Conference Report

**Prepared by the
Mid-Atlantic Addiction Technology Transfer
Center at Virginia Commonwealth University**

and

the Virginia Department of Veterans Services

January 2008

Funding for this conference was made possible in part by TI13415-07 from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

We do not have the ability to affect military members while they are on active duty;

but, we do have complete ability to affect how they are treated

when they return to the Commonwealth.

Governor Timothy Kaine
Commonwealth of Virginia

Table of Contents

Executive Summary 4

Introduction 6

Seven Key Actions to Meet the Needs of Veterans, Members of the National Guard and Armed Forces Reserves, and their Families 10

Action 1: Recognize and Accept the Impact of Deployment 12

Action 2: Eliminate Stigma 14

Action 3: Reach and Connect with Veterans and their Families 16

Action 4: Build a Service Delivery Infrastructure 20

Action 5: Make Healthcare Accessible 22

Action 6: House Veterans; Prevent Homelessness 24

Action 7: Hire Veterans 26

Epilogue 28

Appendix 1: Virginia is for Heroes Conference Planning Committee List 30

Appendix 2: Participants List 32

Appendix 3: Conference Presenters and Staff 38

Appendix 4: Conference Agenda 40

Appendix 5: Workshop Recommendations 46

Executive Summary

On October 17, 2007, the Mid-Atlantic Addition Transfer Technology Center (ATTC) at Virginia Commonwealth University and the Virginia Department of Veterans Services hosted *Virginia is for Heroes*, a state-wide conference on polytrauma and combat/operational stress among veterans of the Global War on Terror. The conference's primary goals were to:

1. Raise awareness of the impact of polytrauma and combat/operational stress injuries on military service members, veterans, families, employers and the community; and
2. Create a road map to mobilize resources in our communities and at all levels of government.

The conference brought together clinicians, educators, employers, state and federal government representatives, members of the faith-based community, criminal justice professionals, policy makers, and the media, and included veterans and active duty service members including top leadership of the Virginia National Guard.

Through workshops and panel discussions, participants determined that to adequately meet the needs of returning veterans, members of the National Guard and Armed Forces Reserves[1] and their families, political leaders, government agencies at all levels and community organizations—working as partners—must take action to:

1. Recognize the impact of deployment on military service personnel and their families
2. Eliminate stigma associated with combat/operational stress injuries
3. Reach and connect with veterans and their families
4. Build a service delivery infrastructure
5. Make healthcare accessible
6. House veterans; prevent homelessness
7. Hire veterans

In their recommendations, conference participants made it clear that caring for our returning veterans and their families requires active partnerships between federal, state, and local governments and community organizations. These government agencies and organizations must function as first responders to veterans and their families[2] so that there is No Wrong Door to which they can present for accurate information and effective service. Initiatives addressing veterans issues must be sustainable and their effectiveness evaluated. Measures put in place today to address current needs among our veterans and their families are the cost-avoidance strategies for tomorrow. We must be willing to make a long-term commitment to these men and women—a commitment that extends over the remainder of their lifetimes and ensures that they and their families have access to the educational and employment opportunities, medical care, prosperity and well-being that ought to be enjoyed by all citizens.

[1] The term *veterans*, as used in this report, includes members of the National Guard and Armed Forces Reserves.
[2] Throughout this report, the term *first responders* is used to refer to federal, state, and local government agencies, community and other organizations that provide services to veterans. Most of these service providers serve a broad clientele that includes the veteran population.

Introduction

On October 17, the Mid-Atlantic Addiction Technology Transfer Center (ATTC), located at Virginia Commonwealth University, and the Virginia Department of Veterans Services (DVS) hosted a day-long conference on polytrauma and combat/operational stress in military service personnel returning from the Global War on Terror. The conference took place at the Lewis Ginter Botanical Gardens in Richmond, Virginia. The nearly 200 conference participants included the Governor; commissioners of the Virginia Departments of Veterans Services, Rehabilitation Services, and Mental Health, Mental Retardation and Substance Abuse Services; a delegate from the Virginia legislature; leaders from all branches of the military; leaders in local mental health organizations; substance abuse and suicide prevention specialists; college and university experts; leaders in law enforcement, emergency services, faith-based organizations, education, courts and correctional facilities; and specialists in brain injury, polytrauma, and psychiatry from two VA Medical Centers.

In the workshops and interactive panel discussions, conference participants identified seven key actions that must be taken in order to meet the needs of veterans and their families. Although these actions represent seven distinct dimensions, they are all interrelated, and one cannot be addressed without addressing the others.

1. Recognize the impact of deployment on military service personnel and their families
2. Eliminate stigma associated with combat/operational stress injuries
3. Reach and connect with veterans and their families
4. Build a service delivery infrastructure
5. Make healthcare accessible
6. House veterans; prevent homelessness
7. Hire veterans

To effectively serve veterans, we must cultivate interoperability among first responders (the federal, local, and state government agencies and community and other organizations that serve veterans) to effectively create a No Wrong Door[3] approach to service delivery. With a No Wrong Door approach, no matter where the veteran first touches government or the community, he or she will be evaluated in terms of a continuum of service model and assisted with obtaining needed services from all of the appropriate first responders. Service providers must migrate from the existing stovepipe approach where the provider looks at a veteran only in terms of that provider's area of expertise to a continuum of service approach. In a continuum of service approach, providers look at individuals holistically, in terms of all of the services needed to make them and their families effective members of their communities.

[3] No Wrong Door is a collaborative public/private effort among Virginia state agencies, local governments, and local providers. This policy initiative, integrated through information technology (IT), will collect client data using the Uniform Assessment Instrument. In addition, an electronic system is being designed to maintain a directory of service providers that will be used to coordinate the best available services for clients, track referrals and service delivery, coordinate services, measure outcomes, and evaluate gaps in service.

Key to creating interoperability among first responders is increased awareness of the issues that veterans face, such as polytrauma, combat/operational stress injuries, and traumatic brain injury. Awareness can be raised through traditional approaches such as the media as well as through a host of other activities such as cross training for staff in first responder organizations. Awareness raising must target and help dispel the stigma associated with combat/operational stress injuries, especially post traumatic stress disorder (PTSD). No matter what tools are used to raise awareness, the effort must be aggressive and must push information to veterans, their families, and the public.

In serving veterans, case management is essential so that they and their family members have the expertise of seasoned professionals to guide them through the various systems, ensure that first responders are working cooperatively, and resolve conflicts across systems. In short, these case managers constantly advocate for the veteran and his or her family. They visualize the big picture and ensure that all parts of that picture are addressed.

It is essential that we continue to hold conferences, like *Virginia is for Heroes,* that bring together multiple disciplines to learn about veterans issues as well as the functions of their colleagues in other agencies and organizations. Also essential is training on a spectrum of topics, from cross-training on services available in other agencies to case management techniques and clinical practices. Conferences and training must be held at both state and regional levels.

With nearly 200 professionals from a wide array of disciplines participating in the *Virginia is for Heroes* conference, it is clear that there is tremendous interest in supporting our military service personnel, veterans, and their families. Our military men and women are mobilized to defend our country and have deployed to fight a war beyond our borders. Now we need to mobilize government at all levels and our communities to support those who have given the nation a blank check payable for an amount "up to and including my life."

Background

Mid-Atlantic Addiction Technology Transfer Center

The Mid-Atlantic Addiction Technology Transfer Center (ATTC), located at Virginia Commonwealth University, serves to improve the quality of addiction treatment and recovery services within its region by facilitating alliances among policymakers, treatment agencies, clinicians, consumers and other stakeholders and connecting them to the latest research and information through technology transfer activities. Through a variety of materials, programs and courses, the ATTC enhances the knowledge and skills of all professionals working the front lines of addiction and mental health treatment.

The Mid-Atlantic ATTC creates linkages to build a network of infrastructures for unifying professional leadership, for creating and supporting high-standard training and education, for developing cohesive responses to legislative initiatives, for activating grassroots support for the field, and for enhancing the professionalization of addiction treatment.

Virginia Department of Veterans Services

The Virginia Department of Veterans Services operates 22 benefit services offices where representatives assist veterans and their family members in filing claims for federal veterans benefits. The agency

operates two veterans cemeteries: the Virginia Veterans Cemetery in Amelia and the Albert G. Horton, Jr. Memorial Veterans Cemetery in Suffolk. A third state veterans cemetery in Dublin is in the initial stages of development. DVS operates the Virginia Veterans Care Center (VVCC) in Roanoke. The VVCC is a 240-bed long-term care facility offering nursing and domiciliary care for veterans. The 160-bed Sitter & Barfoot Veterans Care Center is located in Richmond. The agency also certifies that post-secondary educational institutions meet G.I. Bill funding and eligibility requirements, enabling veterans and family members to pursue educational opportunities.

Impetus for the *Virginia is for Heroes* conference came out of the Mid-Atlantic ATTC's mission to provide substance abuse services and their work with veterans issues in North Carolina as well as Governor Kaine's Executive Order 19. This executive order directed DVS and other state agencies to find ways to offer new, expanded or customized services that will meet the educational, health care and social service needs of Virginia's veterans, giving special attention to disabled veterans.

Conference Goals

- Raise awareness of the impact of polytrauma and combat/operational stress injuries on military service members, veterans and members of the National Guard and U. S. Armed Forces Reserves, families, employers, and the community.
- Create a road map to mobilize resources in our communities and at all levels of government.

Conference Format

After introductory remarks, the conference began with two general sessions. In the first, "Boots on the Ground," Colonel Jenny M. Holbert, USMC, relayed her personal experience with post traumatic stress disorder (PTSD) as the child of a WWII veteran who suffered from PTSD, as the wife of a deployed Marine, and her own personal experience following her deployment to Iraq. Captain William Nash, M.D., a Navy psychologist, followed with a clinical explanation of combat/operational stress, using Colonel Holbert's story to illustrate the manifestations and effects of combat/operational stress behavioral health disorders.

In the second session, Harold Kudler, M.D., Manager, VISN 6 Mental Health Service Line and Duke University, described the services provided by the U. S. Department of Veterans Affairs. In his presentation, Dr. Kudler defined polytrauma as a combination of traumatic brain injury plus other major injuries. He provided explanations for post traumatic stress disorder (PTSD), traumatic brain injury (TBI), and combat and operation stress response.

Following the presentations, participants moved to six work groups:

1. Child advocates and educators
2. Veterans service organizations and other nonprofits
3. Criminal justice system
4. Faith-based leaders
5. Clinical
6. Public policy

Each workgroup began with a 15 minute presentation by a subject matter expert. In a facilitated discussion, each workgroup compiled a list of the most pressing issues and recommendations.

The afternoon began with a presentation by George Lamb, OIF/OEF Outreach Coordinator for McGuire VA Medical Center. Mr. Lamb reviewed the VA's current outreach initiatives.

David Cifu, M.D., Physical Medicine and Rehabilitation, McGuire VA Medical Center, followed with a synthesis of the recommendations produced by the workshops. Workshop presenters assembled on stage as a panel and discussed with audience members some of the recommendations and responded to audience questions. The panel discussion concluded with a summary of key points by Dr. Cifu.

Dr. James Reinhard, M.D., Commissioner of the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, told participants that despite their apparent differences—veterans and non-veterans, different service branches, local service providers and state and federal administrators, and the many other differences—participants have more similarities than they have differences. Dr. Reinhard then introduced Governor Timothy Kaine.

