the event (Appendix A)
- Slide handouts from each of the plenary presentations (Appendix B)

If these materials inspire you to contribute your thoughts, time, or energy to this ongoing process, please contact Von Wrighten at vswrighten@dhr.state.ga.us, or (404) 657-2386.

CHAPTER 2

Plenary Presentations

The first plenary session began with a few words of welcome from Facilitator Vonshurii Wrighten, MDiv, MAC, CCS, SAP, Adult Program Specialist for the Division of Addictive Diseases, Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD). He first introduced three partners who would provide brief Welcome addresses:

Onaje Salim, LPC, MAC, CCS, Director, Division of Addictive Disorders, DBHDD

Colonel Tom Carden, Director of Military Personnel, Georgia Army National Guard

Thomas E. Cook, Jr., Assistant Commissioner, Georgia Department of Veterans Services

The next two plenary speakers brought professional and personal perspectives from opposite ends of the continuum of need:

In "Prevention for Young Adults Ages 18-25 In the Military Service," *Brenda J. Davis Rowe,* PhD, Director of Prevention Services and Programs for the Division of Public Health, DBHDD, brought both her experiences as a child growing up in a military family and her expertise in prevention research, practice, and administration.

In "The Warrior Family Program: Georgia's Veterans Helping Veterans," *Lee Stuart,* Founder and Director of the Warrior Family Program, brought stories from his more than three decades' worth of military service, his experience in designing innovative programs for service members and veterans, and a liberal dose of humor.

In the panel discussion that followed those presentations, the group heard from five prominent representatives of agencies that provide services to returning and transitioning veterans:

Paula Crane, CEO and Executive Director, Clayton Community Service Board

Senita Thorne, Vocational Rehabilitation Counselor, Georgia Department of Labor

Kerry Traviss, LMSW, CAAC, OEF/OIF Project Manager, Atlanta VA Medical Center

George Langford, Director, Claims Division, Georgia Department of Veterans Services

Amy Stevens, EdD, LPC, Director, Psychological Health Program, Georgia National Guard

During lunch, the group heard from two more experts, one national and one local:

Erika Elvander, Advocacy Program Analyst for the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, gave an overview of the impressive array of resources available from the seven Centers in that "Center of Centers."

Laurie Ott, Executive Director of the Central Savannah River Area (CSRA) Wounded Warrior Care Project in Augusta, Georgia, inspired the group with an overview of the many innovative programs and partnerships in place at the Augusta Regional Satellite for Warrior Care.

WELCOME
from the Division of Addictive Diseases

Onaje Salim,
LPC, MAC, CCS
Director
Division of
Addictive Disorders
Georgia Department of
Behavioral Health and
Developmental Disabilities

Good morning, ladies and gentlemen. Thank you so much for being here today and for starting relatively early for this conference. We know in your everyday life this is not an early start, and certainly for our men and women in the Armed Services this is probably a late start, but we're glad to see you. We know that more people are coming to join us, but we're going to get underway.

As I was introduced, I'm the Director of the Office of Addictive Diseases, in the Georgia Department of Human Resources, soon to be the Department of Behavioral Health and Developmental Disabilities. By an Act of the Georgia Legislature, that will be effective in about a month.

I'd like to welcome you on behalf of the Commissioners of both Departments, Commissioner B.J. Walker, Commissioner of the Department of Human Resources, soon to be the Department of Human Services; and also Commissioner Dr. Frank Shelp, Commissioner of the Department of Behavioral Health.

We are fortunate that in this time of transition we can still keep our eye on the ball in terms of what's important. Later today, we actually expect to have a Proclamation from the Chief Executive of the State of Georgia, Governor Sonny Perdue, who also has recognized this proceeding and this occasion.

The impetus for our being here I'm sure is no secret, and by your presence, you all are certainly affirming the importance of responding to the needs of our men and women, brothers and sisters, who serve in the Armed Forces,

who are returning home, and may have been affected by substance abuse and mental health—also called behavioral health—concerns. What we have been hearing nationally is that there has been a great increase in the number of these types of problems—suicide, overdose, family problems, issues of unemployment. One of the things that I hope will come out of today is a clearer picture of what the needs really are.

And so this is not a leisurely conference. We're not going to be taking a break and going to the mall or anything like that. This is a working conference, as a matter of fact. We will provide you with some refreshments, but we'll be staying here and gathering together. We really want your best efforts, your mind, body, and spirit dedicated to sharing with one another, and we're going to be reporting, from our workshop settings, your thoughts on how we can be better partners with all of the different agency entities that are here—from the military, from the Department of Veterans Affairs, from community behavioral health, hopefully even from some folks who have been recipients of our services. It's really not going to be a day of what some people might call "speechifying." We're going to move swiftly from here and try to accomplish a lot before we end the day.

I really appreciate you taking the time away from your schedules. It's difficult to be away from work, especially in a period of economic downturn, but this is probably one of the single most important issues that we face as a nation: How do we take care of those who have sacrificed so we can be free to continue to live the lifestyle that we desire?

Thank you so much, and I look forward to working with you.

"Nothing says more about who we are. . . than the way we treat those who have risked so much for our way of life."

WELCOME
from the Georgia Army National Guard

COL Tom Carden
Director of Military Personnel
Georgia Army National Guard

Good morning everybody, I'm Colonel Tom Carden. I'm the Director of Military Personnel at the Georgia Army National Guard. I'd like to thank you all for allowing us to participate and be here today.

In FY2009, the Georgia Army National Guard deployed over 4,000 Soldiers of 11,500, and for all these Soldiers, it's time for them all to come home. We want them all home in one piece, but the law of averages says that we'll have Soldiers come back who will have visible wounds, and some of them will have wounds that are not visible.

The fact that these Soldiers are going to return to the support of their communities is critical to the security of our state and our nation. Nothing says more about who we are as Georgians or Americans than the way we treat those who have risked so much for our way of life.

So with that I'll tell you that I'm really looking forward to it. I'm going to participate today and think of each and every one of you as a partner, so we can provide better services to our Soldiers and their families.

Thank you.

WELCOME
from the Division of Veteran Services

Thomas E. Cook, Jr.
Assistant Commissioner
Georgia Department of Veterans Services

Thank you and good morning. I'm glad to be here with you this morning. My name's Tom Cook, Assistant Commissioner. I'm representing Commissioner Pete Wheeler. I'm not Commissioner Wheeler by any stretch, but I did stay at a Holiday Inn Express last night.

I applaud what you're doing here today, and so does Commissioner Wheeler. Anything that can benefit our veterans and our friends that are serving and their families deserves our support, and the more we can do for them, the better. God bless you in these efforts, and all that can happen.

Times are tough, with the budget cuts and all at our Department. But of course the Commissioner has been doing a lot of what we're talking about for more years than most of us have been alive. He's been around in the Department since 1949, and been the Commissioner most of that time. So he's about as famous in Georgia as General Oglethorpe and has accomplished just about as much.

In terms of collaboration, it was the Commissioner's idea, back in 1966 in Columbus Georgia, and of course the 1st Cavalry Division had been deployed to Vietnam in late 1965, and all the sudden there were hundreds of casualties, and families and agencies running around with their hair on fire trying to deal with that crisis. Commissioner Wheeler had the idea to have the first supermarket of veterans' benefits. It was held in Columbus, Georgia in 1966, to bring all the different agencies together under one roof, to help these families and Soldiers and veterans in their time of need. And since then, we have had, I think, 43 Veterans Benefit Supermarkets, and this past December, the last one was once again in Columbus.

There are a lot of similarities between what's going on now and what started back then, a lot of parallels, and more than we can do, and working together is certainly of benefit. We had 45 agencies in the Civic Center in Columbus, had 4,600 veterans and Soldiers and family members in there. And we certainly are encouraging more efforts along this line, because the more we can get out of our silos, the better. We all want to do good, we want to do the

right thing and help, and to know what other people are doing and bring to the table, and how we can interact and share and work together. We need to know. And the more we can do and can work together, that's most certainly what we need to be doing.

Going back to, I think it was June of 2007, Commissioner Wheeler signed a Memorandum of Understanding with—forgive me if I leave some of the agencies out—I know the Georgia Department of Defense, the Department of Veterans Affairs, the Department of Labor, and several other departments signed a Memorandum of Understanding, because of the deployment of National Guard forces, to begin to do what you're talking about here today, to work together to bring everything that we can bring to bear to help with these needs.

And since that period of time, Commissioner Wheeler has launched an initiative within the Department of Veterans Services—we have maybe 48 Field Offices throughout the state, and our Claims Division located in the VA Regional Office—that we have a person, a representative there at every pre-deployment briefing, and then after the deployment, when they come back. The Commissioner has pushed that very hard, and for very real reasons, and regrettably, just this past week, we've seen the reality of that. One of our representatives was there in the room when that Unit was getting ready to deploy as part of those pre-deployment briefings. And now three of those Soldiers were killed in a roadside explosion. And we're there to help deal with what has to be dealt with now, with the survivor benefits, and all that's involved.

Good to see folks in uniform are here today, and God bless you. I served 21 years myself, and, I have to say, I served back when it was fun to be in the Army. But anyone who has served since 9/11, things are different. It's a different world, and every day is full of stress and heartache for you guys. We need to do all we can for them.

I could ramble on a long time, but I need to shut up, and just say that what

you're doing is important, in terms of the difference you can make, whether it's the agency that you're with or you as a person.

It reminds me of a story. A man walked along the seashore, and he saw a little boy out there, darting back and forth from the beach to the ocean, and the closer he got, he saw that the boy was picking up starfish who were stranded on the beach. He'd pick 'em up, one by one, then take them down and throw 'em out into the ocean. But there were thousands of starfish that had been washed up on that shore. So the man walked up to the boy, and he said, "You know, there are thousands of starfish on this beach. What you're doing here is not really going to do any good. You can't really make a difference." But the boy just picked up another starfish and looked at the man, and said, "It'll make a difference for this starfish."

We are faced with choices like that every day. We can be overwhelmed by the sheer volume of problems and needs. We can choose to give up and do nothing, or we can take it one problem at a time, one life at a time, one Soldier, one veteran, one family member at a time.

We can make a difference, so let's go make a difference. I thank you.

PREVENTION for Young Adults Ages 18-25 in the Military Service

Brenda J. Davis Rowe, PhD
Director of Prevention Services and Programs
Georgia Department of Behavioral Health
and Developmental Disabilities

This subject is near and dear to my heart, because I am one of those children whose father was deployed several times during my life. I was known as an Army brat. So I wanted to start my welcome this morning with a little bit about me and why I'm so passionate about this subject matter.

I remember when I was eight years old, and my Dad came back after being away for a while on one of his missions that we weren't supposed to know about, and I donned his flight suit. As I look back on it, this was a way for me to connect with him when he came home, to let him know I was thinking about him and I felt very strongly about what he was doing. Even at eight years old, I was very clear about that.

One Christmas at Fort Benning, Georgia, a group of us kids were all climbing onto a horse-drawn wagon, and they were all giving us rides around the airfield as part of a Christmas treat. Then we'd go into a hangar, and they'd have gifts for us. It was one of those affirming things that Army Community Services did to let us know that we were loved and cared for.

My father believed very strongly in taking family portraits, and for years I didn't understand why. But he's now writing his memoirs, and one of the things he said to me was that he wanted to always have a photo of the family with him wherever he went. He also wanted us to have photos of the family, to always remember we were a family, even if he wasn't with us. My little brother was growing up when my father was really being deployed to a lot of places, and he always wanted my brother to have the most current picture of him,

just in case he didn't come back. So that's why we have lots of family portraits.

One example of the kind of support provided troops, during an era that was very controversial—the Vietnam War—this is a picture of a group of Army wives, standing on a stage, wearing the fatigues of their spouses. One is my Mom, and they're giving a show; they're singing a song in tribute to their husbands. This was to let them know they supported them, even though they weren't there.

You're looking at a woman who will be 60 years old this year, who lived through a time when the wars that my father was involved in were not popular—not to say that the current wars are—and I want to talk to you about how people like me made it through.

As an Army Brat, traveling with my Dad, I attended five different elementary schools, two different countries, four different high schools, one each year. How did a young girl who flunked algebra in the ninth grade in one school, in one state, but who aced it the next year in another school in another state, go on in the eleventh grade to do differential equations and get so advanced in math that they had to offer me college courses?

Resilient

How does a young girl living among young GIs (as they were called in my Dad's day) not create a pregnancy or come to use drugs or alcohol? How does a young boy whose father is away for most of his early years not get into drug abuse or wind up in the juvenile justice system?

I will tell you that it has to do with something that we in prevention call "resilience." I have this wonderful definition of resilience from the scientific arena that I want to share with you, and talk about what that really means for us in terms of the social sector. "Resilience" is the quality or state of being flexible, to have bounce, elasticity, malleability, plasticity. It is the property of the material to absorb energy when it is deformed elastically, and then, upon unloading, to have this energy recovered. In other words, it is the maximum energy per unit volume that can be elastically stored.

Now, what does all that mean? Let's talk about it in biomedical terms. An example in biomedical terms is the articular cartilage, the substance lining the ends of bones in the articular joints such as the knees and the hips. What happens is, when that articular cartilage wears away, we feel the stresses and strains as the bones rub against one another.

So what does this scientific jargon have to do with prevention and our returning veterans, and their need for behavioral health services—whether it's prevention or treatment services, whether it's the family that needs support services, or whatever they think they need—and we need to provide for them? It has to do with those things that mitigate against the harmful effects of the stresses and strains of war, and all that accompanies them—those strains being unemployment, fear, doubt, loneliness, anger, separation, worries, feelings of abandonment, the strain of parenting alone, fears of parents not returning or returning maimed.

Layers of cartilage, that's what we would be, between our military and their families and what commonly have been referred to as risk factors. They must be enfolded in layers of cartilage translated into what are commonly referred to as protective factors. Now, some of you in the treatment arena may or may not have heard of some of this from people in the prevention arena, but that's kind of the basis upon which we do our work.

