A health care provider is only as good as its performance. Northwood Health Systems, headquartered in Wheeling, West Virginia, is one of the top performing health care providers in the United States. In fact, outside experts agree that Northwood’s success and accomplishments have made the company an industry leader.

That’s why Northwood received national recognition when it earned the Process Innovation Award at the Solution World Conference Expo for its customized electronic medical records system. And why Northwood has also received multiple international awards, competing with thousands of other companies from more than 50 countries, for its industry leading web site.

No wonder Northwood’s success and accomplishments have received positive national recognition for both the company and the state of West Virginia. Media outlets such as CNN TV, The Chronicle of Philanthropy, and several prominent national publications including Behavioral Healthcare, Health Management Technology, and Behavioral Health Management have reported on Northwood’s achievements.

In addition, West Virginia Executive magazine has featured CEO Pete Radakovich on the front cover and recognized Mark Games, Chief Operating Officer, as a Young Gun.

It all adds up to a world-class organization. All for the Glory of God.

If you want to join the Northwood team please contact us.

www.northwoodhealth.com
Veterans on the Road Home

As increasing numbers of soldiers return home from Iraq and Afghanistan bearing the scars of battle in the form of mental illnesses and addiction disorders, the need for treatment far exceeds the capacity of the Veterans Administration.

Across our nation, more than 2,000 community-based mental health and addictions organizations are ideally equipped to treat our troops for disabling mental and substance use disorders and help them reintegrate into civilian life. With deep roots in their communities, these providers deliver critical mental health and addictions services to nearly six million Americans annually and now they’re opening their doors and extending their services to veterans and veterans’ families.

This issue of National Council Magazine highlights the difficult road home and what treatment organizations around the country can do to make homecoming easier for our wounded heroes.

Coming soon from the National Council
(check at www.TheNationalCouncil.org)

Meeting the Mental Health and Substance Use Needs of Veterans Returning from Operation Iraqi Freedom and Operation Enduring Freedom and Their Families: An Orientation and Training Manual
The wars in Iraq and Afghanistan no longer dominate the evening news or the public’s consciousness. According to a recent Pew Research Center poll, only 16 percent of Americans name the Iraq war as the story that first comes to mind when asked what has been in the news lately. But for the thousands of U.S. servicemen and servicewomen still serving in these war zones, the war remains a central part of their lives. And for the thousands of veterans who return home with physical and mental scars, their wounds can present particular challenges for years to come.

This is why the National Council is dedicating this issue of our magazine to veterans and their continuing struggles with mental health and addiction issues. As for returning serviceman and servicewomen, the war looms large for National Council members—community mental health and addictions services organizations—working with the families left behind during tours of duty and dealing with the war's aftermath in the form of veterans returning with posttraumatic stress disorder, anxiety, depression, and substance abuse.

And our involvement may intensify—we may soon be on the frontlines of the veterans’ battlefield back home. At this writing, Congress is considering legislation to extend and supplement the treatment systems for the U.S. Department of Veterans Affairs by funding the nation’s network of existing public community mental health and addictions agencies. The legislation would enable more returning veterans and their families to take advantage of the mental health and addiction treatment services in their own communities.

Our members’ deep roots in the community leave us well suited to take on this welcome task. For one, veterans can receive treatment in their hometowns and not have to travel to VA centers located in other towns and cities. Our services go beyond our doors as we engage churches, schools, and other community
stalwarts to become involved in a holistic approach that treats the whole family.

As our communities gear up to effectively meet the needs of returning veterans and their families, they are faced with a multitude of important questions. What do we need to know to effectively serve veterans returning from Operation Iraqi Freedom and Operation Enduring Freedom and their families? What does cultural competency mean with respect to those who have served in the military and their families? What are the unique characteristics of the conflicts in Iraq and Afghanistan that should inform treatment? What lessons can be learned from behavioral healthcare providers who already specialize in treating these veterans and family members?

To help address these pressing questions and to advise behavioral health providers about where to find additional information, we’ve developed an orientation and training manual, *Meeting the Mental Health and Substance Use Needs of Veterans Returning From Operation Iraqi Freedom And Operation Enduring Freedom and Their Families*. Funded by the Center for Mental Health Services within the U.S. Substance Abuse and Mental Health Services Administration, the manual aims to equip mental health and addictions staff to fully engage veterans and their families. By providing strategies, techniques, and advice, the manual is designed to serve as a resource compendium and reference tool with detailed information to guide readers who seek additional learning. The manual will soon be available on our website at www.TheNationalCouncil.org.

In compiling the manual, we seized on the combined wisdom detailed in case studies of six community behavioral healthcare providers and state associations with special expertise in and commitment to serving veterans of Iraq and Afghanistan and their families. These innovative and collaborative aspects of their services turned into eight “lessons learned”:

**Lesson #1: Understanding military culture is key**

The focus is on perceptions of military service and mental health and on substance use service needs.

**Lesson #2: Navigating the military’s behavioral healthcare system is a challenge**

The focus is on the VA, VA medical centers and clinics, vet centers, women’s health programs, and homeless programs.

**Lesson #3: The gap between needs and resources is wide**

Much is being done, and more needs to be done, now and perhaps for years to come.

**Lesson #4: Financing services for veterans and families demands creativity and patience**

The complexities of accessing TRICARE, VA, and other fiscal systems require attention if those resources are to be available to community behavioral health agencies.

**Lesson #5: Local planning matters**

States and communities are unique, yet they share common needs.

**Lesson #6: Veterans, family members, and community leaders are our best allies**

Veteran peer specialists, primary healthcare professionals, faith-based providers, and others in the community constitute a corps of highly effective advocates to build treatment and recovery support services.

**Lesson #7: Behavioral health staff excel when carefully trained and deployed**

The current training of community behavioral health staff in critical areas, such as trauma, recovery, and family service systems, provides a solid foundation on which to build specialized services for returning veterans and their families.

**Lesson #8: Adjust, adjust, adjust**

It is no surprise to community behavioral health providers that systems of services and supports evolve most effectively when people are prepared to adjust to expected and unanticipated developments.

And let us not forget perhaps the biggest lesson learned: The wars may no longer be front-page news, but they are still front and center in the lives of returning veterans. Every community in our nation has been affected, and every community behavioral healthcare organization stands ready to respond.
The Road Home

Operation Iraqi Freedom and Operation Enduring Freedom

Key Statistics and Facts

Mental health is the second largest area of illness (after orthopedic problems) for which veterans of the wars in Iraq and Afghanistan seek treatment at Department of Veterans Affairs facilities.1

Veterans and their families face a wide range of mental health and addiction issues, including major depression, alcohol abuse (sometimes beginning in an effort to sleep), narcotic addiction (often beginning with pain medication for combat injuries), generalized anxiety disorder, job loss, family dissolution, homelessness, violence toward self and others, and incarceration.2

Nearly 1 in 5, (300,000) soldiers who have served in Iraq or Afghanistan have posttraumatic stress disorder or depression; only about half of that number actually have sought treatment.3

Unusual circumstances of the wars in Iraq and Afghanistan add to the normal stresses of war, increasing the potential for traumatic stress-related disorders. For example, absence of a clear distinction between frontline and rear echelon reduces the ability to escape high-stress situations; other issues include extended and multiple tours of duty and intense involvement of National Guard members and reservists, many of whom are drawn away from established careers and young families.

Approximately 19 percent of returning service members report that they experienced a possible traumatic brain injury while deployed, and 7 percent of service members report both a probable brain injury and current PTSD or major depression.4

Many service members said they do not seek treatment for psychological illnesses because they fear it will harm their careers. But even among those who do seek help for PTSD or major depression, only about half receive treatment that researchers consider “minimally adequate” for their illnesses.

45 percent of homeless veterans suffer from mental illness, including many who report high rates of PTSD.5

Veterans represent roughly 26 percent of homeless people but only 11 percent of the civilian population 18 years and older, even though veterans are better educated, are more likely to be employed, and have a lower poverty rate than the general population.