In closing the conference, Governor Kaine emphasized that while we do not have the ability to affect military members while they are on active duty, we do have complete ability to affect how they are treated when they return to the Commonwealth.

Seven Key Actions to Meet the Needs of Veterans, Members of the National Guard and Armed Forces Reserves, and their Families

Following the two general sessions, conference participants split into six workshops that addressed public policy, clinical practices, child advocates and educators, faith-based professionals, criminal justice professionals, and veteran services organizations and other nonprofit organizations. The workshops were scheduled for an hour and 15 minutes; however, some continued working through lunch. In each workshop, a subject matter expert made a 15 minute presentation on the topic. A facilitated discussion followed the presentation.

Common themes and recommendations emerged from the workshops. These recommendations encompassed seven critical actions that government at all levels and communities must take to care for our returning veterans.

1. Recognize the impact of deployment on military service personnel and their families
2. Eliminate stigma associated with combat/operational stress injuries
3. Reach and connect with veterans and their families
4. Build a service delivery infrastructure
5. Make healthcare accessible
6. House veterans; prevent homelessness
7. Hire veterans

An overview of each action is provided as well as the top recommendations from the workshops. Comprehensive lists of recommendations for the key actions are provided in Appendix 5.

Action 1
Recognize the Impact of Deployment

Military deployment affects the warfighters, their families, and their communities. Today's military service personnel face longer deployments, repeated deployments, and more exposure to combat than previously experienced at any other time in U. S. history. Plus, the National Guard and reserves make up a significant percentage of the combat force—roughly 40 percent. Warfighters routinely spend more than a year away from family and traditional support systems, living in a foreign and hostile culture and facing prolonged exposure to combat, acts of terrorism, and daily life in an environment of fear. These factors all increase the probability that the war fighter will experience some form of injury.

An additional factor involves the warfighter's return to civilian life. In less than 24 hours, military service personnel go from the stress of a combat zone—where any passenger vehicle could be carrying insurgents and a pile of trash could hide an improvised explosive device (IED)—to civilian life where the wars in Iraq and Afghanistan are little more than stories on the evening news. Prior to the war in Vietnam, warfighters returned from deployment with their units, and travel time was measured in days and weeks rather than in hours. During the return journey, they had the opportunity to decompress and discuss their experiences with their buddies. For today's National Guard and Armed Forces Reserves, the shock of return can be even more profound since they do not meet up again with their colleagues for 90 days.

While deployment has a significant impact on the war fighter, the brunt of deployment is also felt by his or her spouse, children, and parents. Following deployment, the family unit is split, family members must take on new roles, and spouses must alone shoulder the responsibilities that were previously borne by both the spouse and the war fighter. Income may be cut if the deployed service member had to leave a high paying job for active duty, and numerous small business have been lost as a result of active duty deployment. In addition to these tangible adjustments, there is the family's anxiety and uncertainty about the war fighter's safety and well-being and, likewise, the war fighter's anxiety and uncertainty about the safety and well-being of his or her family. While the war fighter generally gets frequent information about the well-being of his or her family, family members frequently are kept in the dark for extended amounts of time about the well-being of their war-fighter.

Children of U. S. military service personnel may be some of the most vulnerable and often overlooked casualties of the Global War on Terror. Initially, they must cope with the stress resulting from a parent's absence during deployment. While children are often quite resilient, researchers have shown that support from the parent remaining at home is a critical factor for the successful adjustment of these children. Yet, studies have shown that the rates of child neglect and abuse increase among the spouses of deployed military. The children of single parents, divorced parents, and dual military couples are particularly at risk because these children may lack the family support necessary to ensure successful adjustment to their parent's deployment.

Once the parent returns, children face new challenges. If the parent was wounded, physically or emotionally, children must cope with the sight and effect of the parent's injuries and daily needs resulting from those injuries. They must cope with changes in the parent's personality and changing

priorities within the home. They may become victims of parental abuse and/or neglect. And, in their struggle to survive, they may develop unhealthy coping mechanisms.

The classroom may be the most effective point to recognize children in trouble and intervene; however, educators must recognize the warning signs, understand the effects of parental deployment, and have the training and tools necessary to assist these children.

Deployment requires shifting adaptations by both the war fighter and his or her family and supporters throughout the deployment cycle. The U. S. Army and other service branches have developed combat and operational stress response programs, such as Battlemind, which teach adaptive strategies to both warfighters and their families and supporters. Problems occur, however, when the warfighters or family members and supporters become overwhelmed and abandon the adaptive strategies. In the long-run, the nature of the events experienced by warfighters, their families and supporters, and individual levels of tolerance will have more impact on these individuals' ability to adjust to and cope with the effects of deployment than the length of the deployment.

Recommendations

1. Service providers and policy makers must understand the nature of the deployment cycle and recognize that warfighters and their families and supporters experience different events and have different needs throughout the deployment cycle.
2. Service providers and policy makers also must understand that the needs of warfighters and their families cover the spectrum of social services, from behavioral and other forms of health care to financial, housing, and employment assistance.
3. Resources above the current level will be needed to address the issues facing warfighters and their families and to provide the services that they need to successfully reintegrate into their communities.

Action 2
Eliminate Stigma

Before we can care for any veteran and his or her family, we must reduce the long-standing stigma associated with injuries such as combat/operational stress and traumatic brain injury (TBI). Perhaps one of the best illustrations of stigma can be seen in the dramatization of a real-life episode presented in the movie *Patton.* In this scene, General Patton slaps a soldier who expresses his anxiety about battle and calls the soldier a coward.

This attitude toward troops who "lose it" has prevailed through both World Wars, Korea, Vietnam, the first Gulf War, and the Global War on Terror. Medical researchers have established that combat/operational stress and its medical manifestations such as PTSD, depression, and anxiety are genuine medical conditions, not manifestations of laziness, cowardice, and weak character. Yet, the stigma is deeply rooted and military service personnel routinely report a reluctance to acknowledge and seek treatment for symptoms of combat/operational stress for fear of negative career implications (both in and out of the military), ostracization, and their own negative biases. The stigma associated with combat/operational stress, post traumatic stress disorder, and TBI has been identified as the number one barrier to military service personnel, veterans and their families seeking the care that they need, deserve and have earned.

Recommendation

1. Conduct an outreach campaign across the first responders—the partnering agencies that serve veterans and members of the National Guard and Armed Forces Reserves. This campaign should include:
    - Awareness and sensitivity training for military service personnel, their families and first responders;
    - Peer support for veterans and their families;
    - Holding individuals accountable for their behavior;
    - Working with the media and through other channels to increase awareness of and publicize the facts about combat/operational stress disorders and TBI.

Action 3
Reach and Connect with Veterans and their Families

Creating services to care for veterans and their families is only the first step; service providers and policy makers must be as proactive as military recruiters in seeking out veterans and their families and ensuring that they receive the care they need. This must be done through aggressive outreach efforts as well as through a service delivery system that proactively screens all clients for possible veteran status. Once veterans are identified, care must be taken to ensure that they successfully navigate the system and receive the full array of services that they need and the benefits that they have earned.

Reaching Out

As service providers and policy makers, we cannot sit back and expect veterans and their families to find the information, services, and support that they need. Many may not be physically, mentally, or emotionally able to seek help. Others may be overwhelmed by the sheer complexity of state and federal government agencies and the plethora of organizations volunteering to assist veterans. Difficulty finding help may be exacerbated in rural areas where government agencies and other resources may be located hundreds of miles away.

On the flip side of the coin, from the perspective of government agencies, service organizations, and nonprofits, their resources can be more effectively utilized through systematic and structured tools designed to identify veterans, evaluate their situation and assess their needs, and systematically match them with the appropriate information, resources, and services.

Outreach efforts must be targeted not only to veterans and members of the National Guard and Armed Forces Reserves and their families, but also to other stakeholders—the numerous government agencies that provide health, social, housing, and criminal justice services because many of these agencies and their employees may not realize that they, too, are stakeholders in the effort to assist veterans and their families. Outreach also can be extended to primary care providers, pediatricians, and the financial services industry.

Recommendations

1. Task the Virginia Department of Veterans Services (DVS) with mapping the process that military service members experience in transitioning from the DoD to the VA and to state and community service providers.
2. Task DVS with identifying key service providers at the local, state and federal levels of government and in communities that provide services needed by veterans and their families. These agencies and organizations will constitute a network of first responders to veterans and their families. Once identified, DVS should promote awareness of veterans issues such as polytrauma, combat/operational stress injuries, and traumatic brain injury; cross-train staff in these agencies and organizations; and develop memorandums of understanding to create a No

Wrong Door approach to service delivery and to build a continuum of service for veterans and their families.

3. Task DVS with ensuring that an infrastructure is developed that systematically identifies veterans and matches them with the appropriate information, resources and services.
4. Conduct increased outreach to veterans, their families, first responders and the public about the issues facing veterans and the resources available to assist them. This can be accomplished through traditional avenues such as public service announcements, paid advertising, and media relations as well as through non-traditional avenues such as the faith-based community.

Connecting with Veterans and Their Families

Veterans and their families blend into their communities and become indistinguishable from other individuals and their families. Yet, because of their military service, they may have unique needs and circumstances and may qualify for special benefits and services. The need for help may not become apparent until the veteran ends up in the social services, mental health, or criminal justice systems and even then may go undetected because those programs don't routinely ask about veteran status. To effectively serve veterans and their families, providers must recognize the unique circumstances and needs of each potential client and know how to link him/her with the right resources. This can be accomplished in a simple screening process by which service providers at all levels of government and nonprofit organizations ask their clients if they are veterans or if they are the spouse or dependent of a veteran. This basic level of screening is a critical component in building an effective No Wrong Door service delivery philosophy and system.

Many people assume that veterans receive all necessary care through the U. S. Department of Defense (DoD) or Department of Veterans Affairs (VA); but, this assumption is not necessarily accurate. The stigma associated with reporting mental health problems is so powerful that many will not turn to DoD or VA for help. Veterans qualify for care and benefits based on numerous and complex factors established by Congress, DoD and VA. Some combat veterans of Iraq and Afghanistan have already gone past their two year window of free access to VA care for deployment-related conditions. Finally, VA is not authorized to provide direct services to family members. For these reasons, DoD and VA cannot shoulder total responsibility for the care of veterans and their families.

In order to meet the needs of returning service members and their families and to properly honor their service, we must *all* be first responders. If we are to build a system in which there is No Wrong Door, there must be a partnership between federal, state, and community governments and services that provides screening; information; educational, vocational, and clinical services; and other resources needed to promote productive and satisfying lives.

Recommendations

1. Identify and create interoperability among government agencies (local, state, and federal) and other organizations that serve veterans—these organizations are the first responders to veterans and their families. All first responders should be aware of each other's services and how these services can be used to assist veterans, resulting in a No Wrong Door approach to service delivery.

2. In screening tools used by first responders, include a question that asks the applicant if he/she is a veteran or the family member of a veteran. In addition, train first responders such as law enforcement and emergency medical services personnel to ask if the individual is a veteran or family member of a veteran.

Action 4
Build a Service Delivery Infrastructure

To effectively serve veterans and their families, agencies at all levels of government and nonprofit organizations must operate in an environment of interoperability where the goal is to provide a portfolio of resources and services tailored to the specific needs of a veteran and his or her family. This can be accomplished through integrated management of service delivery across multiple agencies and organizations and by creating an integrated information technology system to support service providers.