What are the risk factors, and what are the protective factors that can counter those risk factors?

So, for my family, what were those protective factors?

- Well, first of all, parents with high expectations. Wherever we went, my parents expected us to excel, my parents expected us to behave ourselves, my parents expected us never to embarrass my father, never to create a situation in which he was up for an Article 15—and those in the military know what I'm talking about.

- We had a strong, nurturing, present parent. In our case it was my mother; in the current day, it could be a mother or a father.

- My parents, collectively and separately, demonstrated family values, with the operative word being "demonstrated." My mother, my father, all our relatives, and the military community on the Army posts on which we lived, all demonstrated high family values.

- We had community and faith supports.

- We had activities with strong youth-development components, such as the Girl Scouts and the Cub Scouts. I remember one time my father was Cubmaster for my brother in Germany—one of the few times that my father was actually there for a significant length of time—and that was one of the most fulfilling things in his life. We were members of youth groups, we were in choirs, we were on softball and baseball teams, I was in ballet, my brother played football.

All of these things we were involved in, but you can't dismiss the parents' desire for us to succeed. All of the protective factors notwithstanding, some youth have an innate, internal desire that's born in them, an internal need to be well, to succeed. We can't dismiss that.

I'd like now to provide some other information, stats, that I hope will be helpful to you in your small-group discussions. First, the young people who are in the military service are no different than the young people in our general society.

What factors are influencing young adults in general regarding drug abuse? They include:

- student status—whether you're in college or out of college, whether you're doing well or not doing well, whether you're working toward a career or not;

- your marital status—we know that young people who get married earlier are more likely to engage in substance-using behavior;

- living arrangements;

> pregnancy;

> parenthood; and also

> military service.

Now let's talk about our young military service members: young adults in the military. A recent study conducted by DoD—the Department of Defense—in 2005 and published in '08 showed that about half of the service members were 25 years old or younger, and that age group, the 18-to-25-year-olds, accounted for about 53 percent of the active-duty enlisted service members. Now the data is fairly dated and based on 1,373,534 members. This is really important, though, when we talk about how to help them deal with things like depression and substance use, with our prevention and treatment services.

So let's talk about some specific behaviors exhibited by these young people. The data from the DoD study showed that, of the young people in the military, about 25% of them reported binge drinking at least once in the past 30 days, which was significantly higher than the 17.4% rate among civilians in the same age group. So we still have the problem in the 18-to-25-year-old cohort, more than in the

Positive

general population. Part of the problem is that they're coming into the service already engaging in those behaviors, and they're continuing those behaviors. Even though the military has very strict rules and protocols and consequences, the tensions associated with service foster engaging in those behaviors.

Let's talk about tobacco. After accounting for demographic differences, 18-to-25-year-old military personnel have significantly higher smoking rates than civilians in the same age group—40%, as opposed to 35.4% among civilians. And of course we know why, because they're under those stresses and strains that we've talked about. So they smoke and they drink, not only to belong—they're bringing those behaviors in with them—but they're also doing it to medicate their stresses and strains—to feel better, to deal with the loneliness, to deal with the fear, to deal with the conflict they have internally about doing what they are asked to do, and also just to fit in with the expectations of others.

Now let's talk about the good news, and this is very surprising to me, but it makes sense: Illicit drug use among military personnel is relatively rare, just 5% in 2005. Now that does not mean it does not exist, because I have some other data that shows that, yes, we do have crack cocaine use, we do have marijuana use, we do have some other illicit drug use among our military population, but by-and-large it's lower than in the general population. The problem we are seeing is the non-medical use of painkillers, but we're also seeing that in the general population. Once again, they're bringing that behavior, the use of those kinds of medications, into the military system when they join out of high school or college.

So let's talk about alcohol prevention. Dr. Harold Holder talks about the research being done on effective prevention strategies for minors and young adults—policy strategies that affect the price, availability in drinking context, or perceived risk. We've really worked hard on some of these prevention strategies. This is not the forum to talk about what those strategies are, but we can talk about them any time you'd like to have a conversation about the subject.

One of the things my office has been doing for about a year now began after we were at a meeting in which some other states outlined their policies on prevention among the military populations. We came back and began to pull together data about our military population in our state. Many people are surprised to know that we have 14 military installations in our state. I think, if I'm not mistaken, that we have the highest number of any state. We have every service branch

represented in the State of Georgia. Many other states may have a number of Air Force bases or a high number of Marine bases, but Georgia is home to every branch.

Our collection of data started as a "fact sheet" that actually became a "fact book," and it's going to be posted on our website as soon as it's completed. I have a SAMHSA Fellow in my office, paid for by the Substance Abuse and Mental Health Services Administration, who's been working diligently on this. I think that people are always surprised to see how many installations we have, and how well covered we are in the State of Georgia.

We've also collected data on our military veterans in the State of Georgia by age, race, and ethnicity as of September 30, 2007. What we wanted was to try to get a feel for the demographics of this population, because, in order to know what's needed in prevention or treatment, you really have to know who you're talking about. Now I realize the VA and other organizations have similar information, but again, we wanted to pull it together from a variety of sources—from secondary sources, anything we can get our hands on—so that it was specific to Georgia. We wanted to get it in one repository, so it would be a really quick tool or resource for people who wanted to work with this population, so they could get their hands on it and see what the demographics looked like.

Let's talk about military families really quickly, because again, I grew up in a military family, so that is very near and dear to my heart. We do know that deployment causes stress, not only on the deployed Soldier, male or female, but also on the family—the parents, the children, and other relatives. It creates situations where people may increase their use of substances out of depression, out of fear, out of loss, out of abandonment. And with children it's particularly difficult, because children will mask some of their challenges under different behaviors. What we've learned in our research is that in children, and especially young children, you'll see some acting-out behaviors, some bed-wetting, and they won't be able to articulate why they are doing it, but their fears and their loneliness and their missing that parent will manifest itself in very different kinds of behaviors. We also see increases in calls for reported child abuse.

Some of the most highly populated military installations are Fort Benning, Fort Gordon, Fort McPherson, and Fort Stewart. And what I wanted to know was the demographics of the children and youth who were attached to those military populations. What would they look like, and what can we do to assist in those communities through

our prevention efforts?

Of the calls from Military Members to our Georgia Helpline, 29% are from active duty military personnel, with approximately one fourth of those seeking assistance for substance abuse problems, and one third seeking assistance specifically for alcohol problems. (See the Slide Handout for this presentation in Appendix B.) Alcohol seems to be the drug of choice. The two branches of service that most seem to exhibit the alcohol-related problems are the Army and the Marine Corps. Thirty-five percent of callers to the Helpline were African American, 18% of the callers were female, and 37% of callers were from the Macon/Warner Robbins area. Though cities from across the state were represented in the call list, interestingly, there were also calls from other installations in other states, such as Fort Knox, Kentucky. We had some calls from Germany. Most of those calls were from spouses seeking help for child abuse problems and other assistance needs. Fifty-seven percent of our military callers had children, and 37% of military callers reported being unemployed.

So I think we've got some very rich data with which to begin to formulate ideas around the nature of the problem. That's what we do in prevention: We look at the needs, and then we say, "What kind of capacity do we have to address those needs, and strategies are best for addressing those needs?"

So who can help?

> 134 community based prevention providers

> Nine statewide contractors specializing in targeted service delivery and TA:

- MSA-CD at Emory University
- Drug Free Workplace Program
- Underage Drinking Prevention Initiative
- Helpline GA

We've got 134 funded prevention providers out there in communities across the state. We've got Prevention Specialists who work with our funded providers. We also have about nine Statewide Contractors who provide services and technical assistance in a targeted prevention area, such as Maternal Substance Abuse Child Development, who come and talk to you about the harmful effects of substance use during pregnancy. This is an important resource, because we have women in the Service who are drinking, who can create an alcohol-related birth if they're not careful.

We fund a Drug-Free Workplace Program. I know that there's a lot of talk about employment, and we need to understand the relationship between getting our troops back into the workforce and what that's going to look like in terms of working in an environment that's going to be promoted as drug free, and what the Employee Assistance Programs might be in those drug-free workplaces as well.

Two years ago we also established an Underage Drinking Prevention Initiative, focused primarily on those under 18, but we also focus on the 18-21 group, because of the legal drinking age. We just held an Underaged Drinking Prevention Summit in April that was very successful in getting the word out about our focus on underage drinking. I think our young military population—especially those 18, 19, 20, and 21-year-olds—need to be enfolded in what we're doing in our Underage Drinking Prevention Initiative.

Finally, in the "fact book" to be posted on our website, we've included several other resources. Many of them are also listed in other places, but we wanted to pull together as many of them as possible for our troops stationed in Georgia and our families in Georgia. Some key prevention resources include the Prevention Pathways at SAMHSA, the NREPP (National Registry of Evidence-based Programs and Practices) web site that identifies evidence-based programs, and the Prevention Platform. I'm actually Director of Substance Abuse and Violence Prevention and Behavior Development within the Division of Public Health, but we will be redirected to the Department of Behavioral Health and Developmental Disabilities effective July 1.

In closing, I would just like to say this is an area of personal interest to me because of my background, and of professional interest to me because I'm always interested in working with groups and individuals, forming collaborations and partnerships that address health problems and their consequences.

I'd like to end with a quote from a gentleman by the name of John Gardner, and I think it's very compelling for what we're doing here. "We are constantly faced with new opportunities brilliantly disguised as insoluble problems."

I think the problems that we're talking about—the high rate of suicide, depression, stigma, the fact that many of our service members do not report or underreport what's going on with them because of their fears of stigma and the image of being tough guys—are not insoluble. They give us a great opportunity, and I look forward to working with all of you. Thank you very much.

"We are constantly faced with new opportunities brilliantly disguised as insoluble problems."

John Gardner

THE WARRIOR FAMILY PROGRAM: Georgia's Veterans Helping Veterans

Lee Stuart
Founder and Director
Warrior Family Program

Let me introduce myself real quick. My name is Lee Stuart. Somebody came up to me this morning and said, "You know, you look like Richard Gere." I'll do the autographs and photos later, at the end.

I'm a native Georgian. I was raised in Morrow, and I graduated from Jonesboro High School. They only passed me to keep me from coming back the next year. I went to Georgia State College, where I majored in socialization and fraternization and accumulated a 1.33 GPA. Before long the Service said, "Come here, do this." They sent me off to Vietnam. I was over there, got shot up a couple times, got bombed, got put up for a couple awards and all that stuff, grew my hair long, became a hippie when I got out, and found out I didn't belong out. I had a run-in with the law, went back in, I got my commission, and I stayed in. I did 32 years, six months and 20 days.

I come from a long family history of serving in the military. My kids are in. My daughter was the lead pilot going into the Haiti Operation. My son is a Special Forces officer right now. He's on his fourth tour in Afghanistan.

When I retired, the Army turned around and asked me to go to Iraq in 2003. They needed somebody to be in charge of rebuilding Northern Iraq infrastructure. I went over there and I started working with the Generals there, and I worked with the soldiers, and I worked this last time with General David Petraeus's team.

And in dealing with all of the soldiers at work I found that, when I was walking around, everybody was saying, "Who's that long-haired, gray-haired contractor?" I was working with senior officers

and NCOs, people who've never been through this before. And last year—March, April, and May—we averaged a thousand rounds a month in the Green Zone. I hadn't seen that many rounds since Vietnam. Eighty percent of the headquarters were Guard and Reserve people. They're bankers and staff when they come in, and they've never been through this before.

And normally everybody knows I'm in the gym every day from 1:30 to 3:30. The one day I didn't go—I just felt tired—we took a direct hit on the gym, and it wounded 17 people and killed three. The good Lord takes care of little Indian boys, because there's not many of us left. While I was there, this is when I decided I've got to do something. I'm getting tired, I've got to go back to the States. And I sat down and I started thinking about what I could do when I got back, because my PTSD is I'm scared of civilians. We speak a different language. I turn around and go, "That's not what I said!" But that's the way they interpret it. And when you go over there and come back here, then the shoe doesn't fit. So I said, "I'm going to start a program." So I've done this working with some of the other agencies and with the Active Duty, the Guard and Reserves, and everybody.

We call it the "Warrior Family Program," because there's a lot being done for warriors, but the families are the ones falling through the cracks.

I'm an old Ranger, and we have a motto: We will never leave a fallen comrade. But we are leaving fallen comrades all through. If we don't take care of the family members, it's the same as treating a person for alcoholism, and sending him home when the family's still drinking. If we don't do something for the families, and we send the guys home, they're not going to know how to deal with it.

Joseph Patrick Dwyer died June 28th, 2008.

This is a famous photo of him, considered a portrait of the heart behind the U.S. Military. But he was consumed by the demons of combat stress after he returned, and he took his own life. Georgia's own Master Sergeant Russell C. Bledsoe, a 19-year Army veteran who won the Secretary of the Army Reserve Component Career Counselor of the Year award in 2005, took his own life 11 months after he returned from Iraq. After I came back, my roommate was a young Colonel I was giving a place to stay for a while, a young man who worked in the office, and he had PTSD. Outstanding guy. He took his life. Georgia's own Third Infantry, this year they've lost three to suicide. They've been having one a month take their lives.

Georgia's own: A cry for help.

My phone rings on a Monday morning, and a lady says "I understand you've got a PTSD program." I said, "Well, yeah, it's not up and running yet, but we're getting there." And she started crying, breaking up, and said, "Well, do you have some time?" And I said, "Yeah, I've got all the time in the world." We talked about 45 minutes, and what it comes down to, her brother served in Beirut, in the 1983 bombing. He was one of the Marines that survived that bombing, and he had to load 200-plus body bags. Her dad was the one who had told him, "You join the military. It's good for you."

Now, every time this guy starts drinking, those demons come out. And they haunt him. And he ended up having family problems. And she said, "It's getting worse. It's just keeps getting worse and worse." And on the 26th of April, it was a Sunday, he was fixing to go over there and kill her father on that Sunday. He had a gun, and he was fixing to go kill him. And the family interceded, and they asked me,

"How can we get help?" We have a Chaplain who works with the military and does counseling, and we're in the middle of working with this guy. Beirut was 26 years ago, and those demons still came out.