Approximately 70 percent of homeless veterans suffer from substance abuse problems.6

Although these rates of mental illness and substance abuse are similar to those of other homeless men, some research suggests that alcohol dependence and abuse are more common among homeless veterans than among homeless nonveterans. People with substance abuse problems may have trouble maintaining employment and meeting their monthly housing costs.

A suicide prevention hotline started by the VA and the Substance Abuse and Mental Health Services Administration in July 2007 has served 22,000 veterans and prevented 1,221 veterans from taking their lives in the first year of operation.

In 2006, the Army reported the highest suicide rate—17.3 per 100,000 soldiers—since it began recording such deaths in 1980. A VA study found that 53 percent of veterans returning from Iraq and Afghanistan who committed suicide between 2001 and 2005 were reservists or National Guardsmen, citizen soldiers who may be less able to navigate the bureaucracy to get help.7

Saluting our men and women in uniform and their families.

Lilly salutes those who serve.
My name is Travis Williams, and this is my story...

I have lived in Montana since I was 6 years old. I graduated from Helena Capital High School in 2002 and shortly thereafter joined the Marine Corps. I guess I was attracted to the challenge, so I decided to test myself against their standards. I found I was able to adapt to the rigors of the Marine lifestyle quite readily. This was strange, because in high school I was completely the opposite of every ideal they could throw my way. I found a sense of direction in the Marine Corps.

When I returned to Montana after basic training, I checked into my reserve unit in Billings. In August 2003 I enrolled at the University of Montana and attended classes between my monthly drills. In December 2004, nine Marines, including myself, received orders to activate with Lima Co. 3rd Battalion 25th Marines out of Columbus, Ohio.

We met up with our new unit in 29 Palms, Calif., on January 5, 2005. We spent 2 months getting acquainted and training with Lima Co. before we left for Iraq. By the time we stepped on the plane, we were analogous to a family. We said our goodbyes and headed into the unknown.

On arrival in Kuwait, we were informed that we were going to Iraq’s now infamous Al Anbar province. Our home base was Haditha Dam, which was guarded by the Azerbaijanis. They ran the security so that we would be able to conduct mobile operations throughout Iraq’s largest province.

Our battle rhythm was demanding, to say the least. We were 180 strong patrolling and clearing an area half the size of the country. My first major firefight was a 2-hour siege of the town of New Ubaydi, Iraq. This town lies near the Syrian border, where we were always sure to find resistance. During 2 hours of door-to-door fighting we had moved two blocks into the city. My platoon already had five casualties, and the platoon adjacent had lost. This was my first taste of what war really was. It was most definitely unlike anything I had ever experienced, but it still felt exhilarating; never have I felt so alive and so scared at the same time.

After experiencing the sights, smells, and sounds of battle and its aftermath, my emotions seemed to dull or shut down. I later learned that this was a defense mechanism that allowed me to continue to operate in a combat zone. To the best of my knowledge, every Marine seemed to experience this in one form or another.
By our 2-month mark, we had all been engaged and fancied ourselves combat veterans. Everyone had either lost a friend or seen one carried away in a Medevac. We faced improvised explosive devices, mortar rounds, rockets, and small arms fire on a daily basis. Soon it was becoming hard to distinguish the real enemy, those we fought or those who made us fight. This double-fronted battle only strengthened our small unit’s fraternity.

Eventually, we recognized that someone on our side was continually putting us in harm’s way. We came to trust only each other, and the outside world became irrelevant. We fought for each other, not national policy or the ideals of democracy. Little did we know that this was only the beginning.

In August 2005, our battalion lost 24 Marines in about 10 days. Thirteen of them were from our company. On August 1, a team of our snipers was compromised, and all six of them were killed. On August 3, we headed into the city of Barwanna, which was about 8 miles from our dam, to recover the weapons of our fallen comrades. While entering the city, one of our troop transport vehicles—or “tracks,” as we call them—was hit by a massive improvised explosive device. It was the largest I had seen, and I knew whoever was in that vehicle was probably dead. As I ran closer, I realized that it was my squad that was in the track. In that moment, I truly understood the meaning of loneliness.

In one fell swoop, the only family I had known for 6 months was taken from me. The bonds tempered by the fire of battle are stronger than any others. I felt alone and beached in a world I no longer wanted to be a part of.

After a couple hours, we were ordered to continue with the mission as though nothing had happened. By noon you could already see the videos of the explosion on Al Jazeera. We stayed out for another week before they let us go back to the dam. I lost my appetite, and I most certainly did not sleep. It only got worse from there. We still had another month of operations ahead of us. I had become indifferent as to whether I lived. The battalion flew in a team of psychologists for us to speak with. During the middle of the first meeting, one doctor had fallen asleep. This only reinforced the belief that all we had was each other. That incident left me absolutely bitter toward anyone who was not part of our unit.

When we arrived home, it seemed surreal. I felt more out of place here than I had in Iraq. I isolated myself from friends and family and dwelled in my emptiness.

In November 2005, I went to Ohio to meet the families of those I called my brothers. The experience was second in terms of difficulty only to accepting the loss of my best friends. I was drunk and angry, and the only person I could blame was myself. I was certainly on the beaten path of destruction.

On my return to Missoula, I received a phone call from Deb McBee, a veteran’s service officer from the Military Order of the Purple Heart. She had read an article about what had happened to my squad and recommended I see someone at the Veterans Administration clinic. I took her advice and enrolled for medical services. My VA physician referred me to David Anderson, the veterans’ liaison for Western Montana Mental Health Clinic.

Dave made an immediate impression on me as someone who had experienced the atrocities of war firsthand. He served with the 18th Battalion 9th Marines, the most engaged unit in the history of the Marine Corps. If I had a glimmer of hope, it definitely came from this man. He only works with true combat vets, so I was honored when he offered to help me out.

About 8 months later, I received a disability rating of 50 percent for posttraumatic stress disorder from the VA. Shortly thereafter, I was discharged from the Marine Corps. With a rating of that degree, I was eligible for the Veterans Outreach Center rehab program, so I decided to pursue it.

With Dave’s help I changed my major to premed, and I am currently pursuing that field. I still see Dave on a weekly basis, and his wisdom has been paramount in terms of my recovery.
The Road Home

Veterans Speak Out About Stigma

Jeannie Campbell, Retired Master Chief Petty Officer and Executive Vice President, National Council for Community Behavioral Healthcare

Based on interviews with Jon Grable, Chris Hill, Scott Swaim, and Travis Williams for National Council Magazine

When Chris Hill was honorably discharged from the U.S. Marine Corps in 1982, he removed the medical record in his permanent file indicating he had seen a psychiatrist. Hill, who was having anxiety attacks, said he did not want to be labeled as someone with psychiatric problems.

“I was embarrassed about it at the time,” said Hill, who now works as a mental health counselor for the Jefferson Center for Mental Health in Jefferson County, Colo. “There was a stigma in my own mind about it being bad to get psychiatric help. As a former Marine, I didn’t want to appear weak.”

Research shows that Hill’s trepidation about receiving psychiatric care is not unique among members of the Armed Forces. A 2004 study of 6,000 military personnel involved in ground combat operations in Iraq and Afghanistan found that of those whose responses indicated a mental health problem, only 23 to 40 percent sought psychiatric help. Many who did not seek treatment cited fear of being stigmatized as a reason.

After leaving the Marines, Hill struggled with alcoholism and attempted suicide; he said he “lost every material thing I ever owned.” Hitting bottom taught him he had to deal with his addiction and depression, and he finally began psychiatric counseling.

“I tell veterans to go after the help they need,” he said. “Don’t be too prideful, and be open to recovery plans.”

Jon Grable also came close to hitting bottom—and to hitting anyone who crossed his path.

“The military set me up to be a firm person,” said Grable, a six-foot-two-inch, 300-pound Army veteran who was dealing with anger over the death of his wife and his loss of custody of his stepchildren. He said, “I felt like, ‘Everybody will feel my pain if they cross me.’”

Grable struggled with schizophrenia and had difficulty adjusting to civilian life when he left the Army in 1993.