Integrated Management and Support

Undoubtedly, there are dozens, if not hundreds, of government agencies and community and nonprofit organizations offering assistance and services to veterans and their families. However, no single catalog or directory of these service providers and resources exists. Thus, finding the help needed often becomes a hit-or-miss venture for veterans and their families. Further, navigating systems such as the VA can be difficult and frustrating for healthy and fully-functional individuals, and potentially impossible for wounded veterans and their family members.

Integrated management of services across multiple agencies and organizations provides veterans with one or more knowledgeable and experienced professionals who navigate the veteran and his or her family through the various systems, who ensure that different service providers are working cooperatively and who resolve any conflicts across systems, who gather information and identify additional available resources, and who continuously advocate for the veteran and family members. These professionals, sometimes referred to as case managers, are capable of visualizing the big picture for the veteran and his or her family, thereby ensuring that all components of the veteran's needs are met, from healthcare and rehabilitation to housing, financial assistance, and ongoing care.

Recommendations

1. Once a network of first responders (agencies and organizations that provide services to veterans) has been identified, provide training to employees who function as case managers. This training should assist case managers in understanding the functions, services, and protocols used in a variety of agencies that serve veterans so that these individuals can work effectively with their counterparts in other agencies. When multiple case managers are involved in a veteran's case, the case managers should develop a treatment plan for the veteran, thereby spelling out the steps in the veteran's treatment and clarifying the roles and responsibilities of each case manager and his or her respective agency.
2. Task DVS with ensuring that an integrated management and support system is developed across state, local, and federal agencies, creating one-stop shopping for serving the needs of veterans and their families.

System Integration

To complement and support integrated management and support, information technology (IT) systems in agencies at all levels of government must be integrated. Effective IT integration between agencies reduces bureaucratic red tape for veterans using the services of the agencies; reduces data entry volume, data entry errors and data storage requirements; and, ultimately, improves data security. Effective IT integration between government agencies is essential for implementation of a No Wrong Door service delivery system. It will build an integrated system that facilitates collaboration across the agencies and organizations that serve as first responders, facilitating collaboration, creating an information infrastructure, and allowing seamless service to veterans by multiple agencies.

Recommendations

1. Although system integration is a long-term technological goal, significant progress can be achieved in the short-term by holding more conferences like the *Virginia is for Heroes Conference* to begin making connections between agencies, raising awareness among agencies of their role as first responders, and establishing an exchange of information about agency services and resources.
2. Explore the concept of building systems of service. Systems of service provide services not in the traditional terms of different disciplines, but in terms of a continuum that provides an array of services specific to each individual's unique circumstances and needs. Web technology enables information providers to build pages "on the fly." That is, information is compiled and presented to the viewer based on the viewer's demographics and personal preferences and interests. Likewise, systems of service build individualized packages of service based on the individual's unique circumstances and needs.
3. Task DVS with ensuring that the agency's future technological enhancements support an information technology infrastructure that enables collaboration, data exchange, and service delivery among first responders.
4. Task the Secretary of Health and Human Resources with ensuring that the Department of Mental Health, Retardation, and Substance Abuse Services (DMHRSAS), DVS, and other first responders are active leaders in the Commonwealth's No Wrong Door initiative.

Action 5
Make Healthcare Accessible

Polytrauma and combat/operational stress are among the terms most often applied to the healthcare needs of military service personnel returning from the Global War on Terror. Polytrauma refers to injuries to more than one physical region or organ system which result in physical, cognitive, psychological, or psychosocial impairments and functional disability. Some components of polytrauma among returning service members and veterans include traumatic brain injury (TBI), fractures, amputations, burns, hearing loss, and visual impairment.

Combat/operational stress refers to a wide range of behavioral health conditions including (but not limited to) severe anxiety, irritability, trouble concentrating, social and emotional withdrawal, depression, substance abuse, and post traumatic stress disorder (PTSD). Most returning service members will not develop a diagnosable mental illness but all combat veterans and their families face important readjustment issues upon their return home. Evidence-based care is available but is often not accessed. The stigma associated with reporting mental health problems is the single greatest barrier to appropriate healthcare. Long-term complications may include job loss, family breakdown, homelessness, incarceration, and suicide.

Polytrauma and combat/operational stress have significant clinical, social, and economic impact on citizens in every community of the Commonwealth. Key questions include: Given the cultural barrier against reporting post deployment mental health issues in DoD and VA settings, how can needed healthcare services be most effectively delivered to new veterans and their families? How can we develop the necessary number of appropriately trained healthcare providers and an effective system to triage the right patients to the right services at the right time? How can DoD, VA, the Commonwealth, and the community best work together to meet the needs of new combat veterans and their families?

Recommendations

1. Identify and disseminate clinical practice guidelines for the assessment and treatment of polytrauma and combat/operational stress responses including PTSD, major depression, and substance abuse.
2. Alert and train state and community providers about military culture and post deployment health issues including TBI, PTSD, major depression, and substance abuse and about the adaptive responses to deployment which are routinely encountered by returning service members/veterans and their families
3. Maximize the number of TRICARE providers in communities across the Commonwealth.
4. Develop a coordinated partnership across the DoD/VA/state and community continuum of medical care (including both healthcare and benefits assistance).
5. Identify and train community services board (CSB) liaisons in support of this partnership.
6. Engage other natural formal community support systems including congregational leaders, clinical pastoral counselors, school personnel, college campus veterans benefits advisors, court and correctional personnel, law enforcement, employers and employee assistance programs, and

veterans service organizations in connecting service members/veterans and their families with the right help

7. Coordinate this partnership through the Virginia Department of Veterans Services.
8. Institute a public education campaign supported by public service announcements.
9. Establish a 24/7 toll-free information/triage service and companion website for veterans, their families, their providers and community partners (supported by a database identifying DoD/VA/state and community services by type and by location).

The heart of these recommendations is to establish a public health approach that reaches out proactively to service members, veterans and their families in order to engage them before mounting problems undermine their health, their careers, their homes, and their communities.

Action 6
House Veterans; Prevent Homelessness

According to the U. S. Department of Veterans Affairs, male veterans are 1.3 times more likely to experience homelessness than their civilian counterparts, and female veterans are 3.6 times more likely to experience homelessness than their civilian counterparts. Veterans are particularly at risk for homelessness because they may struggle with physical disabilities, post traumatic stress disorder or other combat/operational stress illnesses. These conditions, as well as multiple and extended separation from home and family, can wreak havoc on their family life, their support networks, and their ability to maintain employment. Additionally, the effect on members of the National Guard and Armed Forces Reserves may be even more pronounced. Many of these individuals left their jobs or businesses to go on active duty deployment significantly reducing their income and creating financial strain which can result in the loss of housing.

The National Coalition for Homeless Veterans estimates that nearly 900 veterans in Virginia are homeless, approximately one-third of all homeless individuals. However, these counts do not take into consideration veterans who are staying with friends or relatives but who, none-the-less, are unable to afford or maintain housing for themselves and their families. Homelessness must be addressed as a continuum—ranging from emergency shelter, to transitional housing, and, most importantly, affordable permanent housing.

Recommendations

1. Adopt the Housing FIRST model as a best practice to help veterans and their families at risk for and already experiencing homelessness. The Housing FIRST model operates under the premise that families are more responsive to social service and other forms of assistance after they are in permanent housing.
2. Ensure that Virginia takes full advantage of federal funding for housing and for homeless veterans.
3. Provide financial education to veterans, members of the National Guard and Armed Forces Reserves, and their families.
4. Develop tools to identify veterans and their families at risk for homelessness and create early intervention programs for these veterans and their families.

Action 7
Hire Veterans

Veterans offer a wealth of skills and abilities, often developed through their military experience, making them outstanding employees. And, employers are clamoring for the skills and personal attributes that veterans bring to the work place—technical training, leadership, discipline, and team spirit.

According to a residential survey conducted by Waldman Associates and Reda International in 2003[4], slightly more than 23 percent of veterans in the household population were either purchasing or starting a new business or were considering purchasing or starting up a business. Nearly 72 percent of these potential veteran entrepreneurs intended to hire at least one employee. Clearly, there is a demand for veterans in the workplace and veterans as entrepreneurs can and do have a significant impact on the economy.

Multiple state and local agencies in Virginia, plus federal agencies and private sector organizations, offer career and employment-related assistance to veterans, disabled veterans, and employers. Rehabilitation, training and education programs are offered as well. However, these programs are rarely integrated or linked and little attention is given to employment of spouses and dependents of veterans.

Are there enough veterans available to meet the demands of employers, and are there enough employers and positions to meet the employment needs of returning veterans? Where is the disconnect and why are the needs of both employers and veterans going unmet?

Recommendations

Discussion among conference participants supported the EO 19 initiative to create a task force to examine workforce development for veterans. This task force has been established by the Secretary of Public Safety and is charged with developing recommendations for a comprehensive workforce development initiative for veterans in Virginia, with special emphasis on veterans with disabilities and those returning from the Global War on Terror. The goals of the Task Force are to develop recommendations to (1) effectively match veterans with employers and positions, (2) encourage public and private sector employers to hire veterans, (3) encourage public and private sector employers to hire veterans with disabilities, and (4) develop a more comprehensive technological approach to better inform veterans on where and how to obtain job and training opportunities in the private sector. The Task Force will present a comprehensive report, including legislative and budgetary recommendations, to the Secretary by September 1, 2008.

[4] *The Small Business Economy: A Report to the President*. Office of Advocacy, U.S. Small Business Administration. United States Government Printing Office, 2005.

Epilogue

The Virginia is for Heroes conference provided substantial research material and recommendations for substantive actions that first responders in Virginia can take to address the needs of and serve the Commonwealth's veterans and their families. As demonstrated by the conference, there is significant interest in serving veterans and their families, and there is support from a wide variety of disciplines as well as from Governor Kaine and the Secretaries of Public Safety and Health and Human Resources. Professionals attending the conference were able to share insights about their work with veterans and learn about services for veterans delivered by their colleagues in other agencies. This exchange increased awareness about veterans issues and, for some, brought home the fact that they too are stakeholders in the effort to assist veterans returning from the Global War on Terror.

Since the Virginia is for Heroes conference was held in October, several initiatives have been started.

1. A Wounded Warrior Mental Health bill before before the 2008 General Assembly proposes establishing a state-wide program to provide first class mental health treatment and rehabilitative services for PTSD/TBI injuries to our Wounded Warriors and their families. Creation of a statewide coordinator housed in DVS will provide the oversight necessary to ensure the efficient utilization of federal, state, and private resources. Mental health initiatives like the Wounded Warrior Mental Health Bill are strongly supported by the Joint Leadership Council of Veterans Service Organizations, one of three boards that provides guidance to the Virginia Department of Veterans Services.

2. The Secretary of Public Safety has established a task force charged with developing recommendations for a comprehensive workforce development initiative for veterans in Virginia, with special emphasis on veterans with disabilities and those returning from the Global War on Terror. The goals of the Task Force are to develop recommendations to (1) effectively match veterans with employers and positions, (2) encourage public and private sector employers to hire veterans, (3) encourage public and private sector employers to hire veterans with disabilities, and (4) develop a more comprehensive technological approach to better inform veterans on where and how to obtain job and training opportunities in the private sector. The Task Force will present a comprehensive report, including legislative and budgetary recommendations, to the Secretary by September 1, 2008.

3. Members of the planning committee responsible for hosting the Virginia is for Heroes conference, in partnership with the Newport News/Hampton Community Services Board, are planning the first regional conference. This regional conference is slated for March 26 at Fort Monroe. Planning committee members hope to host similar regional conferences around the state throughout 2008.