Basically the facts:

Thirty percent of the people who go over there will have PTSD. I'm not talking about just OIF and OEF. You've got guys like me, old retired guys, Agent Orange, burned out, retired, walking around here, and I could go off. I would not talk to you about it. I had a guy come up to me and ask me, "Lee, why don't you put in a story about one of your purple hearts, and tell them your story?" and I said, "It's none of your business. I do not talk about it."

We can argue about how you want to count military installations, but we have anywhere from 11 to 15. But basically, there's 1.4 million people here in Georgia—Active Duty, Guard, Reserve, retired, family members, contractors, others—who draw a paycheck from the DoD. But veterans and their family members, trying to reintegrate them back into society, one day they're coming to you, whether it's 32 years later, or it's four years later, three years. Or if they go over for six months, they're going to come back to you. And if they come back, there's going to be someone who has those problems.

And here's the key. You can get treatment for the service member, and they'll send him off. 'Cause the money silos go to Active Duty, the Reserve's got their money, Guard's got their money, VA's got their money—and never shall the twain be mixed together. But try and take a dependent with you. It's very hard to get orders to send family members anywhere. So you're leaving part of it out. They're the ones who end up having to deal with it when it's all over.

The Warrior Family Program was started by the leadership of several organizations working with veterans: The Army Aviation Heritage Foundation, the Native American Indian Management Organization, Hearts Toward Home International, and Historic Banning Mills.

Our program is a mix of everything. It could be on a weekend; it could be on a weekday. Basically, what we do, we have counseling services for them, we have retired Chaplains who are working with us, Active Duty Chaplains, we've got Dr. Bridget Cantrell doing her therapy. I do the actual hands-on filling out the applications. We could sit here all day and talk about trust and respect and

communication skills. But depending on what their abilities are, they may need help just physically filling out the forms.

Let me tell you about this UH-1 Huey helicopter, like they used in Vietnam. There were some kids who were missing their limbs. Those guys stopped by to see us, and they wanted to ride in a UH-1. And we said, "Why would you want to ride in an old tank of a helicopter?" But we know that link: Veterans can talk to veterans. There was one young man who lost his leg all the way up to the hip. He said, "I want to get in there, and I want to be a Door Gunner, and to watch him crawl in that aircraft and wince in pain…but he wanted in there, and we just let him in there, we put him in there. And he came back, and we sat around and talked with him there, because we've all been there, and that made a difference.

And here's one that blows my mind. I'd always heard about this guy, Samuel Tso, in World War II, one of the original code talkers, and I found out he was going to be there. And I couldn't get him talking much. So I said, "Let me get you a ride on a UH-1 helicopter." (They never had UH-1s in World War II.) We put him on that helicopter, and he came off and had a big old grin on his face. Thirty days later, I got an email from his daughter, who said, "Lee, thank you so much for giving Dad that ride on that UH-1." She said, "He's hardly ever talked about what happened in World War II, but that there—you reaching out, a Vietnam veteran—has really helped him open up, and has helped our family a lot."

That UH-1 is powerful. We're going to give everybody a ride who comes to our program.

When guys come in, we'll do all the counseling and talking, then I'll take them out and do some of those activities with them. We'll basically bring 'em in, check them in that night, we'll have ceremonies for a day and a half, and then on Saturday afternoon they'll get a UH-1 helicopter ride. And my cousins are coming down—we already have permission—and they have a drum all ready. We have a drum, his name is Thunder—all Indian drums have names—and we'll use it in our PTSD ceremonies.

Anybody ever been to a Native American Pow-Wow? When you go to a Pow-Wow, the first thing is a welcoming song and dance. The second thing, wherever you go, they ask for all veterans—if you've ever served—to come forward. It's been a tradition in the Native Americans to honor your warriors that have been before you. And I've got the Native American Nations to approve awarding

the Warrior's Medal of Valor. Now Native Americans can give it to non-Native Americans, but it must come through a Native American. And we've got all the medals sitting there, and we can give them out. But we know, too, that things change, because we have vets that are females as well. And we also have the medal of courage for the spouse. So it could be either/or. And they can come with their families, and they'll be taken around, with the Medicine Dance and given the traditional welcome-home celebration that we give to Native American warriors.

When I started the program over in Iraq, I was called by the White House to explain about my Character Education program. I taught it to Iraqis, so they could integrate it into their physical education curriculum. And I went up north and did it for the Kurds, came back down, and the Minister of Youth Sports said they were going to incorporate it into their youth programs. It works; you've just got to be patient.

Our first program had 15 warriors, and it has now moved to 27-to-30 warriors. They've got their families with them, and we invite people to come out there if they want. And the funding for this thing, we

Powerful

believe the American public will reach in their pockets and make donations, and we will raise funds so the wife and kids and whoever can come and participate in the program. And it seems to be working.

Our major supporters include Mr. Johnny Yates—he's one of my heroes. He's 87 years old, he's one of the last World War II veterans left around, and he was the one who made this thing possible. He got the House to pass a resolution supporting our program, and he got the Georgia Director of Veterans Affairs to support our program, and Mr. Tom Cook is here on his behalf. And of course we've got Governor Sonny Perdue to sign onto our program, and he thinks it's a very good program.

We need your help to get the word out, to get the donations for our Wounded Warrior program, because the clock is ticking, and I'm not turning those kids down. When they need help, we're going to take care of them. These are the finest soldiers that have ever served in the military. I don't want to see them treated like I was after Vietnam. When I went back to Georgia State in my uniform as an E5, I got a paper shoved in my face, a guy was calling me a baby-killer. We're not going to have that. My son and daughter, your sons and daughters, they deserve to be brought home the correct way. It's the least we can do.

Thank you very much.

"... I'm not turning those kids down."

Panel Discussions

Paula Crane
CEO and Executive Director
Clayton Community Service Board

Georgia has 26 Community Service Boards (CSB), some serving single counties and some serving multiple counties. The CSBs coordinate services for mental health, addictive disorders, and developmental disabilities, largely through a contract with the Division of Addictive Diseases, though the Boards do bill Medicaid and private insurance carriers.

I attended the recent "Wounds of War" conference at Columbia University, and I agree with the information presented by Dr. Rowe. We are seeing more service members and veterans addicted to painkillers and other prescription medications, and excessive drinking is still part of the military culture

Many of the challenges we are seeing come from the fact that service members are undergoing longer deployments, multiple deployments, and experiences more severe in nature than those seen in the past several years. When we look at the rates of addiction and trauma, so much can be attributed to the fact that people are trained to subdue their feelings, and as they encounter problems, simply not talk about it— just "man up."

We have so much depending on these young people. We have kids facing astronomical problems in the theater of war, and they're returning home. We must engage families in our efforts to improve health and reintegration. At the Community Service Boards, we provide treatment for addiction, individual and group counseling. Many Centers have people trained in trauma who can provide direct treatment for PTSD, and we work with children and families.

We can provide non-threatening environments for service members and veterans to receive help. Many military people hesitate to seek help from military service providers, worried about the possible

consequences for their careers. The Community Service Boards contract with the Veterans Administration, and people are in the process of working on these arrangements to get these contracts to come alive, so we can help the people who need our help. We are prepared to take referrals and ready to provide services.

We have some questions that I'd like to put out there to address here today:

How can we collaborate with the military to help heal our returning soldiers? How can we get the word out that there is help in our communities? The Community Service Boards are the quietest, best-kept secrets. What can we do, and how can we help? We operate on a sliding-fee scale, so if a veteran is out of work, that doesn't preclude our getting help to that veteran. And how can our staff get better trained so that they will be better equipped to serve the unique problems of returning and transitioning veterans?

Senita Thorne

Vocational Rehabilitation Counselor
Georgia Department of Labor

As a Rehabilitation Counselor with the Georgia Department of Labor's Vocational Rehabilitation program, I serve newly returning veterans in a 14-county area. I was hired 18 months ago by our Regional Director, who knew we were going to have a large number of veterans returning who need our help. How do we complement what other organizations can do? How do we assist the Veterans Administration and serve people with disabilities?

I'm also the wife of a veteran. As of March, he has served in the military for 28 years, and he is an Operation Enduring Freedom veteran. This is a unique population, with unique needs. Addressing those needs is more than the Department of Defense and the Veterans Administration can do. How do we as a community and as a state agency help?

Vocational rehabilitation is not new to veterans. It started in the 1920s, when the purpose was to get World War I veterans back to work. Having a vocational rehabilitation agency that gets people back to work is our number-one focus and goal. For veterabs, having a service-related disability that affects employment makes it very difficult to reintegrate back into civilian life.

Vocational rehabilitation is not an entitlement, but an opportunity program. It works with the client and leads toward employment. We have employment specialists who find out what clients need and make sure they receive the training they need to qualify for work. We work on resume development and job interviewing skills—how do people sell themselves to employers?

As a Counselor I serve 14 counties, but we have more than 50 offices ready to help. In Augusta we reach out into Fort Gordon and the Warrior in Transition battalion. There is a very strong traumatic brain injury component in Eisenhower Hospital. Some of the men and women we serve come from Georgia, and some are going back

to other states. So we have to think about how we can best link them with state-level Vocational Rehabilitation, to complement Veterans Administration Vocational Rehabilitation. Basically, how do we get them well and ready for work?

For Reservists and Guard members, who combine military service with civilian careers, these questions can get complicated. For example, if you were a carpenter before deployment but now you have a herniated disc, you can't go back to being a carpenter. That's where Vocational Rehabilitation comes in. We can identify these kinds of challenges before they lead to so many other problems. Work is so important to people, and such a big part of basic resiliency. We plan and take an active role in getting the veteran population back to work.

"... how do we get them well and ready for work?"

Kerry Traviss LMSW, CAAC

OEF/OIF Program Manager
Atlanta Veterans Affairs Medical Center

The Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) program began to develop in 2005, and now it operates in every VA across the country. Part of the program includes staff whose primary role is advocacy and outreach. A large part of the outreach efforts take place when military units are demobilizing and when they conduct post-deployment health reassessments (PDHRAs). The primary purpose is to let service members and veterans know about the benefits and entitlements that are available to them at the VA.

The OEF/OIF program consists of a program manager and case managers. These are social workers and nurses who provide case management services to this veteran population. A primary goal of the program is to ensure a seamless transition from their military service to VA healthcare. Part of the intake process for these veterans is to complete a physical and mental health evaluation and assign them to a primary care physician. Another important part of case management is assisting the veterans with filing claims for disability with the VA.

Some of the presenting problems the OEF/OIF staff have encountered with this population are: mental health issues (depression, PTSD—mild, moderate, and severe); traumatic brain injuries; psychosocial stressors (financial problems, unemployment, unpaid mortgages, bills, and re-establishing a viable career); relationship/marital issues; and drug and alcohol problems.

We need to make sure we assist the veteran in every way, by linking them not only to VA resources, but to resources that are available in the community as well. Participating in today's Meeting was a good way to begin linking resources.

George Langford
Director of Claims
Georgia Department of Veterans Services

I'm Director of Claims for the Veterans Service office, and we are advocates—sometimes advocates with an attitude. We'd like to enlist you as full-time advocates for service members, veterans, and family members. The VSO does the Lord's work.

I didn't know what to think when they asked me to come here, all these substance abuse, alcohol, mental health folks, federal employees, state employees, military personnel. At first I thought it was going to be like herding cats. It's a very eclectic group, all kinds of backgrounds, but it hasn't been difficult.

The VSO includes people with backgrounds in a variety of organizations—Chaplains, state employees, federal employees. We're trying to marshal our resources, to help military veterans by providing a panorama of the services that are available. Together we can collectively represent the fact that the State of Georgia cares about our veterans and their families, and we know what the resources are and how we can help.

We have people with the education to help survivors and their dependents. We are an authorized representative by power of attorney with the VA. If the veteran needs direction to a VA Medical Center or another service, we can get the veteran started by making a claim. If you live in Macon, you can see people in our Macon office. As our commissioner always says, "You have to make a claim. The VA doesn't know what you want unless you tell them."

With so many deployments and pre-deployment processing, a lot of our guys work on weekends. We have 49 Field Service Offices; each county is represented by a local office. If you're a clinician and we have a veteran who needs your services, people send that veteran to you. We also need to get to know them on a first-name basis: "This is Larry. I'm sending Joe to see you." We talk to these professionals on a one-to-one basis.

We can also refer to community-based outpatient clinics, medical centers, Vet Centers, all fairly important parts of the service system. I've thought about how we can help build resources and increase the awareness of problems and solutions: It's all about information and how to get to it. We have a fact sheet on benefits for veterans in the state of Georgia. Veterans who were 100% connected to the service get lots of stuff, but those with partial connection also get stuff.

We have State cemeteries for veterans, two of them, and everything's free but the casket. That's something you will have to do sometimes, and you can use the Department of Veterans Services office to do that. We have three nursing homes for wartime veterans, and we're the only state that does. This is a very expensive service, and our commissioner has to fight for that every year. We provide a list of websites, VA medical centers, and clinics. The VA has a handbook of benefits, with an index that you can use to find out anything you want to know.

Our Department will assist you in any way possible—with medical care, pension issues, etc. We use our employees as a starting point, but we can work with all partners throughout this process.

Amy Stevens, EdD, LPC

Director of Psychological Health
Georgia National Guard

I am the Director of Psychological Health for the Army and Air National Guard of Georgia. I'm also a Navy veteran. I served 11 years active duty—overseas but never in harm's way—but I know a lot of people who have been there, and a lot more who are over there now. There are almost 100,000 veterans and active-duty service members in this state alone. There are 11,000 Army National Guardsmen in this state. These are the people who live next door to you.

We are looking at the kinds of resources provided for the psychological health of our troops and our veterans. After previous wars, you were lucky if you got a handshake, and some got protest lines when they returned home. Things have gotten a little better since Vietnam, but we still have work to do. In 2007 the Department of Defense conducted a study of mental health in the military, and found lots of gaps and services. If we were where we wanted to be, we wouldn't have veterans living under bridges, or beating on their wives or husbands, or their children crying in the dark.