“My years in the military were very orderly; you get use to a regimented life,” he said. “When you get out, there’s no one showing you how to organize your day.”

When he stopped taking the psychotropic drugs for his illness because he said they interfered with his work, he eventually lost his job, slipped into homelessness, and found himself sleeping in his truck. Two and a half years ago, he was accepted into the Shelter Plus Care Program in Marietta, Georgia. He now lives in government-funded housing, receives regular treatment for his schizophrenia, and has plans to start a landscaping business.

“There’s a double stigma about mental health problems among many veterans,” said Scott Swaim, a 15-year Gulf War veteran and senior director of veterans’ services at Valley Cities Counseling and Consultation in Auburn, Washington. “You’re trained to be a warrior, to suck it up and perform the mission.”

Swaim works with community organizations to reach out to members of the military and make them more “veteran friendly.” He teaches groups about the importance of cultural competence, pointing out that the military is a culture in itself.

“The military has its own laws, its own clothes and its own language,” he said. “To serve them better and help ease their fears about treatment, we first need to understand what being a veteran is all about and be familiar with all things military.”
Swaim said an initial step to working more effectively with veterans is for organizations to count the number of service members receiving treatment.

“It can be hard to identify vets, as they don’t wear uniforms anymore,” he said. “Knowing they served in the military can make a big difference. Many veterans don’t feel safe disclosing information after the ridicule and abuse following Vietnam.”

Organizations can make their lobbies appear more welcoming by displaying information about veterans’ benefits, Swaim said.

“After serving, many veterans have a difficult time fitting back into this culture,” he said. “They may find themselves walking around a shopping mall thinking the people here cannot understand what they went through.”

Swaim noted that feelings of alienation among veterans today may be heightened by the added stress of multiple deployments. He also emphasized that it is important for organizations to understand little things like the difference between Veterans Day and Memorial Day and what events may trigger certain emotions in veterans.

When Travis Williams returned from Iraq in 2006 after four years in the Marines, he did not hesitate to initiate counseling. Williams was having nightmares about a road bomb explosion that killed all 11 members of his rifle squad. He was the lone survivor.

“I just happened to be riding in the lead vehicle carrying Iraqi soldiers,” said Williams, whose horrific story was featured in an A&E documentary. “We drove right over the IED, but the insurgents waited for the vehicle carrying American soldiers to detonate it. The closest guys I ever had as friends were all dead.”

Williams said the 2005 incident left him with intense feelings of anger.

“I looked back at the accident site and saw guys throwing blankets over the body parts,” he said. “I went up on a roof and just wanted to start shooting anything moving that wasn’t wearing desert cammies. After that, everywhere I went I thought I’d see my old buddies.”

He knew he needed help and began receiving mental health counseling as soon as he returned to Montana as a civilian.

“I’d say you’re being a coward if you don’t get [counseling],” said Williams, now a student at the University of Montana. “You can’t be scared of what some doctor is going to think. I can testify that it helps a lot.”

Not every returning veteran may be haunted by memories so intense, but Swaim emphasized that “all of us are already serving veterans, so it’s everybody’s job to learn how to serve them better.”
A June 2007 report from the Department of Defense Mental Health Task Force highlighted the growing mental health problems that troops returning from Iraq and Afghanistan are experiencing. The report pointed out that nearly 50 percent of National Guard members and reservists report symptoms of mental disorders—and many find it difficult to access military-provided clinical care and support groups. Across our nation, more than 2,000 community-based mental health organizations are ready and qualified to provide quality psychological care to our veterans close to their homes. Community providers’ 40-year track record of providing critical mental health services to nearly 6 million Americans annually, combined with their comprehensive geographic coverage and deep roots in our communities, ideally equips them to answer the growing need to treat our troops for posttraumatic stress disorder and other disabling mental disorders.

The National Council has advocated for legislation that requires the Department of Veterans Affairs to partner with community mental health organizations to supplement its capacity.

Moreover, the National Council, in partnership with the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, has developed an orientation and training manual to equip mental health and addictions professionals who may not be veterans themselves to fully engage this population. In addition to providing strategies, techniques, and advice, the manual serves as a resource compendium and reference tool that provides detailed information to guide readers who seek additional learning.

The following lessons synthesize the experiences of community and state behavioral health organizations that are already delivering mental health and addictions services and supports to returning veterans and their families.
Lesson #1
Understanding military culture is key

Military culture is complex and completely separate from the civilian experience. Mental health and addictions professionals must “get it right,” especially with combat veterans. Understanding military culture is critical, and the key is the concept of “Battlemind,” defined by the U.S. Army as a soldier’s inner strength to face fear and adversity with courage. Battlemind skills help service members survive in combat but can cause problems when soldiers return home if not adapted to the civilian environment.

Skills that are essential in combat, such as unit cohesion, responsibility for one’s peers, aggressive behavior, awareness of dangers in the environment, and ability to control emotions, must be adapted to the civilian environment. For example, hypervigilant driving behaviors that saved lives in Iraq can become aggressive driving at home (e.g., speeding, ignoring lanes and posted signs). Emotional control can become isolation and detachment from family, friends, and community.

Battlemind also adds to the stigma regarding mental and emotional disorders and the abuse of substances in the military, which is pervasive and a significant barrier to veterans seeking care. In its most pronounced form, fears related to stigma, coupled with untreated mental health symptoms, cause some service members to be charged with “wilful misconduct” when they were actually experiencing manifestations of PTSD.

Lesson #2
Navigating the military’s behavioral health care system is a challenge

An understanding of returning veterans’ behavioral health needs is bolstered by knowledge of the behavioral health service system that exists for active-duty military, including active-duty reserve components. Providing for the psychological health of active-duty military and their families is the responsibility of the DoD, but no single mental health or substance abuse treatment program exists across the DoD. Numerous programs related to psychological health are administered within and outside the confines of the Defense Health Program, and considerable variation in mental health service delivery exists among the military services and TRICARE (see Lesson 4).

The VA system is the nation’s largest integrated health care system; it includes more than 1,400 hospitals, clinics, and nursing homes. Behavioral health services are available through the VA to everyone who serves on active duty in the Army, Navy, Marines, or Coast Guard (and who was not dishonorably discharged). Former VA Secretary Jim Nicholson referred to the medical care that the VA delivers—especially to older veterans—as the “gold standard.” Outside studies confirm Nicholson’s statement, suggesting that VA care does exceed services typically available in the private sector.

The DoD Mental Health Task Force (2007), however, noted that three significant obstacles constrain development and provision of adequate and appropriate mental health and substance abuse care:

- The military system does not have enough resources, funding, or personnel to adequately support the psychological health of service members and their families in peace and during conflict.
- Mental health professionals are not sufficiently accessible to service members and their families.
- Significant gaps exist in the continuum of care for psychological health.

The National Council believes that these findings present community behavioral health agencies with an opportunity to reach out to federal, state, and local officials, particularly to those connected with the VA. The VA system offers great opportunities and challenges for community behavioral health agencies that want to develop service partnerships to care for returning veterans and their families. Networking is key to developing and strengthening service partnerships.

Lesson #3
The gap between needs and available resources is wide

In the first study of its kind to assess the mental health needs of American service members who have served abroad, psychiatrist Charles W. Hoge of the Walter Reed Army Institute of Research found that about one-third of 300,000 troops returning from Iraq, Afghanistan, and related Operation Iraqi Freedom or Operation Enduring Freedom deployment locations later sought help for mental health problems. According to the
continued... Meeting Veterans’ Behavioral Health Needs: Lessons for Community Providers

study, this number represents less than half of returning troops who actually need mental health services. The VA has estimated that one-third of returning combat veterans who seek care from the VA may have a mental disorder.

Accessing care can be challenging. Many veterans live far from VA health facilities; long-distance travel may inhibit or prevent them from receiving needed care. Troops returning from Iraq and Afghanistan may encounter VA and community-based service systems that are not sufficiently prepared to help them effectively reintegrate into communities. Readjustment information for families has been described as sporadic and, in some areas, not available at all.