4. Recommendations from conference participants support many of the recommendations made in the report submitted to Governor Kaine in May 2007 in response to Executive Order 19. DVS continues to work on establishing the relationships and laying the foundations necessary to implement these recommendations.

Appendix 1: Virginia is for Heroes Conference Planning Committee List

Anne Atkins
Director of Communications
Virginia Department of Veterans Services

Rosemary Bosher
Global War on Terrorism Technician
Dept of Veterans Affairs Outreach Center

Vincent Burgess
Commissioner
Virginia Department of Veterans Services

David Cifu, MD
Chief of Rehabilitation
Hunter Holmes McGuire VA Medical Center

Steven Danish, PhD
Director, Life Skills Center
VCU Department of Psychology

Zach Dameron, MD
Vice Chair of Clinical Affairs
Department of Psychiatry and Neurobehavioral Sciences
University of Virginia School of Medicine

James Evans, MD
Medical Director, Off. of Health + Quality Care
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

Jenny Holbert
Joint Leadership Council of Veterans Service Organizations
Women Marines Association

Sally Holzgrefe
Heroes Conference Project Coordinator
Mid-Atlantic Addiction Technology Transfer Center
Department of Psychiatry Virginia Commonwealth University

Paula Horvatich, PhD
Director
Mid-Atlantic Addiction Technology Transfer Center
Department of Psychiatry Virginia Commonwealth University

Harold Kudler, MD
Interim Director, MIRECC
Veterans Integrated Service Network 6
Mental Health Service Line

George Lamb
OIF/OEF Outreach Coordinator
McGuire Veterans Affairs Medical Center

David McGinnis
Decision Support Manager
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

Martha Mead
Project Manager, Executive Order 19
Virginia Department of Veterans Services

Walt Phillips
Northern District Manager
Virginia Department of Veterans Services

Anthony Soltys
Board Chair
Hampton/Newport News Community Services Board

Kay Springfield
Administrative Manager
Virginia Association of Community Services Board

Susan Storti, PhD
Consultant
Rhode Island Veterans Initiative

James Thur
Executive Director
Fairfax/Falls Church Community Services Board

CDR Donald P. Troast, CHC, USN
Deputy Force Chaplain
U.S. Marine Corps Forces Command

Appendix 2: Participants List

Ed Ablard
Attorney
eablard@ablard.com

Camille Adams
Program Coordinator
Chesterfield County Day Reporting Center
evewasframed@hotmail.com

Shelby J. Assad, LCSW
OIF/OEF Program Manager
Salem VAMC
shelby.assad2@va.gov

Heather Aubain
Combined Armed Support Command, Ft. Lee
abn3916@comcast.net

Christine Baggini, MSW
Director of Family Resources
Brain Injury Association of Virginia
christine@biav.net

Sue Bailey
sbailey1@mindspring.com

Ervin A. Barksdale
Program Specialist
DMHMRSAS
ervin.barksdale@co.dmhmrsas.virginia.gov

Nancy Barnes
Private Practice
ngbarnes@aol.com

Susan Barnum
Clinician II
Dept. of Human Services, MH Substance Abuse
sbarnum@vbgov.com

Jeffrey T. Barth, Ph.D.
John Edward Fowler Professor of Clinical Psychology
Chief of Medical Psychology
Medical Director, Neuropsychology Assessment Laboratories
University of Virginia Health System
Department of Psychiatric Medicine
JTB4Y@hscmail.mcc.virginia.edu

Dorian Bell
Transition Assistance Advisor
Virginia National Guard
dorian.n.bell@ng.army.mil

Sharon Benedict, Ph.D.
Rehabilitation Psychologist
Polytrauma Rehabilitation CTL, McGuire VA MC
sharon.benedict@va.gov

John Benesek, PsyD
Clinical Psychologist, Interim Dir., PTSD Program
McGuire VAMC
john.benesek@va.gov

Roger Biraben
Director, MHSAS
County of Loudoun
rbiraben@loudoun.gov

Katharine Bloeser
Veterans Affairs Medical Center
Katharine.bloeser@va.gov

Michael B. Booker
Aide de Camp
Department of Military Affairs
michael.b.booker@us.army.mil

Rosemary Bosher
Global War on Terrorism Technician
Dept of Veterans Affairs Outreach Center
rosemary.bosher@va.gov

Christine Bott
Clinician
Center for Child & Family Services
gigibott@aol.com

Colbert L. Boyd
Chief Operating Officer
Department of Veterans Services
bert.boyd@dvs.virginia.gov

Christine Bradshaw-Earl
Emergency Services Program Supervisor
Chesapeake CSB

CPT Russell Britt
VAARNG PDHRA Program Manager
Virginia Army National Guard
david.russell.britt@us.army.mil

Laura Browder
VCU
lbrowder@vcu.edu

Karen Brown
Executive Director
Brain Injury Services, Inc.
kbrown@braininjurysvcs.org

Lydia Brown
Program Director
Richmond Treatment Center
richmondmetro@earthlink.net

Pat Brown, LCSW
Mental Health Therapist
Chesterfield Mental Health
brownpat@chesterfield.gov

Robert S. Brown, M.D., Ph.D.
Retired Army Office, Psychiatrist
Clinical Professor of Psychiatry
Rsb6d@virginia.edu

Sgt Roger K. Bullis, Jr.
Supt., Air Combat Command Airman & Family Readiness
HQ Air Combat Command
roger.bullis@langley.af.mil

Rhonie Butler, LCSW
Program Supervisor Counseling Services
Commonwealth Catholic Charities
rhonie_butler@cccofva.org

C. Frederick Capps, Ed.D.
Psychology Director
Woodrow Wilson Rehabilitation Center
c.fred.capps@wwrc.virginia.gov

Levi M. Cary
Interim Coordinator-Wounded Veterans Internship Program
Virginia Dept. of Transportation
Levi.Cary@VDOT.Virginia.gov

Laura Clevinger, LCSW
Suicide Prevention Coordinator
Veterans Affairs Medical Center
laura.clevinger@va.gov

Linda Cox
Crisis Clinician
Richmond Behavioral Health Authority
coxl@rbha.org

Zach Dameron, MD
Vice Chair of Clinical Affairs
Department of Psychiatry and Neurobehavioral Sciences
University of Virginia School of Medicine

Jim Daniels
Chaplain (Colonel) US Army Retired
Projert: Soldier Help (Virtual Life Solutions)
jim.daniels@soldierhelp.net

Steven Danish, PhD
Director, Life Skills Center
VCU Department of Psychology
sdanish@vcu.edu

Col. Donna Diamond
Kenner Army Health Clinic Commander
Kenner Health Clinic

Cherah Diehl
Therapist
Prince William County CSB
cdiehl@pwcgov.org

Ken Ductor
Benefit Advisor
Wounded Warrior Regiment, HQ USMC
Ken.ductor@usmc.mil

Robert E. Durbin
Emergency Services Clinician
Richmond Behavioral Health Authority
Durbinb@RBHA.org

April Easter
Mental Health Therapist
Prince William County CSB
aprileaster@gmail.com

Kimberly Evans
Relocation/Mobilization Deplyment Manager
Army Community Service
kimberly.evans1@us.army.mil

Bobby Ferguson
Certified Rehabilitation Counselor
Department of Rehabilitative Services
shirley.ferguson@drs.virginia.gov

Antony Fernandez
Acting Chief of Psychiatry
McGuire Veterans Affairs Medical Center
antony.fernandez@va.gov

Robert L. Fitzgerald
Local Veteran Employment Representative
robert.fitzgerald@vec.virginia.gov

Jon Frazier
Psychologist
GenCon
jonmontross@aol.com

Thomas Frazier
President
GenCon
fraziermnt@aol.com

Kelly Furgurson
Director Crisis & Intensive Care Services
D19 CSB
kfurgurson@d19csb.com

Camille Gaffney
Program Director, AFES
Greater Richmond Chapter
American Red Cross
GaffneyC@usa.redcross.org

LTC Doug Gagnon
Deputy J-1
Virginia National Guard
douglas.gagnon@us.army.mil

Christine Galli
Higher Ground Recovery
highergroundrecovery@comcast.net

Wayde Glover
Manager
DMHMRSAS
wayde.glover@co.dmhmrsas.virginia.gov

Teresa Godoy
Suicide Prevention Coordinator
VA Medical Center
teresa.godoy@va.gov

Eugene Gourny
Clinical Psychologist
McGuire VA MC
eugene.gourly@va.gov

Doug Gover, CSAC, CAC. CCJP
Program Consultant
Gateway Foundation, Inc.
dwgover@aol.com

Jim Granger
Regional Manager
Department of Veterans Services
jim.granger@dvs.virginia.gov

Kyle Grohmann
Extern Psychotherapist
Loudoun County Mental Health
66grohmann@cua.edu

Charles L. Gudis
Vice Commander
American Legion, Department of Virginia
1grtgrdpa@comcast.net

Ray Gudum
Chairman
VACSB Board of Directors
rgudum@aol.com

Charles A. Hall
Executive Director
Hampton-Newport News CSB
Chall@hnncsb.org

Sonja R. Hall
Mental Health Therapist
Prince William County CSB
srhall@pwcgov.org

David Harker
Public Relations
Department of Veterans Services
david.harker@dvs.virginia.gov

Pamela Harman
Speech-Language Pathologist
Dept. Veterans Affairs
pamela.harman@va.gov

Priscilla Hawkins, M.D.
Chief Mental Health
Hampton VA Medical Center
priscilla.hankins@med.va.gov

George Hill
Environmental Service Technician
Central VA Community Services
George.Hill@cvcsb.org

Reginald Humphries
Contractor, Axiom Resource Management, Inc.
AHLTA Communications & Marketing Specialist
TRICARE Management Activity, CITPO
Reginald.Humphries.ctr@tma.osd.mil

Robin G. Johnson
Director Soldier & Family Assistance Center
Army Community Service (ACS)
robin.g.johnson@us.army.mil

Julie C. Johnson
Supervisor, Offender Release Services
Dept. of Corrections
julie.johnson@vadoc.virginia.gov

Patricia Jones
Psychologist
McGuire VA MC
patricia.jones4@va.gov

Thad Jones
Board Member
VA Dept. of Veterans Services
thad.a.jones@comcast.net

Sandy Kanehl
General Services Manager
Central VA CSB
sandy.kanehl@cvcsb.org

Daniel Karnes
State MHMRSAS Board Vice Chair
State MHMRSAS Board
jewel.booker@co.dmhmrsas.virginia.gov

Sharon Killian
LCSW Clinic Coordinator
Rappahannock Area CSB
skillian@racsb.state.va.us

Don Kozak
Forensic Case Manager
Middle Peninsula Regional Security Center for the CSB-Warsaw
dkozak@mpnn.state.va.us

Richard Kuhlbars
Creative Director/Owner
Project:Soldier Help (Virtual Life Solutions)
richard@soldierhelp.net

Margaret Anne Lane
Planning Analyst
DMHMRSAS
margaret.lane@co.dmhmrsas.virginia.gov

Jean Langbein
OIF/OEF Program Manager
Department of Verterans Affairs
Jean.langbein@va.gov

Janet Langhorne
Chief, Voluntary Service
McGuire Veterans Affairs Medical Ctr.
janet.langhorne@va.gov

Dasha E. Little, MS, LPC
Counselor/President
Apogee Solutions, Inc.
dasha.little@apogee.us.com