There's a lot of energy around this topic, and a lot of programs funded by Congress. My title is a direct result of the 2007 DoD study. Legislation has mandated that there be a Director of Psychological Health, both on a national level and in every major State installation. This is contracted through deserted Ceridian, the HMO.

My major mission is to find out where the gaps in services are— to name the elephant in the living room.

You'd be amazed at how many different resources there are, and how many of us don't know about the other ones.

I was fortunate to meet Gloria Jones, and she said, "You ought to talk to Von," and so we made that connection, and I was able to come here.

As we also provide clinical services for the Army and Air Force National Guard. We spent this past weekend as grief counselors, after the death of three of our Soldiers in Afghanistan. Every time we have these losses, great needs arise. And as I went to the viewings and met the family members whose loved ones had been killed in action—a horrible tragedy—I thought about the importance of service in the lives of these Soldiers, these families.

If you want to help service members and veterans and their families, you really need to understand the warrior culture.

It's important to have warriors at these events, very important to honor the service of the fallen service member, but also the service of the family. I've met lots of people who were members of the FRGs, the Family Readiness Groups. At first they were surprised when I said, "I'm not just here for the soldiers you've lost. I'm here for you spouses. I have family members are still in Iraq." Unless you're part of a military family yourself, there are many important things you can't understand. But as soon as I say I'm a veteran, and I have buddies who are still over there, we make that connection.

There are a lot of people who are not being served, and a lot of different eligibility criteria determining who can get served. But some simply do not get served. Some of you are out there doing the best you can to serve these men and women and families, but we don't know about you, and you don't know about us. If you have anyone you're serving who's a National Guard member, and you're not sure what services he or she is eligible for, please contact me. I'd like to know about your program, and how I can be a resource for you.

Some states have a unique collaboration among the different resources. Some states have one mental health person for every National Guard Unit. You'd be surprised at how many mental health specialists there are in military service, but there's still a great shortage. If you're a social worker or psychologist, I have a job for you. In the National Guard in Georgia right now, there's one social worker for every 11,000 Guardsmen. There's one more in the pipeline, and I hope he makes it through. All the military services are suffering a shortage of mental health specialists.

So we need your help. Together we can make this better for all Georgians.

"Together we can make this better for all Georgians."

QUESTIONS
for Panel Members

QUESTION: Why does it take as much as three to five years to process a disability claim?

RESPONSE: *In many cases there is a failure on the part of the veteran to provide the information necessary to make a successful claim. The VA is getting more claims all the time, and turning out more work all the time. And there's more work coming in than the VA can deal with. But generally it's all about collecting medical records. You have to show that the disability was incurred or worsened in the service—provide that "nexus statement" linking the disability with military service—and if it's a chronic disability, you have to provide evidence of that.*

Often the veteran doesn't provide this information, and sometimes the VA doesn't do its part in resolving these questions. There's too much work, so much hardship, and the system is really up against it. These are times of financial hardship, and there's a long line of folks asking to be put ahead in line.

It's like a puzzle, and we have to find out what pieces are missing. Ninety-nine times out of a hundred, there's a missing piece, but no one has said what is missing. Most often it's a medical opinion, the nexus between the current diagnosis and the acute injury. At the time of the acute injury, there was no diagnosed disability, so you need a doctor who will say that it's likely that the present disability was related to that injury in the service, and then you can get a service-connected disability determination. You need to see the professional folks, at the VA or other people. If the veteran tries to do it himself or herself, there's less of a chance of success. If you're on trial, you're not going to represent yourself. And there are a lot of good people in the VA, but you really need someone to help you with your case.

QUESTION: I'm part of a Community Service Board, and I've gone to our local Guard Unit many times and made contacts, and we finally did have a meeting with the psychiatrist there. And I told them, "We're here for you. We'll come over on Saturdays if you need us to." But I don't think they get it. If they do need help, they're not reaching out to us. A representative from the local VA was going to talk to them, but I don't know if that's happened.

RESPONSE: *Perhaps you have some misinformation. On the weekends, the National Guard has work to do. It may be a question of timing. You need to find a way to coordinate the services that you have available with what is appropriate to the needs of your local Guard Unit. You can also let them know that the Community Service Board is there for families. For a lot of Guard members, this might not be the only job they do. If you're a two-day-a-month Guard member with no health insurance, you don't qualify for a lot of other veterans services. Also, a veteran is not always a veteran. A lot depends on how many days they've served in active duty. They can't always get on TRICARE. A lot has to do with sharing information on the procedures, organizational structure, and rules. These aren't secrets, but you have to talk to the right person.*

COMMENT: I'm a volunteer for Give an Hour, an organization that provides free mental health services to military personnel and families affected by OEF and OEF, and I've been trying to give away my services, with no luck. And it frustrates me to read everything about the fact that there aren't enough counselors—and I know there are not enough—but there are a lot who want to help. I've called the recruiters four times, knocked on their doors, and advertised in the paper to do a group, but nothing has come of it.

COMMENT: There's a lot of grant money. The Community Service Boards have megabucks to pay for PTSD treatment, but they're not getting referrals.

COMMENT: My pet peeve is that the therapists I know only want self-pay clients. They're not registered under TRICARE or Military OneSource. Those are the resources available, and that's how we refer Soldiers. They have to be credentialed and such, and they get approved for these kinds of reimbursement. And military wives and kids often have no insurance either.

COMMENT: I was raised in a Navy family, and I live near Fort Steward. I have two daughters who have dated Navy men, and I can tell you, the stigma is still here. There's still a lot of shame in admitting that they need help, and some of these young men are gravely wounded, and they've seen a lot of death.

RESPONSE: *I'm part of a program that's involved in reducing stigma. There are lot of resources that are available, that have been put in place throughout the military culture. We are definitely working on it, and things have gotten better, although we still have much more to do.*

QUESTION: I'm a psychologist in a TBI clinic, working with soldiers who are about to leave the military because of PTSD and TBI. When Lee Stuart mentioned his fear of civilians—and they talk about wondering why veterans are not coming to civilian service systems—part of the issue is a deep distrust of civilians. You have to determine how much training and information you have about PTSD and TBI, but also how much you know about the military culture and implications for clinical services. How are we going to get training out to providers? Don't be offering services unless you have a lot of training in all these things.

RESPONSE: *That's precisely why we're here today. I've been in the addictions field for 20 years, and I know what my limitations are. Our objective is to have regional trainings throughout the state. We plan to have trainings near each military installation. This is very much a cultural problem, and an issue of cultural linguistics. Military and civilian partners each need to expand the other's language. We'd like to implement a cross-cultural training borrowed from the SVORI model developed by the ATTC (Addiction Technology Transfer Center) Network, a cross-cultural model developed for criminal justice and addiction providers. It's a matter of both cultural linguistics and the ability to be empathic with those whose experience is different from yours. If you know you don't have adequate knowledge in this area, just know that we're working to make that knowledge available for you. We don't expect you to do that alone. We are hoping someone on the military side will say, "We want to help you train these providers." Were working toward true collaboration, cooperation, and communication.*

QUESTION: I work with criminal justice and the veteran population, and the crime rate is growing daily. I'm in jail diversion within the State of Georgia, and we're seeing a lot of people with TBI, PTSD, and substance abuse, and I can tell you that a lot of law enforcement and criminal justice personnel don't know how to deal with veterans. And training the Community Service Boards is one of my jobs, to help build the State infrastructure for trauma-informed care. If you have an interest and can advocate for veterans, we could use your help. The State Board is here to represent veterans, and we have consumers—veterans—who need advocates. And there are the CITs, the Crisis Intervention Teams. We're trying to get a module for these teams that only deals with veterans. Suicide-by-cop is a big issue with veterans. They'll have a weapon, and they'll want to take their own lives, but they'd rather have a cop kill them. I'm a veteran myself, and a strong advocate, but we see that they're entering the criminal justice system at high rates. One woman approached us, the mother of a highly decorated veteran who is incarcerated. The criminal justice system has no idea what trauma-informed care entails. A lot of these folks returning from OIF and OEF still have that battlemind. It's law enforcement's job to serve and protect, but first our job is to educate and train them, so they understand how to work with veterans.

COMMENT: I'm trying to understand what constitutes realistic time-frames and eligibility criteria for receiving services. We're seeing an influx of veterans coming in for the first time. These veterans are trying to readjust as they're coming back to civilian life—trying to be a father, brother, husband—and deal with all the other risk factors they're experiencing. One thing that keeps coming up is the need to be realistic and up-front about their eligibility and the time-frames for receiving services, not misleading them about wait times and what will qualify them for the services they need. When I talk to vets who call the Suicide Prevention Hotline, they're frustrated in trying to understand these time-frame and eligibility issues. Sometimes it requires that I step back from saying I'm the all-knowing expert, and listening becomes way more important, not assuming that I understand exactly what they're saying. We also work with Kerry Traviss and her program to help veterans understand what other services are out there. There are Recovery Coordinators in a lot of VA medical centers, but we need to know what organizations are out there that can support these veterans.

DEFENSE CENTERS OF EXCELLENCE (DCOE) for Psychological Health and Traumatic Brain Injury: An Overview

Erika Elvander
Advocacy Program Analyst
Clearinghouse, Outreach, and Advocacy Directorate
Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

My name is Erika Elvander. I've been working in Public Health more than 20 years and have been with the Federal Government for nearly 12 years. The Federal government tends to work with the messy public policy stuff, while you're doing the real work here. I work for the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. I've been there six months.

The vision of the Defense Centers of Excellence is to "lead the nation in resilience, recovery, and reintegration for warriors and their families in all areas related to public health and traumatic brain injury." In terms of our mission, the DCoE "assesses, validates, oversees, identifies, and facilitates prevention, resilience, screening, treatment, outreach, rehabilitation, and reintegration programs for PTSD and TBI, to ensure the Department of Defense meets the needs of the nation's warriors, families, and military communities."

Notice the focus on resilience. Warriors and their families are resilient. We target all members of the Service, including the National Guard, Reserve, families, and veterans. The Department of Defense has many, many resources that are available, but sometimes it's hard to navigate that system and coordinate the provision of resources where they're needed.

To put the development of the Defense Centers of Excellence in the overall context of historical events, in 2005 and 2006, reports of high levels of PTSD and TBI started coming in. In 2007, the Washington Post ran its series of reports on Walter Reed. Shortly before those reports broke, the Dole-Shalala Commission had recommended the establishment of a Center of Excellence for Psychological Health and Traumatic Brain Injury. A bit later in 2007 came the establishment of a Senior Oversight Committee and the development of eight task forces. From these eight task forces came the decision to establish the Defense Centers of Excellence on Psychological Health and Traumatic Brain Injury (DCoE). And near the end of 2007, DCoE opened its doors. DCoE is under the DoD but has its Deputy Director from the Department of Veteran's Affairs, demonstrating our commitment to bringing DoD and VA cultures together. These are two cultures that don't always play well together, though they want to. DCoE's focus is on Psychological Health—especially PTSD, depression, anxiety, substance use disorders, family violence—and TBI, and comorbidities for both. Brigadier General Loree Sutton is the highest-ranking psychiatrist in the Department of Defense, and she is at the head of the Defense Centers of Excellence.

We are a "Center of Centers." There were some structures existing that worked on these issues, so they brought four of them in under the Defense Centers of Excellence, and added to them. We are also a collaborating Center, working among these Centers and with a variety of agencies and organizations that are doing this work, with no desire to reinvent the wheel. For example, we had a joint conference that focused on the trauma spectrum, health disparities, and gender issues. We also partnered with the Department of Labor and the Department of Health and Human Services.

There are six Centers:

1. **The Defense and Veterans Brain Injury Center (DVBIC)** is a clinical Center that provides state-of-the-art care for service members and veterans with TBI at 16 sites.

2. **The Center for Deployment Psychology** is there to train military and civilian psychologists and other mental health folks to provide high-quality services to service members and veterans.

3. **The National Center for Telehealth and Technology** provides virtual reality therapy and virtual training, and includes afterdeployment.org, along with telehealth assistance to clinicians who need help knowing how to serve particular clients.

4 **The Center for Deployment Psychology** provides training and research, and has begun outreach to the primary care community.

5 **The Center for the Study of Traumatic Stress** provides research, consultation, education, and training on PTSD and TBI.

6 And the **National Intrepid Center of Excellence** will be a clinical Center that will partner with the DVBIC. We have a Director, and we hope to open that Center in the Spring of 2010.

Some of our recent successes:

> We're very proud of our websites and our 24/7 Call Center.

> The DCoE partnered with Washington DC's local public television station to develop "Brain Line," a series of programs and a website designed to help in TBI prevention, treatment, management, and recovery.

> We worked with the Department of Labor to establish "America's Heroes at Work," which is a website targeted to employers, to reduce employers' stigma and fear about hiring returning veterans. As we know, employers are sometimes reluctant to hire returning veterans, and, rather than finding out what to do for veterans, they often simply don't hire them. This program tries to break down these barriers to employment.

> We produced a Sesame Street DVD for kids, so they can understand deployment. The DVD is available on the website, and free to any military family. We're developing one on deployment and what happens when a family member doesn't come home. Podcasts are also available.

> We have a global video conference series, in which we reach out to people deployed around the world. We have had global video conferences with presentations on topics such as substance use disorders, domestic violence, and pre-testing for TBI. These are available to anyone with military responsibilities, or anyone interested in hearing about these issues.

> We've launched a 24-hour information center on PH and TBI for anyone dealing with these issues

> The Real Warriors Campaign is aimed at veterans and family members, designed to fight the stigma within the military and the general public. As BG Sutton says, "stigma kills." This campaign is designed to break down these barriers, letting people know that, just because you're a warrior, that doesn't mean you don't feel pain.