Lesson #4
Financing community behavioral health services for veterans and families demands creativity and patience

Four funding sources provide key support behavioral health services for veterans and families:

- TRICARE
- The VA
- Special congressional appropriations
- Traditional sources of mental health and addictions services funding

TRICARE is a regionally managed health care program serving active-duty service members; retirees; and their families, survivors, and certain former spouses worldwide. TRICARE supplements the health care resources of the Army, Navy, and Air Force with networks of civilian health care professionals, institutions, pharmacies, and suppliers to provide better access and high-quality service while maintaining sufficient capability to support military operations. All active-duty soldiers are automatically enrolled in the TRICARE program. Reserve and National Guard members called to active duty are covered under TRICARE for 2 years after they return from active duty in OIF or OEF. The growing recognition that certain duty-related disorders (e.g., PTSD) may not become evident during that limited period or may require treatment beyond a 2-year period has led to discussions of extending coverage.

CHAMPVA is a federal health benefits program administered by the VA. A fee-for-service (indemnity plan) program, CHAMPVA reimburses for medical expenses including inpatient, outpatient, mental health, prescription medication, skilled nursing care, and durable medical equipment. CHAMPVA is also available to certain family members who are not eligible for TRICARE.

Lesson #5
Local planning matters

Contract development between community mental health and addiction services agencies and the VA needs to happen at the local and state levels, so that is where the critical relationships must be built. In some states and communities, the VA is not accustomed to reaching out to other agencies or to having other agencies reach out to them for partnerships, especially those that may be funded with VA financial resources. This new dynamic will take getting used to, but the VA is currently under great pressure to ensure that veterans receive needed services. They are moving quickly in many areas to create strong local partnerships.

Providers that have experience with veterans programs suggest that community mental health centers should be clear about what they can offer to meet veterans and family needs and to comply with VA requirements. A significant learning curve marks these partnerships,

The VA has estimated that one-third of returning combat veterans who seek care from the VA may have a mental disorder.
as community mental health centers and VA professionals learn each other’s needs and capacities and develop ways to collaborate for a common purpose. One way to manage the learning curve is to propose specific ways in which community mental health centers can help the VA do its job more effectively.

To succeed, National Council members must become familiar with VA operations and objectives. Experience suggests that VA staff initially tend to have low estimates of the behavioral health service needs that community mental health centers have the capacity to fill. Once the word is out that the center offers highly valued services and veterans and family members grow to trust providers, referrals increase.

**Lesson #6**

Veterans, family members, and community leaders are our best allies

The bridges that need to be built between military and civilian communities include many allies that community agencies already know and others with whom the agencies are typically less familiar. Organizations such as the National Alliance on Mental Illness, the Federation of Families for Children and Mental Health America can help identify needs of veterans and family members and advocate for resources to meet those needs. Relationships must also be forged with individuals and groups such as discharged veterans, their local representatives (Disabled American Veterans and Veterans of Foreign Wars), National Guard and reserve staff, and veterans and their family members.

Community mental health and addictions services agencies observe that families of veterans have substantial support needs. To date, federal programs specifically targeting their behavioral health needs, including those offered through the VA, have been limited. Working with families of deployed and returned veterans is an area of unfulfilled opportunity for community mental health centers, which have significant services and skills to bring to bear in this area of substantial and expanding need.

**Lesson #7**

Behavioral health staff excel when carefully trained and deployed

Experienced veterans program providers know that staff must be well oriented to and trained in military culture, service needs, and best practices. They then must be carefully deployed where they can have the most immediate and greatest impact. Peer-to-peer contact is essential, especially in the early stages of care. If qualified veterans on staff are available to provide intake services (i.e., screening and assessment), consider assigning them that task. If the agency has no or few veterans on staff, reach out to the community.

Community mental health centers have hired OIF and OEF veterans and family members to provide peer case and care management with success similar to what has been seen with consumers of mental health services. Having veterans on staff is important not only for peer-to-peer clinical contact but also to work with other agency staff on general orientation to military culture and on ways to manage interactions with military families.

Successful agencies prepare to meet veterans’ and families’ needs at the outset. During intake, they ask every new client about his or her veteran status, including recent combat experience (which veterans do not always offer voluntarily). Family and friends can fill in incomplete information. In fact, most referrals come from family.

The interests of veterans must remain at the center of all activities and decisions. Services must be available after hours, when veterans and their family members need them. In addition, the VA has specific expectations regarding timely access to community-based services and the quality of those services. Staff must be well qualified in the areas of PTSD and combat trauma.

**Lesson #8**

Adjust, adjust, adjust

As with any new program, community behavioral health agencies should be prepared to be flexible as they build veterans service efforts. Experienced advocates for veterans share many stories related to how they adjusted to services and expectations.

One community program in a rural area could not provide face-to-face services for all veterans, so it developed the capacity to ensure that all first-time visits were in person, with subsequent contacts made by teleconference; the arrangement appears to work well. In another area, the VA was working with many veterans on pain management, and prescribing narcotics was a key component of care. Because the community mental health center’s psychiatric staff did not do pain management, its physicians would not prescribe narcotics. After angry reactions from veterans and some negotiation, the VA contracted with local primary care physicians to prescribe medication to manage pain.

Whatever each community mental health center’s unique situation, the mental health professionals serving veterans urge their colleagues to be patient, flexible, and persistent.

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According to a recent RAND report, Invisible Wounds of War, nearly 1 in 5 (300,000) soldiers who have served in Iraq or Afghanistan have posttraumatic stress disorder or depression, and only about half of that number have actually sought treatment. In addition, a report released by the U.S. Surgeon General's Office found that about 15.2 percent of soldiers returning from Iraq have signs of PTSD or depression and that the 1-year breaks that soldiers receive between successive 12- to 15-month deployments in Iraq do not provide adequate time for recovery.

The National Council, along with Mental Health America, has advocated hard for passage of the Veterans Mental Health Outreach and Access Act—introduced in the Senate (S 38) by Senators Pete Domenici (R-NM) and Barack Obama (D-IL) on May 23, 2007, and introduced in the House (HR 2689) by Representatives Ciro Rodriguez (D-TX), Patrick Kennedy (D-RI), Steve Pearce (R-NM), and Albio Sires (D-NJ) on June 12, 2007. The act is intended to improve access to mental health services for veterans returning from Iraq and Afghanistan.

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The Veterans Mental Health Outreach and Access Act would authorize the Secretary of the Department of Veterans Affairs to develop and implement a comprehensive national program to increase the availability of mental health support so that veterans affected by combat-related mental health problems do not go without access to the care they need. In remote areas of the country in which the VA determines that access to a VA medical center is inadequate, the bill directs the Secretary of the VA to contract with community mental health centers to provide treatment and support services and readjustment counseling. All contracted providers would be required to hire a qualified peer specialist and have its clinicians participate in a training program to ensure that services are tailored to meet the specialized needs of combat-affected veterans.

The bill calls on the VA Secretary to develop a national program to train returning servicemembers for positions as peer outreach workers and support specialists. The bill places particular emphasis on providing services for National Guardsmen and reserve veterans who have served in Iraq and Afghanistan. These civilian soldiers often return from combat duty and immediately resume civilian life and may not have adequate access to readjustment services or VA facilities. The legislation includes provisions to extend counseling services to veterans’ families, who may also experience issues with readjustment after their loved ones have returned from deployment.

Another bill, the Veterans’ Health Care Improvement Act of 2007 (HR 2874 and S 2612), would require the VA (1) to create a national program to train and deploy returning veterans to provide peer outreach and support services and (2) in rural areas not adequately served by a VA facility, to enter into arrangements with community behavioral health centers. The bill, introduced by Representative Michael Michaud (D-ME), was passed in the House on August 6, 2007.

Provisions from both bills have passed Congress in the form of HR 2874 and S 2612. The National Council urges Congress to quickly reconcile and pass a final bill.
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In 2007, the Centers for Medicare and Medicaid Services embraced peer support services as an evidence-based model of care for people with mental illnesses and substance-use disorders, and provided guidance in a letter to state Medicaid directors on peer service delivery.