Dan Longo
Director of Behavioral Health
Colonial CSB
dlongo@colonialcsb.org

Dr. Richard S. Luck
Special Assistant to Commissioner
VA Dept. of Rehab. Services
richard.luck@wwrc.virginia.gov

Heather Malecki, DPT
Polytrauma Coordinator
Veterans Affairs Medical Center
heather.malecki@va.gov

Jack Mallery
Adult Day Support Supervisor
City of VA Beach Dept of Human Services MH SA Division
jmallory@vbgov.com

Lilton Marks
Chaplain U.S. Army - Retired
lilton.marks@verizon.net

Joe Maslanka
Division Vice President
Admiral Security Services
jmaslanka@admiralsecurity.com

Chris Matson
Valor Healthcare, Inc.
cmatsonvalor@aol.com

Cheryl Matteo-Kerney
Director of Prevention Services
MP-NN CSB
cmatteo-kerney@mpnn.state.va.us

William W. May
Clinician III
Loudoun County CSB
bwilsonmay@yahoo.com

Karen McComas
Army Community Services Officer
Army Community Service
kimberly.evans1@us.army.mil

Jo-Amrah S. McElroy
Mental Health Planner
DMHMRSAS
jo-amrah.mcelroy@
co.dmhmrsas.virginia.gov

O'Connell McKeon
Director of Clinical Services
MP-NN CSB
omckeon@mpnn.state.va.us

Niki Mello, LCSW
Clinical Social Worker
Commonwealth Catholic Charities
niki_mello@cccofva.org

Mr. Jean E. Michel
Chief, Air Combat Command
Airman & Family Readiness
HQ Air Combat Command
jean.michel@langley.af.mil

Rosemary T. Mills
Assistant Director
Chesapeake CSB
rmills@chesapeakecsb.net

Barry Moore
Vice President for University
Relations
Liberty University
bnmoore@liberty.edu

Robert B. Newman, Jr.
The Adjutant General
Department of Military Affairs
robert.newmanjr@us.army.mil

Karen Olichwier
Registered Nurse
Department of Veterans Affairs
karen.olichwier@va.gov

Henry J. Olichwier, Jr.
Veteran
owier@excite.com

Stanley Packard
Lt. Col. USMA, Charitable
Organizations OIC
Marine Corps Wounded Warrior
Regiment, HQ, USMC
Stanley.packard@usmc.mil

Preston Page
Counselor/ Director
INSIGHT
Preston@insight-therapy.net

Anita R. Petty, Msgt. USMC Ret.
Intern
Fairfax County - Dept. of Systems
Management for Human Services
anita.petty@fairfaxcounty.gov

Stacey Pollack
Veterans Affairs Medical Center
Stacey.Pollack@va.gov

Kimberly J. Powell
OTR/L
Dept. of Veterans Affairs (117)
kimberly.powell@va.gov

Linda Riffel
Assoc. Chief Nursing Service-
Mental Health
VAMC Salem
Linda.Riffel@va.gov

Deborah Riley
Family Advocacy Program
Manager
Army Community Service

Curtis A. Robb
Cert. Therapeutic Recreation
Specialist
McGuire Vet Admin. Hospital
curtis.robb@va.gov

Candace Roney
SA/Jail Manager
D19 CSB
lturner@d19csb.com

James Rothrock
Commissioner
Virginia Department Rehabilitative
Services
James.rothrock@drs.virginia.gov

Ricki L. Schiessler MRC,CRC
Vocational Rehabilitation
Counselor
Mcguire Veterans Administration
ricks@pva.org

Natasha Session
Soldier Family Management
Specialist
Army Wounded Warrior Program
AW-2Richmond@scrco-na.com

Richard L. Sizemore
Director
Woodrow Wilson Rehabilitation
Center
richard.sizemore@
wwrc.virginia.gov

Marvin Skinner
CEO
Skinner Holistic Health
Corporation
skinpoknights@telpage.net

Thomas M. Slaven
Executive Director
Hanover County CS
tmslaven@co.hanover.va.us

Henry A. Smith
Director of Mental Health Services
Cumberland Mountain CSB
hsmith@cmcsb.com

Ned Snead
Manager Adult SAS
Chesterfield Dept. MH Support
Services
sneadn@chesterfield.gov

Deborah Snyder
Program Manager: MH/SH -
Emergency Services
Loudoun CSB
deborah.snyder@loudoun.gov

Major Susanna Steggles
Chief, Social Work Services
Kenner Health Clinic

Gretchen Stephens
National TBI & Polytrauma
Program Coordinator
Dept. of Veterans Affairs
gretchen.stephens@va.gov

Major Jeff Stewart
Deputy State Surgeon
Virginia Army National Guard
Jeffrey.a.stewart@us.army.mil

Dennis Stone
TecAccess
dstone@tecaccess.net

Gerald Stone
Chaplain (Colonel)
U.S. Army Ft. Belvoir, VA
gerald.e.stone@conus.army.mil

Rhonda Thomas
Clinician, Henrico County Mental
Health
tho41@co.henrico.va.us

Jim Thur
Executive Director, Fairfax-Falls
Church CSB
jthur2@fairfaxcounty.gov

Bill Tracey
Prince William County CSB
billtracey@hotmail.com

Susan Storti, PhD
Consultant
Rhode Island Veterans Initiative
Susan_Storti@brown.edu

Inge Tracy
Statewide Program Administration
Specialist
Dept. of Corrections
inge.tracy@vadoc.virginia.gov
Susan Trotter
ringvoice@aol.com

Ben Trotter
Member of American Legion &
Veterans of Foreign Wars
ringvoice@aol.com

Larry Turner
SA-MH Therapist
D19 CSB
lturner@d19csb.com

Tom Von Hemert
CIT Coordinator, Charlottesville
Area
Crisis Intervention Team Program
Thomas Jefferson Area Community
TomVH@oar-jacc.org

Angela Vaughn
Therapist
Central VA Community Services
angie.vaughn@cvcsb.org

Charles Walsh Jr.
Executive Director
MP-NN CSB
cwalsh@mpnn.state.va.us

Bruce Walsh
Substance Abuse Services Manager
Caring Family Network at Roxboro
bruce@caringfamilynetwork.org

William Ward
Counselor
VA Dept. Corrections
william.ward@vadoc.virginia.gov

Susan Webb
VCU
s2scwebb@vcu.edu

Dr. Zinerva White, Jr.
President
Zin White and Associates
zwhite3@cox.net

George M. White
LPC, LSATP, CAC
mr.butter@comcast.net

Hattie Wiggins
SAC

Sam Wilder
Col. (Ret.) U.S. Army
Chairman, Joint Leadership
Council of Veteran Service
Organizations
sdwilder1@comcast.net

Robert G. Williams
President
NAMI – Hampton/Newport News
robert.g.williams-1@nasa.gov

William H. Williams, Jr.
Director, ADS
Fairfax-Falls Church CSB
williamh.williams@
fairfaxcounty.gov

Abigail Wilson
Emergency Services Clinician
Region Ten Community Services
abigailw@regionten.org

Clarence A. Wood
Disabled American
Veterans/Military Affairs
Retired Military
woodsret3x@msn.com

Lori Wood
Region Ten Emergency Services
Manager
Region Ten CSB
loriw@regionten.org

Appendix 3: Conference Presenters and Staff

Anne Atkins
Director of Communications
Virginia Department of Veterans Services

Missy Barker
Project Coordinator
Mid-Atlantic ATTC

Rosemary Bosher
Global War on Terrorism Technician
Dept of Veterans Affairs Outreach Center

Greg Brittingham
VCU Center for Public Policy

Vincent Burgess
Commissioner
Department of Veterans Services

David Cifu, M.D.
Chief of Rehabilitation
Hunter Holmes McGuire VA Medical Center

Victoria Cochran, JD
Consulting and Facilitation Services

Gary Cohen
Team Leader
The Richmond Vet Center

David Epstein
Psychology Resident
Hampton-Newport News CSB

Patty Gilbertson
Sr. Director, Planning and Marketing
Hampton-Newport News CSB

Denise Hall
Project Coordinator/NIDA Liaison
Mid-Atlantic ATTC

Jenny M. Holbert, Colonel
Joint Leadership Council of Veterans
Services Organizations
Women Marines Association
Headquarters, Marine Corps (MR, M&RA)

Sally Holzgrefe
Heroes Conference Project Coordinator
Mid-Atlantic Addiction Technology Transfer Center
Department of Psychiatry Virginia Commonwealth
University

Paula Horvatich, Ph.D.
Director
Mid-Atlantic Addiction Technology Transfer Center
Department of Psychiatry Virginia Commonwealth
University

Bill Janis
House of Delegates - 56th District

Gail Jaspen
Deputy Secretary of Health and Human Services

Timothy Kaine
Governor of Virginia

Janet Knisely, PhD
Program Evaluator
Mid-Atlantic ATTC

Harold Kudler, M.D.
Interim Director, MIRECC
Veterans Integrated Services Network 6 Mental Health
Service Line

George Lamb
OIF/OEF Outreach Coordinator
McGuire Veterans Affairs Medical Center

John W. Marshall
Secretary of Public Safety

John Mason, Psy.D.
Child & Adol. Outpatient Services Clinical
Administrator, Hampton-Newport News CSB

Martha Mead
Project Manager Executive Order 19
Virginia Department of Veterans Services

David McGinnis
Devision Support Manager
Virginia Department of Mental Health, Mental
Retardation and Substance Abuse Services

William P. Nash, MC, USN
Combat/Operational Stress Control Coordinator

Cathy Reiner
Administrative Staff
Mid-Atlantic ATTC

James Reinhard, M.D.
Commissioner
Virginia Department of Mental Health, Mental
Retardation and Substance Abuse Services

Debra Ruh
President and Founder
TecAccess

Kevin Secor
Special Assistant to the Secretary of Veterans Affairs
Veterans Service Organization Liaison
Department of Veterans Affairs
Washington, D.C.

Kay Springfield
Administrative Manager
Virginia Association of Community Services Boards

Donald P. Troast, CHC, USN
Deputy Force Chaplain
U.S. Marine Corps Forces Command

Mark Whitesides
Web Developer/Tech. Specialist
Mid-Atlantic ATTC

Appendix 4: Conference Agenda

Virginia is for Heroes Conference

Mid-Atlantic Addiction Technology Transfer Center / VCU
Virginia Department of Veterans Services
www.virginiaisforheroes.org

Wednesday, October 17, 2007
AGENDA

CONFERENCE GOALS
Together we will raise awareness of the impact of polytrauma and combat stress injuries on military service members, Veterans, families, employers, and the community, and create a road map to mobilize resources in our communities and at all levels of government.