> There is a 24/7 outreach program as well. So many resources are out there that people often don't know which ones will help them. If the family is in crisis, they often just want someone to talk to. This is not a crisis center, but it does help people cope with events and find appropriate crisis centers. You can also access this through a chat room through the "Real Warriors" website. After you have checked there, their personnel will follow up. Major General Elder Granger tested this service by calling up and saying, "This is Private Granger…" and they handled it well.

In our work to address these challenges, sometimes the goals can seem very far away. In some ways, trying to change the military culture is like trying to turn a cruise ship and make it look like a cigarette boat. But we have a lot of excellent resources working together.

Thank you very much.

QUESTIONS for Erika Elvander

QUESTION: I've been working with wounded active duty Soldiers in an Army hospital. Not one of them has ever heard of these websites. How is the chain of command getting this information down to the soldiers?

RESPONSE: *The leadership and the line leadership have it. The information about it is available at events. And the Real Warriors Campaign was highlighted on cable TV a couple of times.*

Questions (Cont'd.)

QUESTION: Could you say more about the challenges that you encountered in your anti-stigma campaign?

RESPONSE: *General Sutton came up with that campaign nine months ago. They said it would take a year to get off the ground, but they cut the time down by three months. It was launched in May, and there have been spikes in attendance. The information is constantly updated, and it's targeted at various audiences—Guard vs. Active Duty, families in which both parents are deployed, families experiencing difficulties, and so forth.*

AUGUSTA, GA:
Regional Satellite for Warrior Care

Laurie Ott
Executive Director
Central Savannah River Area (CSRA)
Wounded Warrior Care Project
Augusta, Georgia

Good afternoon. I'm Laurie Ott, and I'm very happy to be here today. Before I began this work, I was an investigative reporter and an anchor for the CBS affiliate in Augusta, Georgia. My work there gave me a lot of variety. I covered the Peacekeepers in Bosnia in 1997, covered the Super Bowl, and interviewed James Brown.

But no story impacted me as much as a story I did in March of 2007. I was sent to Fort Gordon to do a story about the Fisher House, and the Public Affairs Officer had arranged for me to interview a wounded warrior and her mother. That's where I met SPC Crystal Davis, who had lost her leg in an IED blast in Ramadi, Iraq.

Now I'm the Executive Director of the CSRA Wounded Warrior Care Project, covering the Central Savanna River Area. You can find our web site at www.projectaugusta.org, and we were fortunate enough to be linked from the NBC Nightly News website after they aired a story about Augusta's Active Duty Rehab Unit.

I am here to tell you about the major role Georgia plays, and the major role Augusta plays in wounded warrior care. Eisenhower Army Medical Center is head of the Southeastern Regional Medical Command, and our Active-Duty Rehabilitation Unit is a collaborative project between Eisenhower and the VA Medical Center. Erica has said that the VA and DoD are separate cultures, but at Augusta, these two agencies collaborate and cooperate.

In Augusta we have the nation's only Active-Duty Rehabilitation Center. Back in 2004, our then-commander of Eisenhower Army

Medical Center, General Eric Schoomaker (who is now the Army Surgeon General), and a VA Service Line Executive, Dr. Rose Trencher, got together and asked, "What can we do collaboratively to help?" The answer was an Active Duty Rehab Unit. In 2004, the first patient was admitted. Fast forward to 2007: SPC Crystal Davis spent 11 months at Walter Reed—she had dozens of surgeries and had nothing but good things to say about her inpatient care. But when it came to her outpatient care and learning how to use her prosthetic leg, she told me she only got one session of PT a day. She told me she "got lucky" and got the chance to transfer to the Active Duty Rehab Unit, and within three weeks of arriving at our unit, she was off her walker and on her prosthetic leg full time.

In the Charlie Norwood VAMC Active Duty Rehab Unit, they have two psychiatrists and one psychologist. They have joint DoD and VA staffing. They're able to give service members access to more joint benefits. Augusta also has the VA's largest spinal cord injury unit in the country. Our VA also operates as a seamless transition center, serving service members, veterans, and their families.

We had a chance to brief the Chairman of the Joint Chiefs of Staff, and he was talking about the challenges of community reintegration, and

Recovery

he said, "We can't do that—that's up to communities." In Augusta, our organization hosts a Transition Roundtable, and we've had a Special Assistant to VA Secretary Shinseki and an advisor to the Chairman of the Joint Chiefs attend, and Assistant Veterans Services Commissioner Tom Cook has been a guest as well. This meeting provides a forum to network and to communicate, collaborate, and figure out how to cooperate.

We are starting a collaborative vocational rehabilitation program, including computer skills training. We have subgroups on pain management and substance abuse. We are starting a jail diversion program, with a Judge (who is also a Marine) in charge of it. He runs the Drug Court and is involved in these plans for Veterans Court, linking people to benefits and services they've earned but generally don't hear about until they reach the criminal justice system. We're also looking to see if we can get a transitional housing program that would bring service members and families closer. This would be a great benefit for those who are in outpatient treatment and don't have access to the Fisher House.

We also have a partnership with the National Cristina Foundation, a non-profit dedicated to supporting people with disabilities with donated technology. We're working with the Charlie Norwood VA Center and other partners to see what we'd need to get our program certified as an information technology training program. We're going to train OEF/OIF veterans, starting with those with disabilities. We'll give them laptops and desktops and Internet access, so they can continue their training online from home.

In March, we were on the NBC Nightly News. Colonel Jack Jacobs was the reporter who interviewed many of us about Augusta and our Active-Duty Rehabilitation Unit. (You can find the interview on our website, under "Making a Difference.") After that segment aired, we heard from all kinds of folks from across the country—Santa America, a lady in Seattle who wanted to donate a prosthetic leg—some really interesting phone calls!

One of the most interesting was from Dr. Sonny Trimble, the program director for the Veterans Curation Project. In Iraq, he was in charge of the recovery of remains from the mass graves where Saddam Hussein's government had executed thousands of Kurds. (You can read about this in an article on archaeology.org.) In that effort, he lost two soldiers, and three were badly wounded. When Dr. Trimble came back from Iraq, he applied for and received funds to set up an archaeological curation project, to train and employ OIF/OEF

veterans to take American archival material, sort it, inventory it, clean it, photograph it, and put it on a website. This project is providing job training and employment, and Augusta is one of only three sites in the country for this. It's all about jobs, and for Dr. Trimble, it's also about paying those soldiers and Marines back for saving his life and the lives of those on his team in Iraq.

We also have a number of recreational activities, including a kayak program. Once you get into a kayak, it doesn't matter if you're an amputee. We also have a marriage enrichment program, with workshops held in the community, a collaborative effort that started with Army and now continues with VA chaplains. This program is having a significant effect on couples' perceptions of their relationships. For example, before participating in the program, 29% of couples perceived their marriages as "poor" and another 29% as "very poor," with only 14% rating their marriages "above average." After participation, only 7% perceived their marriages as "poor" and none as "very poor," and 57% perceived their marriages as "above average."

We also formed a TBI Research Consortium, a collaborative effort of the Army, the VA, The Medical College of Georgia, the Telemedicine

Integrate

and Advanced Technology Resource Center, and the Savannah River National Lab. We submitted a $1.3 million Joint Incentive Fund tele-TBI proposal, and we have another $900,000 in pre-proposals. We continue to support the existing Fisher House, a home away from home for wounded warriors and their families, and we're about to break ground to build a new 20-suite Fisher House for the Active-Duty Rehab Unit. Several people in our community have taken it upon themselves to raise money for this, and so far we've raised $1.8 million.

Until recently, nobody had heard of a Federal Recovery Coordinator (FRC). However, the number-one recommendation of the Presidential Commission chaired by former Senator Bob Dole and former Health and Human Services Secretary Donna Shalala was that every wounded warrior receive an individual recovery plan, with a Federal Recovery Coordinator to coordinate that plan. This is a lifetime relationship, something that spans all these systems (DoD, VA, community) in all areas: vocational, spiritual, medical, psychological. There are only 13 FRCs in America, and we have one in Augusta, a master's-level nurse. The FRCs are bureaucracy busters and red tape cutters. They should be trained where the master's-prepared nurses are trained, through existing Clinical Nurse Leader Programs.

We have a number of community partnerships planned for the future, including a Joint Marriage Enrichment Retreat Center and an intensive PTSD treatment program modeled after the Fort Bliss Center. We've found some property on the lake that the VA already leases, and there's the potential that the Army Corps of Engineers could be a partner in this. Fort Bliss has a waiting list and won't take anyone who is less than two years away from retirement. We're also interested in a joint pain management and substance abuse program.

This may seem like a lot, but when you look at the effects of combat and multiple deployments on the lives of our service members, veterans, and their families, there are a lot of things to address. Sorry to have talked so fast, but I had to try and get 10 pounds of potatoes in a 5-pound bag.

Thank you very much.

QUESTIONS
for Laurie Ott

QUESTION: Do you foresee holding workshops in other major cities in Georgia, to look at how we might get these kinds of programs start in other areas?

RESPONSE (VON WRIGHTEN): *That's the plan. We want to model other programs on what's already happening in Augusta.*

QUESTION: Can you tell us more about the marriage enrichment workshops?

RESPONSE: *The workshop in February was an overnight retreat, and the one held in November was an evening workshop. We had couples drive in from as far away as Atlanta. It really helped return couples to a sense of normalcy and give them an idea how to reconnect with that "new normal." Right now we're working on a workshop that would be two nights and three days, with VA chaplains. The next will be held in Hickory Knob. That's one of the reasons we're looking at possible joint retreat center—we'd like to have the center located within a 20-minute ride of Augusta. This would be for joint use by Army and VA chaplains. There would also be a recreational center for folks with TBI in the community. We're working on pulling the resources together, using our Active-Duty Resource Unit as an example of this kind of collaboration.*

QUESTION: What can we do as a group to petition for more Federal Recovery Coordinators?

RESPONSE: *We need more FRCs in America as a whole, and in Georgia in particular. When you petition, say, "I've heard of Federal*

Recovery Coordinators, and I'd like to meet one. How can we get more FRCs? I'd like to have them assigned to our Guardsmen and Reservists."

These are master's-prepared nurses who meet all the qualifications—knowledge of resources, leadership skills. They need to have this attitude: "If I have to hand-walk it in, I'll do it. Who do I call to make it happen?" They understand that sometimes phone calls are not returned, people change jobs, medical files are lost, somebody doesn't have your forms. I'd love to have a DES (DoD/VA Disability Evaluation System) dual evaluation process in Georgia. There is a need for coordination, coordination, coordination.

You can never underestimate the importance of families in the rehabilitation and recovery process. Chaplains are good at reminding us of this. When someone's deployed, and they come back with TBI, depression, substance use disorders, pain management issues, PTSD—identified or not—how do they reintegrate into the family and community? It's like the family is on an escalator, and when people come back, the family is not at that same spot on the escalator. They've moved on. Not only do they have to catch up, but it takes a lot of work just to feel like part of the family again. One method we use is the Practical Application of Intimate Relationship Skills, the PAIRS approach. You need to have a training of trainers, helping people understand how to get back in the family, how to be mom, dad, the breadwinner. It's a hard thing to do, if you haven't seen your spouse in six months. The transitional housing piece becomes very important.

When it comes to patient-centered care, how do you get everybody on board that this is a good idea, and how do you accomplish this, not as independent agencies, but as collaborators? We have an essay called, "Framing the Challenges," and the one word that is underlined is "coordination."

QUESTION: We talked about the fact that you have an infrastructure for services, and one of your providers, Dr. Martha Tingen. How can we use what she's doing in our prevention programs for families and children? She's at the cutting edge of actually informing the science, by creating something unique and different for families and informing the community about it.

RESPONSE: *You can get more information on projectaugusta.org. Her work is patient centered and forward looking, measuring outcomes, outcomes, outcomes. She's formed a research consortium that is looking for research dollars in this area.*

CHAPTER 3

Discussions and Recommendations

Enriched by the information and inspiration they had received in the plenary sessions—and by the love and dedication behind the speakers' efforts—participants in the Collaborative Meeting were given an ambitious task: the development of concrete recommendations.

It was clear that the scope and nature of the need would demand collaborative effort. It was also clear that, in all 50 states, collaborative efforts between military and civilian service systems are still in their infancy. Georgia's next steps in this area might not only help her own service members, veterans, and families, but also provide a model for other states struggling with the same needs and circumstances. So the five breakout groups were given the charge of considering all the information they had heard and all the expertise they had brought with them to the event, thinking in terms of innovation and collaboration, and focusing on solutions.