As it is the single largest source of funding for mental health services in the country, CMS’s position has enormous significance. Peer support is also slowly finding its way into the nation’s largest integrated healthcare system, which is operated by the Department of Veterans Affairs. And Congress could augment that role.

With more than 5 million veterans under the Department of Veterans Affairs care annually, the Department provides a broad spectrum of mental health and substance-use services through networks of facilities that range from tertiary medical centers to small rural clinics. As an outgrowth of its participation in the New Freedom Commission on Mental Health, the Department has adopted the principle of recovery.

VA mental health service delivery continues to undergo its own transformation to a recovery-oriented model of care. As one element of that recovery orientation, VA’s Mental Health Strategic Plan calls for the development of peer support programs as an adjunct to mental health services. A still small number of VA facilities sponsor or utilize peer programs, which include peer counseling, consumer-run support groups, and peer-led groups on skill building and vocational training. These programs appear to vary greatly in frequency, in the kind of training provided for peers, and in the status of peers—whether they are purely volunteers or paid or unpaid facility staff.

Although VA leaders envision working toward employment of trained peer-support “technicians,” they are unlikely to move forward without the specific statutory authority.

Those who are developing VA mental health policy appear to view peer support services solely as supporting veterans with severe mental illness, identified by VA as having a “diagnosis of psychosis, schizoaffective disorder, major affective disorder, or severe PTSD.” But Congress has before it legislation that would open the door to peer services without regard to diagnosis, reflecting a recognition that many veterans who have served in Iraq and Afghanistan and who need mental health services for problems that may not yet be severe have been reluctant to seek VA care or may reside in areas remote from VA facilities.

Iraq and Afghanistan and who need mental health services for problems that may not yet be severe have been reluctant to seek VA care or may reside in areas remote from VA facilities. This legislation envisions a role for trained peers, who would not only provide support services but also serve as outreach workers. Such peers would therefore have served in Iraq or Afghanistan and have experienced readjustment or mental health problems, which would help them provide effective outreach and support to other veterans of this conflict.
The House and Senate have both passed legislation focused on returning veterans that provides for peer outreach and support and carves out a role for community mental health centers in providing mental health services, including peer outreach and support to returning veterans who live at considerable distance from VA health care facilities. But time is running out for Congress to reconcile the competing bills and pass a strong measure.

The importance of peer outreach and support, and of augmenting the capabilities of the VA healthcare system through community mental health centers, has grown with a recent RAND report, Invisible Wounds of War. This report projects that some 300,000 of servicemembers deployed to Iraq and Afghanistan currently suffer from PTSD or major depression but concludes that only about half of those have actually sought treatment. Even more worrisome is the reported projection of National Institute of Mental Health Director Tom Insel that up to 70 percent of returning servicemembers with these very serious conditions will not seek help from the Departments of Defense or Veterans Affairs.

Among the many factors cited by RAND and others that appear to inhibit veterans from seeking VA treatment are concerns about confidentiality, perceptions about their comfort in that system, the lingering stigma surrounding mental illness, perceptions about the effectiveness of treatment or side effects of medication, and logistical barriers. The RAND report recommends policy changes to encourage veterans to seek needed care but cites a need to improve access to mental health services other than through VA facilities, given the significant travel many face to obtain treatment.

These challenges underscore the risk that many, or even most, veterans with war-related mental health problems will not get needed treatment. This country’s experience with earlier generations of combat veterans strongly suggests that untreated mental health problems will result in increased chronic illness, substance abuse, unemployment, family dissolution, homelessness, and suicide.

Will Congress act to diminish that risk? H.R. 2874, the House-passed Veterans’ Health Care Improvement Act, would direct VA to:

- Mount a national program to train and deploy returning veterans to provide peer outreach and peer support services and
- Enter into arrangements with community mental health centers to provide mental health services and peer outreach and support services to returning veterans in areas that are not adequately served by VA health care facilities.

A Senate-passed measure, S. 2162, includes similar elements but is limited in scope to a very modest two-site pilot program.

Given enormous gaps across the country in access to VA mental healthcare among returning veterans, Mental Health America and the National Council for Community Behavioral Healthcare have been urging Senate and House leaders to enact and fund legislation that would achieve the goals of HR 2874. The VA, by maintaining that such legislation and programming are not needed, has not made the task easier.

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Midway through his tour of duty in Vietnam, **Bobby DeLuccy stopped writing home.**

He was **19 years old, an American patriot** poised to fulfill the dreams of his immigrant grandparents, and **proud to answer the call of his country**, but as the days and weeks and months of combat service took their toll, **his connection to the world back home began to fray**, and **words finally failed him.**

Bobby’s mother, frantic for news, called her congressman, and an order was routed down to the young soldier: Write home. He sat and stared at a blank sheet of paper. He would not write of the hardship, suffering, fear, horror, death, and destruction that he was living through. He could not describe the impact of unrelenting trauma on his own spirit as he grappled with overwhelming grief and loss, rage and shame, loyalty and betrayal, terror and reckless bravado, in a chaotic war zone where every day of survival heightened both his sense of invincibility and his pervasive sense of guilt. Soldiers don’t tell anyone that they’re scared, or what it feels like to watch their buddy die, or that they believe they should have died instead. They learn to face each day by disassociating as best as they can from their emotions, character, and attachments. Bobby signed his name to the blank sheet and sent it home, as he did every week for the remainder of his deployment.

The aftermath of the Vietnam War generated an unprecedented level of interest in the psychological effects of combat trauma. Thousands of disenfranchised veterans, struggling to reintegrate into civilian life, began to manifest symptoms of posttraumatic stress disorder, which was not formally recognized as a disorder until 1985. Negative stereotypes of drug-addicted, unpredictable, and dangerous veterans developed in the public consciousness, while dedicated mental health professionals worked on creating strategies for recovery from these invisible wounds of war. Over time, a population of troubled veterans surfaced within the network of human service agencies, but it was clear that their special needs were often not well met within existing systems.

**Samaritan Builds Communities of Healing for Veterans With Addiction Disorders**

Carol Davidson, LCSW, CASAC, Veterans Program Director, Samaritan Village, Inc.

Samaritan Village, a major provider of addictions treatment services in the New York metropolitan area, designed an innovative residential therapeutic community program for male veterans with addictions, mental health problems, homelessness, and other associated life problems. The program utilized the therapeutic community model to establish a clinical culture based on the natural camaraderie among veterans, an abiding respect for their service and sacrifice, and a balance of professional services and mutual self-help. The program provides addictions and mental health treatment, vocational rehabilitation, health and wellness services, and individualized treatment planning and case management, while emphasizing fundamental concepts of personal integrity, accountability, social responsibility, and purpose.
Bobby was 52 when he found his way to Samaritan Village Veterans Program. Plagued by intrusive memories, self-destructive impulses, and self-loathing that engendered a lifestyle of chronic drug and alcohol dependency, he had lost hope for redemption when he came in off the streets and reached out for help. He was welcomed into a healing community that recognized the warrior spirit camouflaged beneath his rough exterior.

Over time, through participation in counseling, groups, and program activities, Bobby engaged in the formidable work of personal discovery, disclosure, and development and gradually allowed himself to build deep and lasting bonds with his fellow veterans in recovery. Bobby was inspired by the love, respect, and understanding that he found among his brothers. With their support, he grieved for his fallen comrades at the Vietnam Veterans Memorial and proudly marched in the Veterans Day parade. He rebuilt his self-respect and found a sense of purpose in service to the veterans community.

Disabled by respiratory disease associated with Agent Orange exposure, Bobby still worked tirelessly as a volunteer for the United War Veterans Council of New York, gave public testimony on veterans’ issues, and volunteered for the Red Cross at Ground Zero for 6 months following 9/11. Bobby became a recovery role model who gave hope and guidance to fellow combat veterans who served in Vietnam, Grenada, Somalia, Panama, and Desert Storm, as well as peacetime veterans who suffered from addictive disorders. He carried a message of honor restored, dreams realized, and homecoming finally fulfilled.