Time	Session	Presenter
7:30-8:30am	Registration & Refreshments	
		Auditorium
8:30am	**Welcome**	Paula Horvatich, PhD, Director, Mid-Atlantic ATTC
	Posting of the Colors by the Fort Lee Color Guard, Pledge of Allegiance National Anthem sung by Mr. Ben Trotter	
	Opening Statement	Vince Burgess, Commissioner, Virginia Department of Veterans Services
8:50am	**Conference Charge**	John Marshall, Secretary of Public Safety Gail Jaspen, Deputy Secretary of Health and Human Resources
9:00-9:45am	**Boots on the Ground**	Jenny M. Holbert, Colonel, U.S. Marines
	What Does Jenny's Story Mean For Us?	William P. Nash, MD, Captain, Medical Corps , United States Navy
9:45-10am	Break	
10am - 10:45am	**DoD, VA, State & Community Partnerships in Service to OIF/OEF Service Members, Veterans and Their Families**	Harold Kudler, MD, Manager, VISN 6 Mental Health Service Line, Duke University

10:45am – 12noon **WORKSHOPS**

CHILD ADVOCATES AND EDUCATORS **Classroom 2**

Expert: John Mason, Licensed Clinical Psychologist, Child and Adolescent Comprehensive Outpatient Services,
Hampton-Newport News Community Services Board

Facilitator: David Epstein, PhD, Psychology Resident, Hampton-Newport News Community Services Board

Recorder: Janet Knisely, PhD, Program Evaluator, Mid-Atlantic ATTC

VETERAN'S SERVICE ORGANIZATIONS AND OTHER NONPROFITS **Robins Room**

Expert: Kevin Secor, Veterans Service Organizations Liaison, US Office of the Secretary of Veterans Affairs

Facilitator: George Lamb, OIF/OEF Outreach Coordinator, McGuire Veterans Affairs Medical Center

Recorder: Anne Atkins, Director of Communications, Virginia Department of Veterans Services

10:45am – 12noon **WORKSHOPS** continued

CRIMINAL JUSTICE SYSTEM **Auditorium 1 & 2**

Expert: Victoria Huber Cochran, JD

Facilitator: Debra Ruh, TecAccess

Recorder: Denise Hall, LPC, Project Coordinator, Mid-Atlantic ATTC

FAITH-BASED LEADERS **Break Out Room**

Expert: Don Troast, Commander, Chaplain Corps, United States Navy

Facilitator: Missy Barker, LPC, Project Coordinator, Mid-Atlantic ATTC

Recorder: Kay Springfield, Virginia Association of Community Services Boards

CLINICAL **Auditorium**

Expert: Harold Kudler, MD, Manager, VISN 6 Mental Health Service Line, and Duke University

Facilitator: Greg Brittingham, VCU Center for Public Policy

Recorder: Susan Storti, PhD, Consultant, Mid-Atlantic ATTC

PUBLIC POLICY **Classroom 1**

Expert: Bill Janis, House of Delegates, 56th District

Facilitator: Patty Gilbertson, Senior Director of Planning and Marketing, Hampton/Newport News CSB

Recorder: Martha Mead, Project Manager, Executive Order 19, Virginia Department of Veterans Services

12:15pm – 1pm **Lunch**
Box lunches available outside workshop classroom. Continue discussion/visit exhibits

1pm - 1:45pm **Outreach Initiatives** **Auditorium**
George Lamb, OIF/OEF Outreach Coordinator, McGuire VA Medical Center

1:45pm – 2:15pm **Synthesis of Workshop Recommendations**
David Cifu, MD, Physical Medicine & Rehabilitation, McGuireVA Medical Center

2:15pm – 2:30pm Break

2:30pm – 3:50pm **Panel Discussion - Building Roadmaps for Caring for Service Members & Their Families**

Moderator: Greg Brittingham, VCU Center for Public Policy

3:50pm **Summary of Key Points**
David Cifu, MD, Physical Medicine & Rehabilitation, McGuire VA Medical Center

4:00pm **Next Steps**
James Reinhard, MD, Commissioner, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

4:10pm **Call to Action**
Timothy M. Kaine, Governor of Virginia

4:15pm Adjourn

WORKSHOP DESCRIPTIONS
10:45am – 12noon

CHILD ADVOCATES AND EDUCATORS **Classroom 2**

Expert: John Mason, Licensed Clinical Psychologist, Child and Adolescent Comprehensive Outpatient Services, Hampton-Newport News Community Services Board

The effects of a parent's injuries directly impact his or her children and permanently change them. Children must cope with the sight of the parent's injuries and the parent's daily needs resulting from those injuries. They must cope with changes in the parent's personality and changing priorities within the home. They may become victims of parental abuse and/or neglect. And, in their struggle to survive, they may develop unhealthy coping mechanisms. How can we recognize these children and what can we do to give them the tools and support they need to cope with their parent's trauma and also develop into strong, confident, and compassionate members of their communities.

VETERAN'S SERVICE ORGANIZATIONS AND OTHER NONPROFITS **Robins Room**

Expert: Kevin Secor, Veterans Service Organizations Liaison, US Office of the Secretary of Veterans Affairs

The VA website lists nearly 50 federally chartered Veterans service organizations and a Google Search on the term "nonprofit organizations helping combat-wounded Veterans" returned more than 200,000 possible links. While there is a wealth of support available for our wounded warriors, who are all these organizations and what do they do? How can Veterans and their families find the right organizations and, conversely, how can these organizations find Veterans needing their assistance? Participants will explore these questions and the problems commonly experienced by Veterans service organizations and other nonprofits as they try to assist wounded combat Veterans and their families.

CRIMINAL JUSTICE SYSTEM **Auditorium 1 & 2**

Expert: Victoria Huber Cochran, JD

The vast majority of military service personnel returning from Iraq and Afghanistan are law abiding citizens. However, as many as 30 percent may be struggling with combat stress injuries that sometimes can lead to a downward spiral that includes domestic violence, substance abuse, unemployment, and homelessness. If these Veterans have spouses and children, then their collapse results not only in an individual in crisis, but a family in crisis. Law enforcement and the criminal justice system are beginning to realize the need to recognize the symptoms of PTSD and to develop strategies for effectively assisting military Veterans who run afoul of the law.

FAITH-BASED LEADERS **Break Out Room**

Expert: Don Troast, Commander, Chaplain Corps, United States Navy

We've all heard about the men and women who return from war far different from the way they were when they deployed a year or more earlier—the hyper-vigilance, the aggressive behavior, the emotional isolation, the anger and depression. But, what does it really mean and what can the faith-based community do to help heal these warriors and their families? Will the tools that the faith-based community uses to help others in crisis work for these men and women and their families? We know that faith and spirituality are as critical to healing as medical treatment, but what will work as we try to reconcile two opposite worlds—the world of war and the world of those back home?

CLINICAL **Auditorium**

Expert: Harold Kudler, MD, Manager, VISN 6 Mental Health Service Line, and Duke University

Posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), major depression and substance abuse are among the mental health diagnoses and health risk behaviors that make up the field of post deployment health. Each interacts with other medical, psychological, social and spiritual issues to make each returning service member/Veteran and each family unique. Individualized strategies for outreach, engagement, assessment and treatment are necessary and stigma remains the major barrier to care. Effective evidence-based treatments are available. Even when a cure is not within reach, clinicians can succeed in enhancing patient and family resilience (the ability to rebound in the face of adversity) and recovery (the ability to live a productive and satisfying life despite disability). This workshop will address clinical partnerships that can promote effective training, treatment and triage across the Commonwealth of Virginia.

PUBLIC POLICY **Classroom 1**

Expert: Bill Janis, House of Delegates, 56th District

Our democratic process gives us tools to use in enacting changes for the betterment of our society, but, what's the most effective way to use these tools? Participants in this session will explore the public policy-making process and how it can be used to address Veterans issues. They'll discuss methods for identifying and prioritizing issues and techniques for getting these issues in front of law makers, public officials, special interest groups and advocates. Work from participants in this session will be critical in developing an action plan for ideas that come from participants in the other breakout sessions.

Appendix 5: Workshop Recommendations

All recommendations from the workshops are presented here and are categorized by the seven key actions needed to address the issues faced by veterans and their families. The follow codes identify the workshop that made the recommendation.

Workshop codes

PP = Public Policy
CL = Clinical
Ch&E = Child Advocates/Educators
FB = Faith based
CJ = Criminal Justice
VSO = Veteran's Service Organizations

Recognize the Effects of Deployment

Ch&E2 (length of deployment)
Time of separation from parent is a problem and often upon return, families move to different base.
RECOMMENDATIONS:

- There should be one year BETWEEN deployments
- Commanders should look at total life stress regarding deployment
- Governor and Commissioner should send a letter to all returning service members, welcoming them home, thanking them for their service, sending them important information of services available to them. Letter could also include a certificate that service member hangs on the wall.

PP2 (define scope of the problem)
RECOMMENDATIONS:

- Clearly identify scope of the problem for policy-makers. Develop info on the population that will require services.

CL3 (transition to a public health issue)
RECOMMENDATIONS:

- Readjustment services broader than mental health/substance abuse or rehab services outside of Medicaid model

Ch&E1 (length of deployment)
RECOMMENDATIONS:

- There should be one year BETWEEN deployments
- Commanders should look at total life stress regarding deployment

Ch&E2 (Dual Military Couples)
Children face separation twice
RECOMMENDATIONS:

- None

Ch&E5 (awareness of valuable resources)
RECOMMENDATIONS:
- Encourage civilian providers to go on base for tours to discuss service provisions, referral sources
- Encourage media to publicize and increase public awareness

PP2 (define scope of problem)
RECOMMENDATIONS:
- Reach out/proactively identify veterans and family members who will need services.
- Clearly identify scope of the problem for policy-makers. Develop info on the population that will require services.
- Clearly identify the federal, state and private resources required.
- Develop a comprehensive, multi-agency plan to break down barriers for veterans, their families and providers.

PP2 (how to get services where they are needed)
RECOMMENDATIONS:
- Consider the option of providing vouchers to veterans and their families to expand their choice of service providers.
- Determine the most effective way of reaching out to veterans and their families who may be at risk for behavioral healthcare issues. Determine how to "bring the services to" the veterans.
- Take advantage of existing supports available through family and friends. Activate communities. Increase professional capacity (first line) and family/friends (second line).
- Services should be based on a community-based recovery model

CL2 (best way to get info to Vets and others)
RECOMMENDATIONS:
- Partnership with military and local community resources (especially prior to release, discharge from service)
- Mandates, release of information
- Starting information (get it to families at the start of deployment)
- Media release /information - commercial (PSA)
- 1-800 # for state wide assistance
- Internet link to the VA website with information
- Agency to agency communication of services available. Partnership between state (VA) and federal level of services.

CL4 (building systems of care)

RECOMMENDATIONS:

- Why do veterans need systems of care - Veterans have multiple issues/needs that exceed capacity of VA resources
- Veterans do not stay in VA and move care into the community (medical problems surface after)
- Need to identify gaps in treatment/interventions for vets (suicide, SA, spirituality, employment, divorce, family)
- Need to understand what programs are available across systems

Eliminate Stigma

CJ1 (Identification)
RECOMMENDATIONS:
- Identification is easier if stigma is reduced.

CJ2 (treatment)
RECOMMENDATIONS:
- No Wrong Door

CJ3 (stigma)
RECOMMENDATIONS:
- Interagency and professional contacts regarding cross training and
- promote awareness
- Media- need a positive spin, reality, sharing both sides
- Housing issues
- Funding
- Private sector/public sector partnerships

CJ4 (training and awareness)
RECOMMENDATIONS:
- Media awareness
- Workforce development
- Provide training – Crisis Intervention Teams (CIT) model

CJ5 (housing)
RECOMMENDATIONS:
- Addressing homeless vet needs

Ch&E 1 (length of deployment)
RECOMMENDATIONS:
- Commanders should look at total life stress regarding deployment

Ch&E 2 (access to Tri-care)
RECOMMENDATIONS:
- Train military personnel to work with peers

Ch&E 4 (length of insurance)
Especially with the delay in identifying MH issues
RECOMMENDATIONS:
- None

Ch&E 5 (Awareness of Valuable Resources)
RECOMMENDATIONS:
- Encourage media to publicize and increase public awareness

PP2 (define the scope of the problem)
RECOMMENDATIONS:
- Clearly identify scope of the problem for policy-makers. Develop info on the population that will require services.
- Develop a comprehensive, multi-agency plan to break down barriers for veterans, their families and providers.