STRENGTHS

Although the large group engaged in no formal activities for defining its mission or purpose, one overarching goal revealed itself in each of the speakers' and each of the breakout groups' presentations:

> Health, well being, reintegration, and fulfillment for all service members, veterans, and families

It is often difficult to take a positive approach to a subject with as many threats to life and quality of life as one finds in the aftermath of war. However, an overemphasis on the negative aspects of this subject has left our society with stigmas and stereotypes that have often been as destructive as the conditions they describe. So several of the speakers and breakout groups emphasized the importance of avoiding a deficit-based approach, instead recognizing the significant strengths that already exist within service members, veterans, and families, including:

- Love of family; country; fellow service members, veterans, and families
- Patriotism
- Courage, strength, and resilience
- Ingenuity
- Wisdom and maturity
- Spirituality
- Sense of humor

Many recounted the additional internal resources that many service members and veterans acquire or strengthen in the theater of war:

- Knowledge and skills
- Physical strength and discipline
- Cognitive strength and discipline
- Capacity to adapt to adversity
- Experience in cross-cultural communication
- Capacity to "do a lot with a little"
- Wisdom and perspective gained in war
- Strengthened capacity for mission and purpose

CHALLENGES

It was with these and other strengths in mind that the Breakout Groups considered the many challenges that often threaten or compromise the overarching goal of health, well being, reintegration, and fulfillment for all service members, veterans, and families. The essential challenges described at the Collaborative Meeting—and the goals these challenges threaten—include:

> Stress on the family during deployment, and service members' and veterans' concerns about this stress (challenges to service member and family health and well being)

> Differences between military and civilian cultures, experiences, and communication (challenges to reintegration)

> Effects of growth and basic role and personality changes within service members, family members, and friends (challenges to reintegration)

> Psychological effects of war and homecoming (e.g., alienation, grief, guilt, anger, loss of sense of safety, loss of sense of meaning and purpose) (challenges to service member, veteran, and family health, well being, reintegration, and fulfillment)

> The effects of significant embodied stress and threat during deployment, ranging from:

  - Normal and temporary effects that many service members/veterans experience (e.g., emotional numbing, shutting down, confusion, hypervigilance, nightmares, desire for the "rush" of combat) at sub-syndromal levels to:

  - Stress injuries/disorders such as posttraumatic stress disorder (PTSD); depressive disorders; anxiety disorders; substance use disorders; and long-term stress-related somatic conditions (e.g., gastrointestinal, musculoskeletal, immune system disorders) (challenges to service member, veteran, and family health, well being, reintegration, and fulfillment)

> Temporary or permanent impairment or disability from Service-related injuries (e.g., PTSD, traumatic brain injury or mild traumatic brain injury, spinal cord injuries, amputations, somatic disorders, burns) and the resulting loss of mobility, independence, and/or employability (challenges to service member, veteran, and family health, well being, reintegration, and fulfillment)

MEETING THE CHALLENGES

One point that presenters and participants made clear was that an overwhelming number of resources for overcoming these challenges already exist, within:

- Individual service members, veterans, and families
- Peer support networks for service members, veterans, and families
- Extended families, support networks, faith communities, and other community groups
- Veterans' organizations such as the American Legion and Veterans of Foreign Wars
- Military and VA services, benefits, and resources
- Less formal military-sponsored support resources such as the Family Readiness Groups and Military Family Life Consultants
- Non-military government services, benefits, and resources
- Civilian community services and resources
- Internet-based resources and support networks, books, training opportunities, etc.

However, it became clear that it would take significant effort even to grasp the scope of resources available, and far greater effort to catalogue resources and present all the options to the people who need them. The speakers also confirmed that many service members, veterans, and families face formidable barriers to the use of the resources they most need.

So in their work, the five Breakout Groups considered the barriers to seeking, finding, and using needed resources, and discussed ways of overcoming these barriers. The grid on the next few pages is organized under the challenges named above, and for each challenge it presents:

- Resources designed to help service members, veterans, and families meet these challenges
- Barriers to seeking, finding, and/or using these resources
- Action areas—areas of effort and focus that Collaborative Meeting participants and their colleagues can address to create collaborative systems that will help people overcome these barriers

CHALLENGES	RESOURCES TO MEET CHALLENGES	BARRIERS TO MEET CHALLENGES	ACTION AREAS FOR OVERCOMING BARRIERS
Stress on the family during deployment, and service members' and veterans' concerns about this stress	• Love, courage, strength, resilience, spirituality, and ingenuity within family members and the family as a whole	• Lack of knowledge of and belief in their own strength and resilience	• Peer support and training • Outreach to service members, veterans, families, and communities
	• The love and support of other military families, individually and with the help of Family Readiness Groups and other resources	• Lack of contact with other military families • In some areas, scarcity of programs to bring military families together	• Increasing access to services • Peer support and training • Outreach and stigma reduction
	• The love and support of communities (e.g., neighbors, extended families, faith communities, employers)	• Lack of knowledge or understanding of what these families are experiencing • Scarcity of programs to marshal and organize support	• Increasing access to services • Peer support and training • Outreach and stigma reduction
	• Professional counseling services, through military (e.g., VA counselors, Vet Centers, Military Family Life Consultants) or community (e.g., local agencies, Community Service Boards) resources	• Stigma and shame connected with needing or receiving help • Lack of access to needed services	• Increasing access to services • Peer support and training • Outreach and stigma reduction
	• Additional resources (e.g., Internet-based support resources, telehealth resources, social networks, books, periodicals)	• Lack of knowledge of these resources • Lack of computer access • Lack of funds for books, magazines, etc.	• Peer support and training • Outreach and stigma reduction

CHALLENGES	RESOURCES TO MEET CHALLENGES	BARRIERS TO MEET CHALLENGES	ACTION AREAS FOR OVERCOMING BARRIERS
Differences between military and civilian cultures, experiences, and communication	• Military experience in cross-cultural communication	• Service members' and veterans' expectations of home and civilian culture	• Peer support and training • Outreach and stigma reduction
	• Education of service members, veterans, families, civilians, service providers	• Challenges in finding, reaching, and tailoring messages to audiences	• Training and education for service providers • Outreach and stigma reduction
Effects of growth and basic role and personality changes within service members, family members, and friends	• Increased maturity, wisdom, spirituality, and skills among service members, veterans, and family members	• Unrealistic expectations of service members, veterans, families, and friends concerning one another and homecoming	• Peer support and training • Outreach and stigma reduction
	• Warrior Weekends, Yellow Ribbon celebrations, and other reintegration rituals and celebrations	• Challenges in knowledge of, availability of, and access to these events	• Increasing access to services • Outreach and stigma reduction
	• Reintegration education for service members, veterans, families, friends, and communities	• Scarcity of reintegration education programs in the community • Lack of knowledge of those that exist	• Increasing access to services • Outreach and stigma reduction • Expanding and improving services

CHALLENGES	RESOURCES TO MEET CHALLENGES	BARRIERS TO MEET CHALLENGES	ACTION AREAS FOR OVERCOMING BARRIERS
Normal and natural psychological effects of war and homecoming (e.g., alienation, grief, guilt, anger, loss of sense of safety, loss of sense of innocence, loss of sense of meaning and purpose)	• Strength, courage, resilience, ingenuity, spirituality, and skills within service members and veterans	• Lack of knowledge of and belief in their own resilience • Fear of more serious disorders (e.g., PTSD)	• Peer support and training • Outreach to service members, families, veterans, and communities
	• Strengthened capacity for mission and purpose gained within military	• Separation from the mission and purpose found in military service	• Peer support and training • Veteran workforce development
	• Love and support from fellow service members and veterans	• Lack of access to fellow service members and veterans • Cultural differences between generations of veterans	• Peer support and training • Outreach and stigma reduction
	• Professional counseling services, through military (e.g., VA counselors, Vet Centers, Military Family Life Consultants) or community (e.g., local agencies, Community Service Boards) resources	• Stigma and shame connected with having challenges and seeking help • Lack of knowledge of, or access to, appropriate professional counseling • Disconnect between military culture and civilian counseling cultures	• Increasing access to services • Training and education for service providers • Peer support and training • Outreach and stigma reduction
	• Additional resources (e.g., Internet-based support resources, telehealth resources, social networks, books, periodicals)	• Lack of knowledge of these resources • Lack of computer access • Lack of funds for books, magazines, etc.	• Peer support and training • Outreach and stigma reduction

CHALLENGES	RESOURCES TO MEET CHALLENGES	BARRIERS TO MEET CHALLENGES	ACTION AREAS FOR OVERCOMING BARRIERS
The effects of significant embodied stress and threat during deployment, ranging from: • Normal and temporary effects that many service members/ veterans experience (e.g., emotional numbing, shutting down, confusion, hypervigilance, nightmares, desire for the "rush" of combat) at sub-syndromal levels to: *(Cont'd. to next page)*	• Strength, courage, resilience, ingenuity, spirituality, and skills within service members and veterans	• Lack of knowledge of and belief in their own resilience • Fear of more serious disorders (e.g., PTSD)	• Peer support and training • Outreach and stigma reduction
	• Love and support from fellow service members and veterans	• Lack of access to fellow service members and veterans • Cultural differences between generations of veterans	• Peer support and training • Outreach and stigma reduction
	• Love, concern, and support from family, friends, and community members	• Lack of knowledge/understanding of these effects • The family's own accumulated burden of stress • Difficulty living with these effects • Fear of serious disorders	• Peer support and training • Outreach and stigma reduction
	• Education and training for service members, veterans, and families in the stress system, normal reactions to stress and threat, and ways of building resilience	• Scarcity of these kinds of education and training programs within military and community agencies and organizations	• Increasing access to services • Peer support and training • Outreach to service members, veterans, families

CHALLENGES	RESOURCES TO MEET CHALLENGES	BARRIERS TO MEET CHALLENGES	ACTION AREAS FOR OVERCOMING BARRIERS
(Cont'd. from previous page) • Stress injuries/ disorders such as posttraumatic stress disorder (PTSD); depressive disorders; anxiety disorders; substance use disorders; and long-term stress-related somatic conditions (e.g., gastrointestinal, musculoskeletal, immune system disorders)	• Professional counseling services, through military (e.g., VA counselors, Vet Centers, Military Family Life Consultants) or community (e.g., local agencies, Community Service Boards) resources • Additional resources (e.g., Internet-based support resources, telehealth resources)	• Stigma and shame connected with having challenges and seeking help • Mismatch between the timing of assessments and referrals and the progressive nature of these disorders • Lack of knowledge of, or access to, appropriate professional counseling and/or medical treatment • Disconnect between military culture and civilian counseling and medical cultures	• Increasing access to services • Expanding and improving services • Training and education for service providers • Peer support and training • Outreach and stigma reduction
		• Lack of knowledge of these resources • Lack of computer access • Lack of funds for books, magazines, etc.	• Peer support and training • Outreach to service members, veterans, families • Expanding and improving services

CHALLENGES	RESOURCES TO MEET CHALLENGES	BARRIERS TO MEET CHALLENGES	ACTION AREAS FOR OVERCOMING BARRIERS
Temporary or permanent impairment or disability from Service-related injuries (e.g., PTSD, traumatic brain injury or mild traumatic brain injury, spinal cord injuries, amputations, somatic disorders, burns), and resulting loss of mobility, independence, and/or employability	• Service members' strength, courage, resilience, ingenuity, spirituality, and capacity for mission and purpose	• Lack of knowledge of and belief in their own resilience and their viability in family, community, and workplace cultures	• Peer support and training • Outreach to service members, veterans, and families
	• Love and support from fellow service members and veterans	• Lack of access to fellow service members and veterans • Differences between veteran generations	• Peer support and training • Outreach to service members, families, veterans, and communities
	• Love, concern, and support from family and close friends	• Fear of being a burden on family and other caregivers, challenges to resilience of family/other caregivers, lack of access to respite and other sources of support	• Peer support and training • Outreach to service members, families, veterans, and communities
	• Temporary and permanent disability benefits	• Difficulty understanding or applying for benefits • Difficulty gathering required medical documentation for disability claims	• Expanding and improving/ Increasing access to servicesi • Training and education for service providers • Outreach to service members, veterans, and families

CHALLENGES	RESOURCES TO MEET CHALLENGES	BARRIERS TO MEET CHALLENGES	ACTION AREAS FOR OVERCOMING BARRIERS
(Cont'd. from previous page) Temporary or permanent impairment or disability from Service-related injuries (e.g., PTSD, traumatic brain injury or mild traumatic brain injury, spinal cord injuries, amputations, somatic disorders, burns), and resulting loss of mobility, independence, and/or employability	• Physical therapy, occupational therapy, and other services for returning to independence, capacity, and fulfillment	• Lack of knowledge of, or access to, appropriate services • Logistical barriers to access	• Expanding and improving/ Increasing access to services • Outreach to service members, families, veterans, and communities • Expanding and improving services
	• Vocational training, counseling, and advocacy for returning to meaningful employment and fulfilling their goals, mission, and purpose	• Lack of knowledge of, or access to, appropriate services • Employer reluctance to hire veterans, related to disability or stigma	• Expanding and improving/ Increasing access to services • Outreach to service members, families, veterans, and communities • Veteran workforce development
	• GI Bill educational benefits	• Sense of alienation in civilian educational programs which may not accommodate disabilities, surrounded by younger students with very different experiences	• Peer support and training • Outreach to service members, families, veterans, and communities • Veteran workforce development
	• Additional resources (e.g., Internet-based support resources, telehealth resources, social networks, books, periodicals)	• Lack of knowledge of these resources; lack of computer access • Lack of funds for books, magazines, etc.	• Peer support and training • Outreach to service members, families, veterans, and communities

ACTION AREAS FOR OVERCOMING BARRIERS

The breakout groups were given two sessions to discuss the issues and arrive at recommendations, followed by a plenary session in which each group presented its recommendations. To focus discussion, the groups were asked to consider needs at several points along the continuum of care (Outreach, Prevention, Pre-Treatment, Treatment, Recovery, Aftercare, and Advocacy) and structured according to specific areas of need:

- Wounded Warriors Care
- Family Support/Transition Back into Family Life
- Continuum of Care/Service Coordination/Access to Care
- Public and Military Awareness of Mental Health and Addictive Disease Issues/Stigma Reduction
- Workforce Development

The breakout groups were given the charge of focusing on solutions, not an easy task given the many challenges and barriers that easily find their way into any honest discussion of these subjects. However, a focus on challenges and barriers could easily consume a day's or a week's discussion of this topic, leaving the discussants with no practical tools for addressing challenges or overcoming barriers. When the groups presented their recommendations, in person at the Collaborative Meeting and in writing after the event, the recommendations naturally fell into the six Action Areas referred to in the last column of the chart on the preceding pages:

1. Increasing access to services
2. Training and education for service providers
3. Outreach and stigma reduction
4. Peer support and training
5. Expanding and improving services, including advocacy and new initiatives such as Federal Recovery Coordinators
6. Veteran workforce development

These Action Areas—and many of their recommendations—have implications for multiple disciplines and systems of care, further underscoring the need for collaborative effort. The fact that there is no separate category called "Families" reflects three realities: 1) Family members' needs are often inseparable from those of their service members and veterans; 2) As long as families are relegated to a separate category, our society continues to run the risk of marginalizing them and neglecting their needs; and 3) Service systems must find integrated ways of addressing the needs of service members, veterans, and families.

The rest of this chapter, beginning on the next page, presents the specific goals recommended at the Statewide Meeting, organized under the six Action Areas. When the group reconvenes in January, 2010, it will begin the process of considering, clarifying, prioritizing, and planning to carry out these recommendations.