America is currently in the process of reintegrating well over 1 million veterans who have served in Operation Enduring Freedom and Operation Iraqi Freedom. Extensive support systems have been put in place to assist them, and most of them will readjust successfully. Many, however, will need the specialized attention required to treat the complex psychospiritual wounds of war that manifest over time. Samaritan Village has doubled its own capacity to treat male veterans and is currently developing a residential program for female veterans in upstate New York. The agency has provided leadership, training, and consultation on addictions services for veterans.

POSTSCRIPT: Bobby DeLuccy died of respiratory disease in 2006. His courage, generosity of spirit, and commitment to the veterans community is a precious legacy that continues to inspire. This article is dedicated to his memory.
The Road Home

Buffalo Establishes First Veterans Treatment Court

The Honorable Robert Russell, Presiding Judge, Buffalo Drug Treatment Court

War-related illnesses may contribute to an increase in suicide attempts, arrests, incarcerations, divorces, domestic violence, homelessness, and despair among veterans. In Buffalo, as we prepared for veterans to return home from Iraq and Afghanistan, we anticipated that an increased number would show up in our criminal courts and decided to adopt a proactive approach.

We started work to establish a special treatment court to meet the needs of our veterans who were traumatized by war. The planning process took a year—we designed how the court would operate, obtained the support needed, and engaged in collaborations with the Veteran’s Health Care Network, community healthcare providers, veterans’ service organizations, community-based agencies, and volunteer veteran mentors. We also conducted community seminars on the trauma of war, associated behavioral health issues, and the resulting side effects thereof.

After a year of planning, the first Veterans’ Treatment Court in the United States began operating in Buffalo, N.Y., on January 15, 2008.

The court seeks to divert eligible veteran defendants with addiction disorders and/or mental illness who are charged with nonviolent criminal offenses to a specialized criminal docket that substitutes treatment and problem solving for traditional court processing. Eligible veterans are identified through evidence-based screening and assessments. The veterans voluntarily participate in a judicially supervised treatment plan that they help develop, along with a team of court staff, healthcare and mental health professionals, and peer mentors. At regular status hearings, treatment plans and other conditions are reviewed for appropriateness, incentives are offered to reward adherence to court conditions, and sanctions for nonadherence are handed down. Completion of the program is defined according to specific criteria. Many veterans have their charges dismissed, and others are assured of a nonincarcerative sentence on conclusion of treatment.

Veterans who are referred to the special treatment court are often homeless, helpless, in despair, suffering from alcohol or drug addiction, or struggling with serious mental illnesses. Yet many refuse to acknowledge their physical and psychological healthcare needs. The treatment court team finds these veterans, assesses their needs, offers them assistance, manages their care, and helps them solve their problems. If they were not referred to the special court, they would remain untreated and suffer the consequences of traditional jails and prisons.

The VA Health Care Network, the Western New York Veterans Project, volunteer veteran mentors, and a coalition of community healthcare providers collaborate with Buffalo’s treatment court to help veterans regain stability in their lives, strengthen family ties, and find housing and employment. A team of 20 volunteer mentors—veterans who’ve served in Vietnam, Operation Desert Shield, Operation Enduring Freedom, and Operation Iraqi Freedom—also assists the court team. Mentors are assigned to meet with veterans in the drug court program and discuss any ongoing concerns or issues of interest. They work to solve existing problems and bring to the attention of the court any difficulties that it can help in resolving. This relationship fosters a “can do” attitude in the veterans undergoing treatment, gives them a sense that they can accomplish their goals, and lets them know that they’re not alone. The mentors have not wavered in their commitment and dedication, despite the fact that they are not monetarily compensated for their time or expertise.

I hope other jurisdictions will critically examine how they can better serve the veterans who are seen in our criminal court system. As my project director, Hank Prowski, would say, it’s the right thing to do.

Veterans referred to the special treatment court are often homeless, helpless, in despair, suffering from alcohol or drug addiction, or struggling with serious mental illnesses. Yet many refuse to acknowledge their need for help. The treatment court team finds them and gives them an opportunity to change their lives.
"So much more needs to be done"

—Dr. Paul Janssen

That’s why we continue to define ourselves by Dr. Paul Janssen’s vision. To keep going beyond medication to discover new, real-life solutions that change the way the world looks at mental health.

It can be patient advocacy, educational programs, new treatments, or community outreach—when it comes to enabling every person to have a healthy mind, WE WILL never stop doing more.
Colorado Fills Service Gap For Veterans in Rural Areas

Doyle Forrestal, Director of Public Policy, Colorado Behavioral Healthcare Council

Thanks to the Civilians for Veterans Fund, a unique collaborative effort between Colorado’s community mental health centers, private donors, and the Department of Veterans Affairs, veterans of Operation Enduring Freedom and Operation Iraqi Freedom and their families are receiving free, confidential mental health treatment in three rural areas of Colorado.

The Civilians for Veterans Fund gives veterans and their families the opportunity to receive mental health and substance use treatment in a confidential location near their home. With the support of Colorado’s first lady, Jeannie Ritter, the program aims to increase the number of people who are receiving services.

“It’s no secret that our soldiers and their families need more help coping with the stress and trauma associated with this war and the long absence of loved ones,” said Ritter. “This collaborative program between private funders and Colorado’s community mental health centers is an important step toward expanding treatment services to rural areas of the state. Now it’s time to spread the word and get these soldiers and their families in for treatment. I’m thrilled to be a part of this innovative and collaborative effort.”

State and national attention increasingly is being directed to the mental health needs of soldiers serving in Iraq and Afghanistan as well as to the needs of their families. Many soldiers serving abroad are reservists and National Guard members who return to their home communities and civilian jobs when their tour of duty is complete. While active-duty military, National Guard, and reservists are serving overseas, the family members remain at home, left to cope with life’s daily pressures without the support of their spouse or parent. Often, when soldiers return, the families face many readjustment issues that compound any mental health problems involving the absent spouse.

Fear of damage to their careers keeps a large number of veterans from seeking mental health services. In Colorado, additional strain is placed on veterans as a result of the lack of VA mental health in some rural areas. And the VA does not provide services to cover the mental health needs of veterans’ families. To address these needs, the Civilians for Veterans Fund has created opportunities for veterans and their families to seek free services from community mental health centers. The VA provides technical assistance to clinicians at the centers so that they can better serve veterans. Because services provided in a community mental health center are confidential, clients can experience less fear of stigma and harm to one’s career.

Currently, the Civilians for Veterans Fund is helping to provide services in three regions of Colorado: the San Luis Valley, the Gunnison/Montrose region, and the Southeastern areas covering the Arkansas Valley. With additional revenue, this fund can expand to other parts of Colorado so that all veterans and their families can turn to a confidential resource to meet their mental health needs.

Community mental health centers encourage veterans in rural areas to seek help by providing services close to home and in a confidential manner so clients experience less fear of stigma and harm to their careers.
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Maine Survey of Veterans Reveals Critical Needs

Leslie Clark Brancato, President and CEO; Laura Gottfried, LCSW, former Vice President of Program Services; and Elizabeth Wheeler, PhD, Author and Researcher—Community Counseling Center

The Community Counseling Center is a family services agency with a history of working with children, adults, and families recovering from trauma, such as sexual abuse and other types of abuse and neglect, and with previously high-functioning adults for whom traumatic events have caused a loss of functioning.

Almost 90 percent of the Maine Army National Guard was deployed to Iraq, and returning veterans are experiencing many mental health and addictions issues. The Community Counseling Center offers treatment and support under the leadership of two of the center’s clinicians, who are veterans themselves. Individual and couples’ therapy is offered to veterans and family members. The center also operates a postcombat adjustment group for individuals and families.

Clinical staff have attended week-long training offered by the National Center for Post-Traumatic Stress Disorder, a Department of Veterans Affairs program, to learn how to better meet with combat veterans. Staff also train with veterans affiliated with the local Veterans Center.

No dedicated financing has been identified to support veteran-specific clinical services. However, in 2005, the Community Counseling Center initiated a research project—in collaboration with the Maine National Guard—to identify the types of challenges that members of the Maine Army National Guard face after returning from Iraq. The study also determined the kinds of support and mental health services in which Iraq veterans are interested.