Cl2 (best way to get info to the vets)
RECOMMENDATIONS:
- Info-mercials on symptoms i.e., "Are you having trouble sleeping since returning?"

Cl3 (transition into public health model)
RECOMMENDATIONS:
- Making access "safe" for vets
- Integrated community health education model

Cl4 (building systems of care)
RECOMMENDATIONS:
- How do we build systems?
- Roundtable discussion between VA/DOD/ community to identify resources and qualified people

FB1 (become an integrated partner)
RECOMMENDATIONS:
- Intentionally integrate at summits across disciplines

FB3 (leader challenges)
RECOMMENDATIONS:
- raise awareness & sensitivity by providing knowledge to pastors and leaders

Reach and Connect with Veterans and Their Families

Reaching Out

CJ1 (identification)
RECOMMENDATIONS:
- A place to start - by asking, "Are you a veteran?" follow with consistent screening for various SA, MH, nTBI, and polytrauma.

CJ2 (treatment)
RECOMMENDATIONS:
- Utilizing Vet Centers

CJ3 (training)
RECOMMENDATIONS:
- Media awareness

CJ4 (stigma)
RECOMMENDATIONS:
- Private sector/public sector partnerships

CJ5 (housing)
RECOMMENDATIONS:
- Housing FIRST - best practice from MH world?

VSO1 (healthcare)
RECOMMENDATIONS:
- 65 percent of families aren't getting service at VA. VSOs should partner with NAMI, CSBs, faith-based services, National Guard, Department of Rehabilitation Services, VEC, Family Readiness Centers to look at what's in community already and develop state-wide, community-based taskforce
- Connect returning service members/families to Military One-Source
- Develop short-term wellness education program targeting families

VSO3 (outreach)
RECOMMENDATIONS:
- VA and service organizations need to communicate with VSO's to let them know about services they offer and how VSO's can partner with them.
- Bring all service organizations together to talk with Governor and Commissioner Burgess.
- Compose letter from Governor and Commissioner welcoming service member home, thanking them for their service, sending them important information of services available to them. Letter could also include a certificate that service member could hang on their wall.

Ch&E3 (access to Tri-care)
RECOMMENDATIONS:
- Interface between Tricare and Medicaid to help pay for services.
- All eligible recipients should be associated with Military One Source as a provider.
- CSB's should do outreach with military to contract for mental health services.
- Identify liaisons in CSBs to work with the military
- Train military personnel to work with peers
- Military experts in PTSD can cross-train civilian providers

Ch&E5 (awareness of resources)
RECOMMENDATIONS:
- Encourage civilian providers to go on base for tours to discuss service provisions, referral sources
- Encourage media to publicize and increase public awareness

PP2 (scope of problem)
RECOMMENDATIONS:
- Reach out/proactively identify veterans and family members who will need services.
- Clearly identify scope of the problem for policy-makers. Develop info on the population that will require services.
- Increase community capacity without duplicating existing services.
- Clearly identify the federal, state and private resources required.
- Consider the Veterans Care Concept of the Joint Leadership Council – the "Wounded Warriors" proposal presented by Sam Wilder, Chairman, Joint Leadership Council.
- Develop a comprehensive, multi-agency plan to break down barriers for veterans, their families and providers.
- Consider the existing models of the Vet Centers and the Casualty Assistance Officers.

PP3 (recognition differential)
RECOMMENDATIONS:
- Develop a comprehensive, multi-agency plan to break down barriers for veterans, their families and providers.

PP4 (how to get services where needed)
RECOMMENDATIONS:
- Consider the option of providing vouchers to veterans and their families to expand their choice of service providers.
- Determine the most effective way of reaching out to veterans and their families who may be at risk for behavioral healthcare issues. Determine how to "bring the services to" the veterans.
- Take advantage of existing supports available through family and friends. Activate communities. Increase professional capacity (first line) and family/friends (second line).
- Services should be based on a community-based recovery model.

CL2 (best ways to get info to vets)
RECOMMENDATIONS:

- Partnership with military and local community resources (especially prior to release, discharge from service)
- Mandates, release of information
- Starting information (get it to families at the start of deployment)
- Media release /information - commercial (PSA)
- 1-800 # for state wide assistance
- Internet link to the VA website with information
- Agency to agency communication of services available. Partnership between state (VA) and federal level of services.
- Nationwide organization for PTSD/TBI
- Info-mercials on symptoms i.e., "Are you having trouble sleeping since returning?"

CL3 (public health issue)
RECOMMENDATIONS:

- Educate at *not* stigmatizing

CL4 (building systems of care)
RECOMMENDATIONS:

- Broaden scope of triage to include clinical, administrative, psychoeducation, school system, families
- Understand what programs are available across systems.

FB1 (become an integrated partner)
RECOMMENDATIONS:

- Encourage local faith-based organizations to host informational exchange conferences to foster better multi-disciplinary cooperation
- Intentionally integrate at summits across disciplines
- Develop a statewide faith-based listing that includes state agency resources, CSB's, houses of worship, and private providers. (this is currently under construction at DMHMSAS OSAS)

FB3 (leader challenges)
RECOMMENDATIONS:

- Raise awareness & sensitivity by providing knowledge to pastors and leaders
- Recommend that pastors develop teams/mentors/partners by resources from within their own congregational membership, including: *Parish nurses, Stevens Ministry, Physicians, Mental Health professionals, Military service specialty, Local external resources*
- Develop outreach to congregants & non-congregants who may be military veterans/family members via phone calls, small groups, emails, and encouraging storytelling.
- Sermons – incorporate military examples
- Presentations at pastoral and faith leadership conferences.

Connecting with our veterans and their families

CJ1 (Screening)
Screening, falling through the system, female veterans, invisible disability, malingerers versus entitlement. SCREENING AND DATA EXCHANGE (availability of forms is not simple) – top concerns.
RECOMMENDATIONS:
- Consistent screening throughout the criminal justice (CJ) system- "sequential intercept", because all the systems don't have access to records
- A place to start - by asking, "Are you a veteran?" follow with consistent screening for various substance abuse (SA), mental health (MH), traumatic brain injury (TBI)
- , and polytrauma.
- There are some screening instruments in existence already
- Access is key issue here. Not simple: Have forms for vets available at local organizations treating and seeing vets
- Funding
- Stigma

CL1 (Workforce Dev)
RECOMMENDATIONS:
- Sensitize staff to ask the question on screening tool

CL3 (Transition into a Public Health issue)
RECOMMENDATIONS:
- Screening and services

Build a Service Delivery Infrastructure

Integrated Management and Support

CJ2 (treatment)
RECOMMENDATIONS:
Integrated services in treating
Utilizing Vet Centers Look at best practice models that already exist and standardize around the Commonwealth
Work from rehabilitation perspective
Funding
Stigma

CJ3 (training)
RECOMMENDATIONS:
More cross training among systems, awareness of other trainings
Housing, employment opportunities for vets

CJ4 (stigma)
RECOMMENDATIONS:
Interagency and professional contacts regarding cross training and
promote awareness

CJ5 (housing)
Homelessness is more significant than unemployment
RECOMMENDATIONS:
Housing FIRST- best practice from MH world
Funding is not being taken advantage from a federal level
Addressing homeless vet needs
Veteran's housing that includes categories of felonies

Almost every issue and its recommendations address some aspect of case management throughout the powerpoint presentation. Connecting the service member with the appropriate services is THE issue.

System Integration

CJ1 (Screening)
Availability of forms is not simple – top concerns
RECOMMENDATIONS:

- Consistent screening throughout the CJ system- "sequential intercept", because all the systems don't have access to records
- A place to start - by asking, "Are you a veteran?" follow with consistent screening for various SA, MH, TBI, and polytrauma.
- There are some screening instruments in existence already

- Access is key issue here. Not simple: Have forms for vets available at local organizations treating and seeing vets

CJ2 (Treatment)
Coordination in community, referral to existing systems, developing best practices-"No Wrong Door".
RECOMMENDATIONS:
- Integrated services in treating
- Utilizing Vet Centers
- Look at best practice models that already exists and standardize around the Commonwealth

VSO1(healthcare)
RECOMMENDATIONS:
- Connect returning service members/families to Military One-Source

VSO4 (employment)
RECOMMENDATIONS:
- Develop a method of tracking Veterans who access the VEC.
- VSO's adopt a reserve unit or family.

Ch&E1 (length of deployment)
RECOMMENDATIONS:
- There should be one year BETWEEN deployments

Ch&E 1 (length of deployment)
RECOMMENDATIONS:
- Interface between Tricare and Medicaid to help pay for services.
- All eligible recipients should be associated with Military One Source as a provider.

PP2 (define scope of problem)
RECOMMENDATIONS:
- Reach out/proactively identify veterans and family members who will need services.
- Develop a comprehensive, multi-agency plan to break down barriers for veterans, their families and providers.

PP2 (addressing the recognition differential)
RECOMMENDATIONS:
- Increase community capacity without duplicating existing services.
- Clearly identify the federal, state and private resources required.

PP4 (getting services where they are needed)
RECOMMENDATIONS:
- Consider the option of providing vouchers to veterans and their families to expand their choice of service providers.

- Determine the most effective way of reaching out to veterans and their families who may be at risk for behavioral healthcare issues. Determine how to "bring the services to" the veterans.
- Take advantage of existing supports available through family and friends. Activate communities. Increase professional capacity (first line) and family/friends (second line).
- Services should be based on a community-based recovery model.

CL1 (workforce development)
RECOMMENDATIONS:
- Is VA status exclusionary criteria
- Outreach through good PR and identification
- Once we ID – now what?
- Community Re-entry
- Add in family who are affected by this

CL2 (best way to get info to vets)
RECOMMENDATIONS:
- Partnership with military and local community resources (especially prior to release, discharge from service)
- Mandates, release of information
- Starting information (get it to families at the start of deployment)
- Media release /information - commercial (PSA)
- 1-800 # for state wide assistance
- Internet link to the VA website with information
- Agency to agency communication of services available. Partnership between state (VA) and federal level of services.

CL3 (Transition into a PH issue)
RECOMMENDATIONS:
- Increase cooperation between VA and community resources/collaboration
- Continuum of services (not of treatment or care)

CL4 (building systems of care)
RECOMMENDATIONS:
- Veterans do not stay in VA and move care into the community (medical problems surface after)
- Need to identify gaps in treatment/interventions for vets (suicide, substance abuse (SA), spirituality, employment, divorce, family)
- Need to understand what programs are available across systems
- How do we build systems?
- Roundtable discussion between VA/DOD/ community to identify resources and qualified people
- Move away from vacuum of services within VA/DOD/community toward shared resources
- Broaden scope of triage to include clinical, administrative, psychoeducation, school system, families
- Understand what programs are available across systems.

FB1 (become an integrated partner)
RECOMMENDATIONS:

- Encourage local faith-based organizations to host informational exchange conferences to foster better multi-disciplinary cooperation
- Intentionally integrate at summits across disciplines
- Develop a statewide faith-based listing that includes state agency resources, CSB's, houses of worship, and private providers. (this is currently under construction at DMHMSAS OSAS)
-

FB3 (faith-based leaders)
RECOMMENDATIONS:
develop outreach to congregants & non-congregants who may be military veterans/family members via phone calls, small groups, emails, and encouraging storytelling.