ACTION AREA

one

Increasing Access to Services

Planning and Policy Development

- A policy academy focused on overcoming barriers to collaboration among military and civilian service systems
- A cost-benefit analysis comparing successful treatment to the consequences of delaying or failing to provide appropriate treatment
- Efforts to shape federal policy concerning service members' and veterans' eligibility for services and the confidentiality of those services
- Expansion of disability eligibility criteria to include all disabled warriors and provide for their families
- Development of grant programs and state-level supplements to increase veterans' access to treatment
- An inquiry into possible legislative barriers to family reintegration, followed by advocacy for any appropriate legislative change

Collaboration and Networking

- Development of a system-of-care approach modeled on the Substance Abuse and Mental Health Services Administration's recovery-oriented systems and services approach and other evidence-based models
- Increased networking efforts among Community Service Boards, to share lessons and solutions
- At the community level, Transitional Roundtables that gather all community members and service providers supporting veterans and service members
- Expansion of the stakeholder community involved in this dialogue to include law enforcement, faith communities, universities, employers, and other essential stakeholders
- The gathering of suggestions and support for building collaborative relationships between local treatment providers and entities such as the VA and Military OneSource
- Community-by-community collaboration with law enforcement and

emergency services to develop procedures for identifying veterans and service members with mental health and addictive disease issues and providing treatment alternatives to incarceration (e.g., the Veterans Court under development in Augusta)

Referral Information and Procedures

- A directory of service providers and their services, organized by region and zip code, with service-specific and location-specific information on navigating service systems
- A service providers meeting similar to the Regional Commission on Homelessness, designed to acquaint all the players with one another's services
- Efforts to increase provider familiarity with common comorbidities, risk factors, disease progression, and other challenges, and their implications for the referral process
- Referrals to clinicians consistently based on qualifications and skills, rather than on familiarity
- Examination of customer service and satisfaction regarding referrals, and technical assistance in making prompt referrals to service providers well matched with veterans' and service members' needs
- Collaboration with other referral systems, such as the United Way's 211 system

Improved Services and Navigation

- Interviews and focus groups with veterans regarding the transition process and access to and effectiveness of services, and use of the results for improved services and systems
- An analysis of the challenges that veterans, service members, and families experience in navigating service systems, with the results used to re-engineer service systems for smooth, rapid navigation
- Interviews with and assessment of agencies that offer services to veterans, service members, and families, to learn more about conditions, challenges, innovations, and effectiveness of services
- An examination of existing and possible methods of expediting referrals and services, with the results used for system improvement
- The development of guidelines and procedures that Community Service Boards will follow in determining an agency's or organization's

eligibility to provide specific services to veterans, service members, and families

- The development of standards that Community Service Boards will apply to ensure that veterans and service members who seek services will receive same-day assessment and see physicians within the same week, and that any housing issues will be determined and addressed

- Efforts to secure more Federal Recovery Coordinators (FRCs) (for a list of possible efforts, see Page 17)

Planning for Pre-Deployment Support

- Development of Deployment Readiness Centers at major military installations

- Collaboration among civilian and military partners to ensure that support systems are in place for service members and families prior to deployment

- Collaborative efforts within prevention and treatment to provide pre-deployment prevention services, briefing, counseling, education, books, movies, and other resources for service members and families

Preparation for Delayed Onset of Symptoms

- Preparation of civilian service systems for the increases in need that will accompany delayed onset of PTSD, depression, and substance use disorders 5 to 10 years after deployment, when veterans no longer have access to military or VA services

Planning to Address Barriers to Access

- Examination of the availability of service member- and veteran-appropriate treatment services throughout the state, and the development of plans to supplement these services where they are scarce or absent

- Direction of additional resources toward the provision of ancillary services to improve treatment access

- Assessment and improvement of public transportation systems and infrastructure, to expand existing systems and make them accessible to wounded warriors

- Development of volunteer programs for the transportation of veterans, service members, and families to services, as needed

- Exploration of the possibility of expanding local Give an Hour services (in which mental health providers may donate an hour of services to veterans, and veterans donate other services within the community) to include the provision of other kinds of services designed to eliminate barriers to service and access

- Exploration and utilization of the veteran volunteer component of the Give an Hour program, using veterans to transport other veterans, service members and families to needed services

- Assessment of the need for and availability of ancillary services such as child care, housing, training, and financial assistance to individuals and families within the Reserve Components (National Guard and Reserves), and development of plans to ensure that needed services are available

ACTION AREA two

Training and Education for Service Providers

Dissemination of Information about Training Opportunities

- Development and maintenance of a web-based list of training providers and opportunities, with quality control and the capacity for trainers and training organizations to submit appropriate evidence and post their training opportunities

Training Based on Model Community Service Boards

- Design and dissemination of a statewide training and technical assistance program, using Community Service Boards with particularly successful efforts to serve veterans as models and concrete examples

Training on the Military Culture and Experience

- The preparation and use of Community Service Boards for training on the military culture

- The use of states such as North Carolina as models for effective cross-training between military and civilian providers
- Cross-cultural training between military and civilian providers, with attention to promoting mutual understanding and trust, cross-cultural competence/sensitivity/ humility, and effective communication
- Cultural and linguistic training of civilian service providers by military personnel, including essential concepts, values, principles, practices, terms, and acronyms
- Training for civilian partners in the experience of war and challenges in homecoming and reintegration
- Regional training for civilians working with military populations in the full spectrum of cultural issues, including issues of ethnicity, military culture, gender, sexual orientation, etc.

Training and Recruiting New Counselors

- The hiring and training of military veterans to provide needed services, to increase newer veterans' levels of comfort in seeking and accepting services
- Incentives (e.g., college credit, repayment of college loans) for well prepared and qualified students willing to work with veterans in underserved areas

Training Navigators (Outreach and Employment Counselors)

- Provision of training and technical assistance to Disability Navigators working with veterans in Department of Labor career centers, and collaboration with the Department of Labor on quality-assurance measures

Training Broader Community Partners

- Provision of appropriate training and education to a variety of community partners, e.g., clinicians, VA employees, community groups, faith leaders, based on the understanding that anyone in the community might be a referral source for veterans in need of services
- Dissemination of up-to-date information among service providers and not-for-profit organizations regarding the eligibility of National Guard and Reserve members for services

- Continued education of primary care physicians regarding the spectrum of challenges and conditions for which service members and veterans are at risk, and effective terminology to use in discussing these issues with service members, veterans, and their families

ACTION AREA three — Outreach and Stigma Reduction

Training in Effective Outreach

- At the outset, regional and state-based education of coalition members in the technology of the effective outreach, including the dissemination of knowledge and understanding and the transfer of skills

General Outreach to Military Families

- Involvement of prevention in pre-deployment briefing and counseling, and the development and dissemination of books and films for preparation for challenges during deployment
- The development of multimedia products and after-school specials on military families and deployment, providing a variety of perspectives in a user-friendly format
- Family education, both upon entering the military and in preparation for return from deployment, including education for the spouse on ways of promoting reintegration (from training programs to brief "infomercials" increasing their awareness of options)
- Increased collaboration between prevention and treatment service providers and the Family Readiness Groups that provide reintegration support and assistance to military families
- Initiatives such as a "Weekend at the Marriott" program, providing encouragement and reintegration resources for military families
- The use of social networking sites (e.g., Facebook, Georgia's "Care for the Troops" page, MySpace, Twitter, Blackberry resource for service members) to target young veterans and families
- Increased access to information through the training of veterans, service members, and families in the use of computers

Outreach Directed Toward Stigma Reduction

Within the Military Culture:

- Collaboration between military and civilian systems in promoting within the military culture: 1) greater understanding and acceptance of the reality of combat and operational stress effects and 2) the strength inherent in seeking and accepting appropriate help
- Within military systems, development of rewards for commanders who encourage service members to seek care for stigmatized conditions such as PTSD or substance use disorders
- Encouragement of military officers who are willing to disclose their own need for, and willingness to receive, help for these conditions
- Continued education of service members in appropriate ways of encouraging their fellow warriors to talk about their stress responses and reacting to such disclosures, through national (e.g., the Real Warriors campaign), state, and local initiatives
- Education for military spouses to normalize their experience of stress and overwhelm, help them understand that they are not weak, and promote greater comfort with the idea of asking for help

Within the Community:

- Strength-based education for communities on issues of resilience, mental health, substance use disorders, traumatic brain injury, and the effects of traumatic stress on the human stress system
- Community education on military culture, values, and terminology, including education within schools, faith communities, medical settings, and social service settings
- Improved use of social networking websites to disseminate this sort of information
- Cross training and continued collaboration between military and civilian families, to increase mutual comfort and understanding

Dissemination of Information About Available Services

Electronic:

- An online directory of service providers, their services, and eligibility/reimbursement, organized by region and zip code, with a "map" or flowchart of services and service-specific and location-specific information on navigating service systems (veterans, service members,

and family members might access this directory with an ID number)

- A hotline that can serve as a single point of contact for Active Component and Reserve Component service members, veterans, and families in need of services

- A consolidated website collecting up-to-date information about military, VA, and civilian service options for service members, veterans, and families

- Development of a clearinghouse for organizing and keeping track of the wide variety of web-based resources

Non-Electronic:

- Development of a service members' and veterans' service resource directory for each county, including military and civilian resources

- Non-electronic outreach to service members and veterans with no Internet access, including homeless veterans and families

- Collaboration between community and VA case managers and Social Workers in an adaptation of the current VA model in which staff disseminate information about services (e.g., fliers, CDs) in person in community settings

- Dissemination of information about national resources such as Military OneSource, Real Warriors, Give an Hour, and many others, through public service announcements, directories or listings, and media campaigns

- A media campaign with information about the hotlines, websites, wounded warrior blogs, and other resources that are available

- "Low-tech" options such as newsletters (new or in collaboration with existing social service newsletters), pocket-sized cards, brochures, and posters, disseminated in schools, doctors' offices, law-enforcement and judicial arenas, faith communities, and community- and faith-based organizations

- Canvassing of communities with information about service providers and the services that are available

- Establishment of a "point person" at each VA office to answer questions from the community

- Development of a resource directory for each county

ACTION AREA four

Peer Support and Training

Peer Education and Training

- Training of veterans in describing and navigating the services and resources that are available, to enable them to serve as resources for newly returned service members and veterans
- Training and college credit for veterans enrolled in higher education who are willing to speak to other veterans and serve as "walking resources"
- Education, training, and recruitment of military veterans in the provision of needed social services for service members and veterans, to increase the acceptability of these services and the likeliness that people will be willing to seek help

Peer Support for Veterans and Service Members

- Examination of existing evidence-based peer-to-peer programs for service members and veterans, to determine their effectiveness and replicability
- Development of local or statewide peer support groups and peer mentorship programs, based on effective, evidence-based models, with peer-to-peer follow-up contact taking place on a regular schedule, at least once a month
- Continuation of peer mentorship beyond the period in which service members and veterans are receiving professional services
- Provision of training, technical assistance, and supervision to peer mentors
- Examination of the possibility and methods of engaging younger veterans in organizations such as the Veterans of Foreign Wars and the American Legion.

Peer Support for Families

- Collaboration with the Family Readiness Groups in the development or expansion of peer-to-peer support services for family members
- Targeting family peer efforts toward preparation for deployment, support during deployment, preparation for reintegration, and knowledge of the resources available to families, service members, and veterans
- At gatherings of military spouses or families, presentations by families who have successfully weathered deployment and reintegration

Peer-Based Housing

- Development of programs for the provision of housing to service members, veterans, and families in buildings or communities in which other military or veteran families live and receive services and/or information about services, to normalize service access (in some cases using models such as the Oxford Houses)

Ongoing Recovery Support

- Involvement of families and communities in the recovery process, from the first raising of awareness to ongoing recovery support
- Investigation or development of peer-based community programs based on the 12-Step model, to address issues such as PTSD and TBI

ACTION AREA

five

Expanding and Improving Services, Including Advocacy and New Initiatives Such as Federal Recovery Coordinators

Pre-treatment

- Collaborative development of a screening instrument (10-20 true/false questions)
- Administration of screening in routine settings, rather than waiting until symptoms reach crisis level or family members intervene
- Timely assessment of common conditions such as PTSD, TBI, depressive and anxiety disorders, and substance use disorders
- Cross-training of screening and assessment personnel in determining military or service status; communicating effectively with the military culture; recognizing symptoms and risk factors specific to this population; and appropriate referral of military members, veterans, and family members

Treatment

- Stigma reduction through the development of culturally appropriate rewards for service members and veterans who seek and accept treatment
- Strength-based approaches to care and support that focus on skill building and emphasize empowerment, resilience, and capability, rather than pathology and deficits
- Culturally competent celebration of short-term gains, to encourage continued treatment and progress
- Involvement of families in the treatment of service members and veterans throughout the process, from pre-treatment through ongoing recovery
- Equal focus on the family's needs in treatment, including weekly sessions in which family members can receive the treatment and support they need, with flexible hours, daycare, and other barrier-reduction measures
- Provision of comprehensive services, including non-traditional Centers in which service members and veterans can receive a variety of services,

including mental health, physical health, knowledge (e.g., benefits, family benefits), and job opportunities

- Provision of alternate treatments such as relaxation, stress management, sleep techniques, skills in managing post-deployment stress symptoms (e.g., hypervigilance, social isolation, flashbacks), equine therapy, and outdoor group team-building and trust-building programs

- Involvement of peer mentors throughout the clinical experience, to lay groundwork for ongoing support

Continuing Care

- Assistance to service members and veterans in developing individual action plans for building support networks, creating financial security, and addressing barriers to recovery and reintegration

- Development and encouragement of peer support groups, with training for group leaders in effective means of managing post-deployment symptoms and reintegration challenges

- Use of a social work model to facilitate reintegration with all significant entities, including family, faith community, school, workplace, neighborhood, and social networks

- Attention to the need for housing or transitional housing, and opportunities for service member- or veteran-specific housing (e.g., Oxford Houses for veterans)