As part of the research project, in 2006, surveys were completed anonymously by Army National Guard personnel in Maine. A total of 532 Guard members were surveyed, of whom 292 were Iraq veterans. Most of the Iraq veterans had returned a year before they completed the survey.

In response to the survey, “Self-reported Mental Health Status and Needs of Iraq War Veterans in the Maine National Guard,” veterans indicated a range of needs:

- 36 percent reported relationship problems with their spouse and children
- 27 percent reported significant depression
- 24 percent reported alcohol abuse
- 43 percent reported problems with anger and aggression.

When analyzed as a group, Army National Guard members who had been deployed to sites other than Iraq generally reported less severe levels of disturbance than Iraq veterans. However, they showed greater levels of combat exposure, life stress, posttraumatic stress symptoms, and problems with alcohol than Guard members who had not been deployed at all.

Veterans’ experiences in the war zone

Responding to the Community Counseling Center’s survey, over three-quarters of Iraq veterans reported that they had been exposed to life-threatening experiences, such as being shot at, going on combat patrol, or otherwise being in danger of being injured or killed. Similar numbers of veterans also had seen dead bodies and/or had known someone who was killed or seriously injured. The severity of these traumatic experiences is highly significant and is in line with the reported severity of combat trauma among members of the Army deployed to Iraq.

Posttraumatic stress reactions

Over one-third of Iraq veterans experienced “hyperarousal” symptoms, the most frequently reported symptoms. These included feeling jumpy or easily startled, feeling keyed-up and irritable, having angry outbursts, having difficulty with sleep and concentration, and generally having a hard time relaxing and letting their guard down.”

Approximately one-quarter of veterans reported “reexperiencing” symptoms, including experiencing flashbacks (when upsetting images of the war zone flashed into their mind, making it difficult to think or concentrate), having nightmares, and feeling very upset and having physical reactions (such as heart pounding, trouble breathing) when something reminded them of a war zone experience.

Nearly one-third of veterans also reported feeling emotionally numb. This included inability to have loving feelings for those close to them, feeling distant and cut off from other people, and losing interest in activities they used to enjoy.

A diagnosis of posttraumatic stress disorder requires that all three of the above types of reactions be strongly present. The Community Counseling Center’s findings indicate that at least 13 percent of Iraq veterans in Maine would qualify for a diagnosis of PTSD. This is similar to published reports of PTSD for members of the Army and Marines who served in Iraq.

One-quarter of Iraq veterans also reported that they drank too much alcohol, which is a common way to avoid upsetting traumatic stress reactions. Unfortunately, alcohol abuse adds to the problems caused by PTSD, interfering with relationships, job performance, and other key areas of functioning.

Depression

About one in four Iraq veterans reported significant symptoms of depression. These symptoms included feeling tired and having little energy, not being interested in pleasurable activities, having poor concentration, and
experiencing changes in appetite and sleep patterns. Depression sometimes causes people to think about hurting or killing themselves, and 1 in 10 Iraq veterans acknowledged such thoughts (among Guard members who had not been deployed, 1 in 14 reported similar thoughts, which is only slightly higher than the rate for the general population).

Effects on relationships, work, and personal life
Iraq veterans face a variety of challenges in readjusting to life with their families and communities. The Community Counseling Center’s research indicates that a year after returning from Iraq, veterans experienced significant stress and problems in relationships with their partners and children. In addition to more interpersonal conflict, veterans indicated that they felt disconnected or detached from loved ones and civilian friends. They frequently reported not having fun in life and not being able to relax. Combat stress reactions, such as problems with anger or concentration, trouble sleeping, or difficulty relating to people, can also make returning to work very difficult. Large numbers of veterans reported significant stress at work. Significant financial stress and physical health problems were also reported.

Interest in mental health treatment
Very few Iraq veterans had sought help for readjustment problems, although roughly one-third of veterans said they were interested in receiving help. Veterans said the kinds of services they were most interested in were support groups with other veterans, individual counseling, education regarding war zone stress and the readjustment process, anger management, and couples’ counseling. Iraq veterans also said they thought family members would be interested in services such as couples’ counseling, support groups for family members, education regarding readjustment issues, and individual counseling.

The Community Counseling Center’s study provides the first systematic assessment of members of the Maine Army National Guard who were deployed to Iraq. Findings indicate that large numbers of Iraq veterans reported mental health problems, as well as significant stress in relationships with family and friends and problems at work. Members of the Guard who were deployed to other sites also reported significant but less severe readjustment issues, consistent with their lower level of combat exposure.

Fortunately, effective, evidence-based treatments exist, and early treatment can prevent worse problems from developing. Needed services include specialized educational support and therapy groups for veterans and their partners, individual and couples’ therapy, groups for children of veterans, and specialized evidenced-based trauma treatments for individuals experiencing significant posttraumatic stress reactions.

To meet the needs of our Maine National Guard citizen soldiers as they return to their families, communities, and workplaces, it is extremely important to have a strong network of services available to them in their communities. In partnership with the Maine National Guard’s Military Adjustment Program Vet Centers and the Veterans Administration, the Community Counseling Center is taking a lead role in Maine to help with the development of a strong network of community providers to help address the needs of returning soldiers and their families.

The Community Counseling Center intends to continue its partnership with the Maine National Guard, participating in weekly pre- and postdeployment veterans gatherings and working to more fully integrate VA facilities and Vet Centers into its service network.


Large numbers of Iraq veterans reported mental health problems, significant stress in relationships with family and friends, and problems at work. However, very few actually sought help, although roughly one-third of veterans said they were interested in receiving help. Veterans were most interested in support groups with other veterans, individual counseling, education for readjustment, anger management, and couples’ counseling.
Finding one's feet in the civilian world after serving in a war zone can be challenging. Soldiers spend months preparing for war before they are deployed to a combat zone. Yet when it's time to return home and face the many demands and stresses of daily living—while trying to recover from the horrors of the battlefield—they're often left to find their own readjustment techniques.

The Minnesota National Guard decided to help its returning veterans avoid this situation by creating a first-in-the-nation program. The program, Beyond The Yellow Ribbon, requires all returning Guard members from the state to attend regular training sessions to address everything from paying bills to reconnecting with family members, with special emphasis placed on negative behaviors associated with combat and deployment stress. The program is groundbreaking because it requires soldiers to attend counseling within 30 days of returning home. The idea is to provide an immediate support structure to soldiers who have no training on how to be civilians again, according to Lt. Col. John Morris, a chaplain in the state National Guard who developed the program at the request of Minnesota Governor Tim Pawlenty.

The Minnesota National Guard's mental health system leaders turned to the state's community mental health and addictions service system for help in providing services to reintegrate soldiers into their communities when an unprecedented 2,600 of them returned home at once in 2007. Beyond the Yellow Ribbon founder Chaplain John Morris's close relationship with Ron Brand, executive director of the Minnesota Association of Community Mental Health Programs, enabled the state to find support in meeting the predeployment, deployment, and postdeployment needs of Minnesota veterans and their families and to raise public awareness of veterans' issues throughout the state.

A special appropriation for the Beyond the Yellow Ribbon program was successfully sponsored by state Senator Norm Coleman to allow the Minnesota National Guard to contract with community mental health agencies to provide services on the lines of Employee Assistance Programs. Family education and supportive counseling are also offered to supplement what is available through the Department of Veterans Affairs system and TRICARE.

Minnesota's community behavioral health agencies—Lakeland Mental Health Center and Sioux Trails Mental Health Center—are assisting with the reintegration. These agencies have been providing a broad range of behavioral healthcare services in the local community for more than 50 years.

Now, with support from the Lutheran Social Services of Minnesota and TriWest Healthcare Alliance, the agencies are making a difference by helping National Guard service members transition back into the demands of civilian and family life. Consultants from the agencies work hand in hand with National Guard units to provide on-site behavioral health resources and education to soldiers.