Make Healthcare Accessible

CJ1 (identification)
RECOMMENDATIONS:
- Consistent screening throughout the CJ system- "sequential intercept", because all the systems don't have access to records
- A place to start - by asking, "Are you a veteran?" follow with consistent screening for various SA, MH, TBI, and polytrauma.
- There are some screening instruments in existence already
- Access is key issue here. Not simple: Have forms for vets available at local organizations treating and seeing vets
- Funding
- Stigma

CJ2 (treatment)
RECOMMENDATIONS:
- Integrated services in treating
- Utilizing Vet Centers
- Look at best practice models that already exist and standardize around the Commonwealth
- Work from rehabilitation perspective
- Funding
- Stigma

VSO1 (healthcare)
RECOMMENDATIONS:
- 65 percent of families aren't getting service at VA. VSOs should partner with NAMI, CSBs, faith-based services, National Guard, Department of Rehabilitation Services, VEC, Family Readiness Centers to look at what's in community already and develop state-wide, community-based taskforce
- Connect returning service members/families to Military One-Source
- Develop short-term wellness education program targeting families
- Try to provide long-term care at home (better/less expensive). Should be smooth transition from hospital to VA to home. Continuum of care.
- Clinicians need training in the military culture as well as TBI.

VSO3 (outreach)
RECOMMENDATIONS:
- VA and service organizations need to communicate with VSO's to let them know about services they offer and how VSO's can partner with them.
- Bring all service organizations together to talk with Governor and Commissioner Burgess.

Ch&E 1 (length of deployment)
RECOMMENDATIONS:
- There should be one year BETWEEN deployments

Ch&E3 (access to Tri-care)
RECOMMENDATIONS:
- Interface between Tricare and Medicaid to help pay for services.
- All eligible recipients should be associated with Military One Source as a provider.
- CSB's should do outreach with military to contract for mental health services.
- Identify liaisons in CSBs to work with the military
- Train military personnel to work with peers
- Military experts in PTSD can cross-train civilian providers

PP1 (money)
RECOMMENDATIONS:
- Propose a dedicated funding stream to fund recommended services
- Determine how to increase the capacity of the Community Services Boards and Department of Rehabilitative Services to provide behavioral healthcare and rehabilitative services to veterans and their families.
- Establish on=going reimbursement systems that are sufficient to cover the costs of care.

PP2 (scope of the problem)
RECOMMENDATIONS:
- Reach out/proactively identify veterans and family members who will need services.
- Clearly identify scope of the problem for policy-makers. Develop info on the population that will require services.
- Increase community capacity without duplicating existing services.
- Clearly identify the federal, state and private resources required.
- Consider the Veterans Care Concept of the Joint Leadership Council –the "Wounded Warriors" proposal presented by Sam Wilder, Chairman, Joint Leadership Council.
- Develop a comprehensive, multi-agency plan to break down barriers for veterans, their families and providers.
- Consider the existing models of the Vet Centers and the Casualty Assistance Officers.

PP4 (getting services where needed)
RECOMMENDATIONS:
- Services should be based on a community-based recovery model

CL1 (workforce development)
RECOMMENDATIONS:
- Increase courses on trauma in graduate programs, training facilities
- Expand reimbursement to provider networks – increase reimbursement rate should be adequate; role must reflect cost
- Use available experts to focus on trauma training; use strengths of clinicians

- More focus training for practitioners; certification = with list of available clinicians
- Once we ID – now what?
- Community Re-entry
- Add in family who are affected by this

CL2 (best way to get info to Vets)
RECOMMENDATIONS:
- Partnership with military and local community resources (especially prior to release, discharge from service)
- Mandates, release of information
- Starting information (get it to families at the start of deployment)
- Media release /information - commercial (PSA)
- 1-800 # for state wide assistance
- Internet link to the VA website with information
- Agency to agency communication of services available. Partnership between state (VA) and federal level of services.
- Address 3 tracks: symptoms of TBI, PTSD, etc.
- Services available
- Fed funds (SC)
- Consider how money set aside for PTSD, TBI, etc. is allocated – community needs; where are services needed, etc.
- Nationwide organization for PTSD/TBI
- Info-mercials on symptoms i.e., "Are you having trouble sleeping since returning?"

CL3 (transition into public health)
RECOMMENDATIONS:
- Making access "safe" for vets
- Readjustment services broader than mental health/substance abuse or rehab services outside of Medicaid model
- Integrated community health education model
- "public health" health and human services; life span approach; top/down investment
- Increase cooperation between VA and community resources/collaboration
- Continuum of services (not of treatment or care)

CL4 (building systems of care)
RECOMMENDATIONS:
- Why do veterans need systems of care - Veterans have multiple issues/needs that exceed capacity of VA resources
- Veterans do not stay in VA and move care into the community (medical problems surface after)
- Need to identify gaps in treatment/interventions for vets (suicide, SA, spirituality, employment, divorce, family)
- Need to understand what programs are available across systems
- How do we build systems?

- Develop a triage system to determine level of acuity and identified need
- Roundtable discussion between VA/DOD/ community to identify resources and qualified people
- Move away from vacuum of services within VA/DOD/community toward shared resources
- Broaden scope of triage to include clinical, administrative, psycho-education, school system, families
- Understand what programs are available across systems.

FB1 (integrated partner)

RECOMMENDATIONS:

- Intentionally integrate at summits across disciplines
- develop a statewide faith-based listing that includes state agency resources, CSB's, houses of worship, and private providers. (this is currently under construction at DMHMSAS OSAS)

FB3 (leader needs)

RECOMMENDATIONS:

- raise awareness & sensitivity by providing knowledge to pastors and leaders.

House Veterans; Prevent Homelessness

CJ1 (identification)
RECOMMENDATIONS:
Consistent screening throughout the CJ system- "sequential intercept", because all the systems don't have access to records
A place to start - by asking, "Are you a veteran?" follow with consistent screening for various SA, MH, TBI, and polytrauma.
There are some screening instruments in existence already
Access is key issue here. Not simple: Have forms for vets available at local organizations treating and seeing vets
Funding
Stigma

CJ2 (treatment)
RECOMMENDATIONS:
Integrated services in treating
Utilizing Vet Centers
Look at best practice models that already exist and standardize around the Commonwealth
Work from rehabilitation perspective

CJ3 (training and awareness)
RECOMMENDATIONS:
Private sector/public sector partnerships
Housing, employment opportunities for vets
Workforce development issues
Media awareness

CJ4 (stigma)
RECOMMENDATIONS:
Housing issues
Private sector/public sector partnerships

CJ5 (housing)
RECOMMENDATIONS:
Housing FIRST- best practice from MH world
Funding is not being taken advantage from a federal level
Addressing homeless vet needs
Veteran's housing that includes categories of felonies

VSO1 (healthcare)
RECOMMENDATIONS:
Try to provide long-term care at home (better/less expensive). Should be smooth transition from hospital to VA to home. Continuum of care.

VSO2 (homelessness)
RECOMMENDATIONS:
No Veteran should ever be homeless. "Stand Down" organizations provide services to veteran (medical, grooming, employment) to improve quality of life.
Increase time limits (from 30 days to 180?) for Veterans to find a job. VSO could research current regulations and advocate for change.
Veterans living with parents or girlfriend are not considered homeless but if relationships go bad, they become homeless.
Reduce federal government waste (closing bases, etc) and lease property to homeless veterans and their families and employ them on the base. VSO's could take this project on.
Talk to Centers for Independent Living – they have knowledge about housing and access to services.

VSO4 (employment)
RECOMMENDATIONS:
Job training and re-employment should be a top priority. College doesn't always meet this need. Tec Access and Woodrow Wilson offer helpful training.
VSOs can support community focus groups to learn more about the needs.
Develop a method of tracking veterans who access the VEC.
Provide assistance to wounded warrior units who need transition resources, physical rehabilitation, etc. (i.e. Fort Lee, Quantico)
Welcome home returning service members but extend concern into the long-term.
VSO's need vehicle to communicate with the Commissioner.
VSO's adopt a reserve unit or family.

PP1 (money)
RECOMMENDATIONS:
Propose a dedicated funding stream to fund recommended services
Determine how to increase the capacity of the Community Services Boards and Department of Rehabilitative Services to provide behavioral healthcare and rehabilitative services to veterans and their families.
Establish on-going reimbursement systems that are sufficient to cover the costs of care.

PP2 (define scope of problem)
RECOMMENDATIONS:
Increase community capacity without duplicating existing services.
Develop a comprehensive, multi-agency plan to break down barriers for veterans, their families and providers.

PP4 (how to get services where they are needed)
RECOMMENDATIONS:
Determine the most effective way of reaching out to veterans and their families who may be at risk for behavioral healthcare issues. Determine how to "bring the services to" the veterans.
Take advantage of existing supports available through family and friends. Activate communities.
Increase professional capacity (first line) and family/friends (second line).

Cl2 (best ways to get info to vets)
RECOMMENDATIONS:
1-800 # for state wide assistance
Internet link to the VA website with information
Agency to agency communication of services available.
Partnership between state (VA) and federal level of services.

CJ3 (transition into public health issue)
RECOMMENDATIONS:
Break down funding barriers
Educate at *not* stigmatizing
Prioritizing veterans eligibility
Making access "safe" for vets
Readjustment services broader than mental health/substance abuse or rehab services outside of Medicaid model
Integrated community health education model
"public health" health and human services; life span approach; top/down investment

Cl4 (building systems of care)
RECOMMENDATIONS:
Why do veterans need systems of care
Veterans have multiple issues/needs that exceed capacity of VA resources
Veterans do not stay in VA and move care into the community (medical problems surface after)
Need to identify gaps in treatment/interventions for vets (suicide, SA, spirituality, employment, divorce, family)
Need to understand what programs are available across systems
How do we build systems?

Cl4 (building systems of care)
RECOMMENDATIONS:
Develop a triage system to determine level of acuity and identified need
Roundtable discussion between VA/DOD/ community to identify resources and qualified people
Move away from vacuum of services within VA/DOD/community toward shared resources
Broaden scope of triage to include clinical, administrative, psychoeducation, school system, families
Understand what programs are available across systems.

FB1 (become an integrated partner)
RECOMMENDATIONS:
Encourage local faith-based organizations to host informational exchange conferences to foster better multi-disciplinary cooperation
Intentionally integrate at summits across disciplines
develop a statewide faith-based listing that includes state agency resources, CSB's, houses of worship, and private providers. (this is currently under construction at DMHMSAS OSAS)

Hire Veterans

VSO4 (employment)
RECOMMENDATIONS:
- Job training and re-employment should be a top priority. College doesn't always meet this need. Tec Access and Woodrow Wilson offer helpful training.
- VSOs can support community focus groups to learn more about the needs.
- Develop a method of tracking Veterans who access the VEC.
- Provide assistance to wounded warrior units who need transition resources, physical rehabilitation, etc. (i.e. Fort Lee, Quantico)
- Welcome home returning service members but extend concern into the long-term.
- VSO's need vehicle to communicate with the Commissioner.
- VSO's adopt a reserve unit or family.

CL1 (workforce development)
RECOMMENDATIONS:
- Focus on vets for employees

CL4 (building systems of care)
RECOMMENDATIONS:
- Need to identify gaps in treatment/interventions for vets (suicide, SA, spirituality, employment, divorce, family)