- Maintenance of peer mentoring after professional services have ended

Advocacy for Individual Service Members, Veterans, and Families

- In developing programs that help people navigate service systems and obtain needed services, examination of terminology to eliminate disempowering language (e.g., avoiding terms such as "case management," with the implication that the person is a "case" to be managed" rather than an individual who has successfully served our nation)

- Establishment of the advocate's position as a single point of contact or entry for service members, veterans, or families in need of services, education, or training

- Ensuring that advocacy is in place immediately after services such as inpatient treatment have ended

- Assertive linkage for service members, veterans, or families, e.g.,

making the call with them, helping the navigate difficult systems

- Ensuring that each VA has a Transition Patient Advocate (through the national TPA program), to conduct outreach and assist veterans and family members

- Collaboration among VA and CSB staff in the development of a Georgia-specific advocacy model for service members, veterans, and families, modifying and building on existing models (e.g., Federal Recovery Coordinators, Department of Labor Disability Navigators, KidsNet program)

- Establishment of a contact person in each county to assist individuals (possibly Family Connections coordinators)

- Establishment of local Veterans Employee Advocates, to assist local veterans in workforce reintegration

- Efforts to secure more Federal Recovery Coordinators (FRCs) (possible efforts including gathering evidence of statewide, regional, and local need for FRCs; advocating the assignment of additional FRCs to Georgia, one at each military installation; and ensuring that Federal Recovery Coordinators have the connections necessary to serve as liaisons. train new personnel, and coordinate the expansion of this program)

ACTION AREA six — Veteran Workforce Development

Model Programs

- Investigation of the applicability and replicability of models such as Top Steps, a Department of Labor program in which individuals in vocational rehabilitation and individuals leaving incarceration are assigned counselors who help them attain bonding and provide tax credits to employers who hire them

- Investigation of the possibility of offering tax credits to employers who hire veterans who have not been referred through government services

- Celebration of existing successes, in the manner of the Department of Labor's list of the top 20 businesses that hire veterans, and recognition of companies such as Walgreens and Home Depot that take steps to ensure that they will hire veterans

Employer Education

- Education for employers in the strengths that veterans bring to the workplace, the values embodied in the military culture, the realities that replace the myths about post-deployment stress affects, relevant laws (e.g., the Americans with Disabilities Act, USERRA) concerning accommodation of disabilities, and ways of creating veteran-competent workplaces

Outreach

- Dissemination of information to veterans concerning the job-seeking and job-training resources that are available, ways of gaining access to those resources, and the people to contact for assistance in these efforts
- Exploring the benefits of social networking sites and other Internet resources in service members' and veterans' career development and job-seeking efforts
- Outreach to families in need of job training or employment assistance while service members are deployed

Removing Barriers to Employment

- Addressing the needs of the whole person, to eliminate distractions and barriers to employment
- Establishment and training of local Veterans Employee Advocates
- Investigation of the possibility of finding sponsors for healthcare services for veterans and families not covered sufficiently by military benefits, to expand employment options beyond those that provide health benefits

Employment Training and Education

- Development and maintenance of a website that presents career and employment training opportunities
- Provision of assistance to service members and veterans in accessing educational benefits through the G.I. Bill
- Development of service members and veterans as entrepreneurs, using

the skill sets they have developed during Active Duty

- Identify Officers with the knowledge, skill, and compassion necessary to train veterans in workforce skills and assist them in employment searches

- Educate veterans in appropriate expectations of Department of Labor Navigators, to ensure that veterans can be effective advocates for the services they are entitled to receive

- Educate and train veterans to provide peer services and (if appropriate) clinical services to service members and veterans

CONCLUSION

Closing Remarks

Vonshurii S. Wrighten,
MDiv, MAC, CCS, SAP
Adult Program Specialist
Division of Addictive Diseases

I'm excited about where we're going from here, and you all will be included in all the documentation that is disseminated from this point. And you all will be called upon, I know for certain, at least a year from now, to come and join us at a Statewide Summit to look at what we've said here. We're going to prioritize as a State, and do all we can with all the recommendations that have been given to us, with whatever resources we have. My intent is to use this information to set Georgia up to seek funding.

We will collaborate, we will seek additional funding, and you may be called upon to say, "I'm a collaborator." When you get that call I hope that we will hear "Yes" from our Bases, "Yes" from the Department of Corrections, "Yes" from the DTAC, "Yes" from the school system, "Yes" from the Department of Veterans Services, "Yes" from the VA, "Yes" from the faith communities, "Yes" from the National Guard, "Yes" from the Community Service Boards, "Yes" from the Drug Courts, "Yes, Yes, Yes!" "Yes, we are interested in being collaborators." When we've all said, "Yes," we may be able to position ourselves for funding to do all these great and wonderful things that we're now talking about.

I know that's not the only way to do it, but by coming together as collaborators, we are increasing our ability to do this work, and decreasing the amount of resources needed from each agency. You put some in the pot, we put some in the pot, and everybody wins. We want to set ourselves up for a win/win. That's what we've come to the table about. And I'm looking forward to sharing with you. Next year we plan to be in Augusta and we'll see what we've done, and we'll write about it. And we'll let America know what we've accomplished here in Georgia.

". . .by coming together as collaborators, we are increasing our ability to do this work. . ."

APPENDIX A

Participants

Participants at the June 17, 2009 Statewide Collaborative Meeting are listed below.

Ava Allison, Clayton BHS
Nancy Anderson, Eagles Landing Christian Counseling
Sara Anderson, LPC, Solutions Community Services, Inc.,
Jeanette Aymerich, State Board, Jail Diversion
Simi Barnes, New Horizons Community Service Board
Subrinia Bennett, Family First Community Services
Linda Bennett, Phoenix Behavioral Health Services, Inc.
Ron Bowen, Community Service Board of Cobb County
Patricia Bradford, Department of Veteran Affairs
Deborah Brehm, American Veterans PTSD Treatment Centers
Monique Brooks, Uplifting the Community
Bernadine Brown, IMANI Associates, Inc.
Saundra Brown, Region 4 Planning Board - Bibb County
Kevin Buckley, Oconee Community Service Board
Dennis N. Cain, MA, LMFT, Advantage Behavioral Health Systems
COL Thomas Carden, Georgia Army National Guard
COL (R) Allen Carr, Skyline-ULTD
Brenda Cibulas, DeKalb Community Service Board
R. Denice Colson, Eagles Landing Christian Counseling
Thomas E. Cook, Jr., Georgia Department of Veterans Services
Karen Cotton-Everett, New Horizons Community Service Board
Paula Crane, Clayton Center Community Service Board
Holly Chruszcz, LCSW, Families First
Alycia Davis, Must Ministries
Ramona Deshield, DFCS - (ARC)
Amy Dupuy, Easter Seals Southern Georgia, Inc.
Erika Elvander, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
Keny Felix, Richmont Graduate University
Elizabeth Felton, Avita Community Partners
Dru Fentem, Georgia Department of Labor, Vocational Rehabilitation Program
Julia Foster-Batth, Fulton County Department of MHDDAD
Gary Fox, MA, LPC, CETR, Redeem Counseling

Vickie Fox, Redeem Counseling
Qwynn Galloway, MA, Department of Behavioral Health and Developmental Disabilities
Ari Gosa, Opioid Treatment Providers of Georgia
Robyn Garret-Gunnoe, Georgia Association of Community Service Boards
Sue Gupton, South Georgia Community Service Board
Henry Hackney, Dawn Ray, Inc.
Karen Hagan, New Horizons Community Service Board
Amanda Hall, South Georgia Community Service Board (d/b/a BHS of South Georgia)
Millard Hall, Clayton Center Behavioral Health Services
Sheila Hawkins, PhD, LPC, Serene Reflections for Holistic Behavior Wellness, LLC
Cheryl Hendrix, JFHQ SARC Family Programs and Services
Sophia Henry, Georgia Rehabilitation Outreach Inc.
Winona Holloway, Imagine Hope, Inc.
Cheryl Holt, Cobb County Community Services Board
Sara Howard, Family Nurturing Center of Georgia
Karen Howell, Maternal Substance Abuse
Wesley Hubbard, McIntosh Trail MH/MR/SA Community Service Board
Gina Hutto, LPC, MAC, GRN Community Service Board
Shawn Hutton, YTF Inc.
Adrienne Jackson, Adrienne McGabee-Jackson
Harell Jamison, Department of Veteran Affairs
Roz Johnson, South Georgia Community Service Board
Timothy Johnson, PhD, Private Practice
Gloria Jones, PhD, Heritage Foundation, Inc.
Leland Jones, Greater New Light Missionary Baptist Church
David D. Kanar, Georgia Mental Health Consumer Network
Becky Ketts, Tommy Nobis Center
Shirley LaForce-Gillians, Dept. of Veteran Affairs-Atlanta VET Center
Michael Laird, Must Ministries
George Langford, Georgia Department of Veterans Services
DeAnn Langley, Eagles Landing Christian Counseling
Barbara Lattimore, Fulton County Department of Mental Health
Renee Lee-Ferguson, Fulton County Department of MHDDAD
Teri Lewis, Families First
Teresa Liggin, Southeast GA Treatment Center
Taunya A. Lowe, PhD, The Resurgent Group of Metro Atlanta, LLC
Curtis Lucas, Marietta Vet Center
Audrey Mack, MS, LAPC, WestCare Georgia
Millard Mall, Clayton BHS
Beth Malone, Department of Behavioral Health and Developmental Disabilities
Peter McCall, CareForTheTroops, Inc.

Gregory McCollugh, Fulton County Department of MHDDAD
M. McGukin, Angie Eagle's Landing Christian Counseling Center
Stephanie McKay, Must Ministries
Brenda Medows, Hope4Heroes
William "Bill" Menefee, BA, Ret. Mil., Imani House, LLC
Nancy Moore, Families First
Angela Mooss, PhD, CPH, Georgia State University
Pathological Gambling Project
Joy Moseri, Newport Integrated Behavioral Healthcare Inc.
Christi O'Hara, Red Cross
Robyn Olivo, Creative Consulting Services
Shelli O'Steen, GPA Treatment of Macon, Inc
Laurie Ott, Central Savannah River Area (CSRA)
Wounded Warrior Care Project
Darrell Partee, Georgian National Guard
LaTonya Patterson, Georgia Mentor
Amber Payne, Family Nurturing Center of Georgia
Sherri Peavy, Hodac, Inc.-Helpline Georgia
Ayana Perkins, MA, MS, Georgia State University
Pathological Gambling Project
Bob Poston, Good Shepherd
Brenda J. Davis Rowe, PhD, Department of Behavioral Health
and Developmental Disabilities
Edward Ruffin, River Edge Behavioral Health Center
Onaje Salim, LPC, MAC, CCS, Department of Behavioral Health
and Developmental Disabilities
Pamela Schuble, Behavioral Health Link
Christopher Sheffield, Heritage Foundation, Inc.
Diane Sherman, PhD, private practice
Emily Simerly, GA Diagnostic & Classification Prison
Marcie Sitton, Georgia Department of Labor/ Voc Rehab Program
Robert H. Smith, Dynamic Interventions
Dr. Dannetta Sparks, Harvestlodge Homes and Services
for Children & Families
Melva Steps, MBA, Georgia Administrative Office of Courts
Amy Stevens, EdD, LPC, Georgia National Guard
Patricia Strooe, National Alliance on Mental Illness
Lee Stuart, Warrior Family Program
Tammy Varnadore-Taylor, Dynamic Interventions
Jennifer Teague, Eagles Landing Christian Counseling
Senita Thorne, Georgia Department of Labor
Jeanette Tolbert, Hope4Heroes
Elaine Tophia, PhD, Private Practice
Kerry Traviss, LMSW, CAAC, Atlanta VA Medical Center
James A. Vaughns, MS, LPC, CCS, MAC, CACII, The Crestwood Group

Jeannine Vinson, Atlanta Veterans Administration Medical Center
Dr. Richard Voyles, Conflict Resolution Academy, LLC
Rosemary Wachtel, LCSW, Families First
Mark Wagemaker, LPC, Solutions
David Wallace, New Horizons Community Service Board
Martina Watson, Person to Person Consulting
Francis Wells, Eastman Youth Developmental Campus
Tousha West, LCSW, Atlanta VAMC
Sasha White, Uplifting the Community
Natasha Whitfield, PhD, Atlanta VAMC
Kimberly Williams, Pineland MH
Wardfell Williams, New Horizons Community Service Board
Yulanda Williams, Georgia Mentor
Deborah M. Wilson, EdD, LPC, NCC, ICADC, Imani House, LLC
Penny T. Wilson, PhD, Hope4Heroes
Russell Wilson, Oconee Community Service Board
Patricia Winter, Phoenix Behavioral Health Services, Inc.
Peggy Withrow, Tommy Nobis Center
Vonshurii S. Wrighten, M.Div., MAC, CCS, SAP, Department of Behavioral Health and Developmental Disabilities
Jennifer Zorland, PhD, CPH, Georgia State University Pathological Gambling Project

APPENDIX B

More Slide Handouts

The four plenary speakers imparted as much knowledge as possible in the brief time allotted, but the information they had brought with them would have taken far longer to present. Fortunately, they contributed their slides for inclusion in this document.

"Prevention for Young Adults Ages 18-25 In the Military Service," *Brenda J. Davis Rowe, PhD, Director of Prevention Services and Programs, Division of Public Health, DBHDD*

"The Warrior Family Program: Georgia's Veterans Helping Veterans," *Lee Stuart, Founder and Director, Warrior Family Program*

"Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury: An Overview," *Erika Elvander, Advocacy Program Analyst, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury*

"Augusta, GA: Regional Satellite for Warrior Care," *Laurie Ott, Executive Director, Central Savannah River Area (CSRA) Wounded Warrior Care Project, Augusta, Georgia*

> To access these presentations please visit the Southeast ATTC at **www.ATTCnetwork.org** and click on the Regional Center link: Southeast ATTC.

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