They are closely involved in the Beyond the Yellow Ribbon, which comprises the following core components:

★ Family Reintegration Academies prepare family members for the homecoming of their soldiers and educate them on what they can do to make the transition as easy as possible. The academies continue to provide resources as family members go through the reintegration process.

★ Monthly Individual Reintegration Training is a 1-day, one-on-one reintegration training event for REFRAD (release from active duty) and MED-HOLD (on medical hold, deemed not deployable for medical reasons) soldiers. This training provides them an opportunity to engage in a conversation about the challenges of reintegration and understand what resources are available.

★ Initial Reintegration Training enrolls all soldiers in the VA, informs them of their veterans’ benefits, and provides them with “10 Commandments of Reintegration” wallet cards.
**Training Event: 30 Days After Return** reconnections soldiers and families with service providers through workshops and round-robin stations. This event allows for more personal contact with service providers so veterans can understand how to access benefits. It includes relationship workshops for married couples and single soldiers, parenting workshops, and a job fair with access to 100 employers looking to hire.

**Training Event: 60 Days After Return** is a unit-focused service that features postdeployment health reassessment and tuberculosis testing for veterans. The event includes counseling in anger management and prevention of gambling abuse and substance abuse. The State Patrol provides a drivers' safety briefing and explains any laws that have changed in Minnesota.

**Training Event: 90 Days After Return** offers a thorough postdeployment health reassessment of combat veterans.

**Community Reintegration Training** educates community leaders about the challenges of reintegration and what they can do to assist combat veterans and their families to successfully reintegrate into the community.

**STRONG BONDS Marriage Enrichment Workshop** is a free, educational, and practical application opportunity to learn what works in marriage (and what makes marriage work).

**Single Service Member Retreat** offers soldiers who have deployed in support of the global war on terror a fun and educational weekend.

The “Roadmap to Reintegration” section of the Beyond the Yellow Ribbon website is comprehensive, current, and easy to use and serves as another valuable resource for veterans. Available in English, Spanish, and Hmong, it offers information and referrals in virtually every area that returning veterans and their families might need to explore. It includes, for example, sections titled Taking Care of Business, Taking Care of Your Health, Taking Care of Your Family, and Taking Care of Benefits, as well as a listing of employment and education opportunities. The website also contains videos and podcasts of training events and special topic presentations, such as the emotional effects of combat, marital issues, parenting, and personal interest stories.

“The support of soldiers cannot end when they return from deployment and the yellow ribbons are untied.”

*Minnesota National Guard, 2006, Bringing Soldiers and Their Families All the Way Home*
Montana’s Community Providers Expand Veterans’ Mental Healthcare

Montana’s four comprehensive mental health centers cover the state’s 56 counties. They offer the full range of treatment and services for mental health and substance use disorders to state residents of all ages in multiple locations.

Montana has just one Department of Veterans Affairs Medical Center, in Helena, to serve the entire state. When the center’s physician retired, the VA Medical Center approached South Central Montana Regional Mental Health Center to purchase psychiatric time for patients being treated by a VA.

Today, three of the community mental health centers—Western Montana Mental Health Center, Center for Mental Health, and South Central Montana Regional Mental Health Center—contract directly with the Montana VA. South Central Montana Regional Mental Health Center subcontracts with Eastern Montana Community Mental Health Center to serve veterans in that catchment area.

Services are available to veterans of any theater of war (e.g., World War II, Vietnam, Grenada). Preauthorization is not required for services at a community mental health center, other than a referral from the local VA office and the transmittal of the veteran’s records. However, none of the contracts allows for services to families of veterans.

United States Senator Max Baucus was instrumental in obtaining funding for the original contracts between the VA and the community mental health centers. Contracts are fee-for-service with a contract cap, which the VA has regularly raised. An inflation factor of 5 percent is built into the contracts. The VA has the option not to renew contracts at the end of each contract year. However, contracts were recently renewed for another 5 years.

Community providers recognize that at the full cost of service, the VA’s reimbursement rate is better than those of virtually all other payers; it is approximately twice that paid by the state mental health agency.

South Central Montana Regional Mental Health Center has three separate contracts with the VA:

- Intensive case management is provided under a statewide, single-source contract. Veterans who need case management outside of the South Central Montana Regional Mental Health Center area are referred to other community mental health centers through contracts with those centers.

- Psychiatric care has been provided in 27 counties since 2002. The psychiatric care contract was expanded in 2003 to include individual therapy. In 2004, the contract was again expanded to include chemical dependency evaluations. Agencies use the TeleMed telemedicine technology to provide services across wide geographic areas. TeleMed ties into a local hospital that connects the doctor with the patient. The connection is free to the community organization, and visits are billed in the same way as face-to-face visits. First visits are not conducted through TeleMed, although subsequent visits may be.

- Readjustment counseling is available to combat veterans who self-refer as long as they served in a conflict area during wartime.

Before the VA contracted with Montana’s community mental health centers, veterans typically had to wait 6 to 8 months for services on an outpatient basis. The turnaround time now is 10 days or less if urgent care is needed.
Services do not cover prescription medications and may not exceed 1 hour per week, and there are limitations on chemical dependency services. Community mental health centers are forbidden to advertise the service under the terms of the contract because it is a function of the VA.

The Center for Mental Health has established a Military Affairs Division to coordinate an array of specific treatment services for veterans, active-duty members of the military, and their families. The Center provides targeted training for clinical staff to meet the treatment needs of veterans. In addition to outpatient psychiatric services under contract with the VA, the Center provides over 90 percent of the inpatient psychiatric and chemical dependency physician services in the region. In 2006, the Center provided 15,781 contacts with individuals identified as veterans, with a total of 100,439 hours of treatment, group home care, assertive community treatment, adult foster care, and other services. It piloted the first certified Peer Support program in Montana and engages veterans as peer specialists to provide support to their colleagues. The Center is currently negotiating a contract to provide dedicated beds for homeless veterans in its Community Transitional Living Center. It has a state-of-the-art electronic medical record system and is a member of the REACH telemedicine network, with the capacity to link with hospitals worldwide, including in Iraq.

The Western Montana Mental Health Center has managed to fill another void for returning veterans by helping them find employment and providing vocational services. The center offers outpatient therapy, individual and group therapy, crisis services, and case management to high-needs veterans who may be suffering from schizophrenia or bipolar disorder.

The number of veterans referred to each of the community mental health centers has far outpaced the VA’s original estimates. South Central Montana saw 600 veterans during the first 6 months, although the VA estimated that no more than 150 veterans would be referred for service in the first year. In 2006 alone, nearly 2,000 veterans received care at community mental health centers.

Before the VA contracted with Montana’s community mental health centers, veterans typically had to wait 6 to 8 months for services on an outpatient basis. The turnaround time now is 10 days or less if urgent care is needed.

Community mental health centers must comply with the VA’s electronic health record-keeping requirements. However, the VA does not require demographic reporting or accounting of the number of people served as part of the contracts.

Montana’s community mental health centers involve veterans in providing services to veterans.

South Central Montana’s medical director is a decorated Vietnam veteran, and its three senior clinicians are veterans as well. Center staff are working to engage Montana’s Disabled American Veterans chapter to serve as a bridge to other veterans’ organizations.

South Central Montana is currently negotiating with the VA to expand services to include chemical dependency and co-occurring disorder services. The center also plans to expand its veterans-oriented services by providing counseling to families. Montana’s VA medical director is interested in recovery and peer-to-peer services, which opens up new possibilities for the community mental health centers that have served veterans’ needs so well in recent years.

In 2006, the Center for Mental Health provided **15,781** contacts with veterans, with a total of **100,439 hours of treatment**, group home care, assertive community treatment, adult foster care, and other services.

<table>
<thead>
<tr>
<th></th>
<th>South Central</th>
<th>Center for MH</th>
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<tbody>
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</table>

CMHCs: Community Mental Health Centers
Life, liberty, and the pursuit of happiness—these are the rights our veterans have fought to preserve for us and for people around the world. A key element of those rights is the ability to live in the community of one’s choice, surrounded by family and friends.

It is therefore ironic that veterans make up almost one-quarter of the nation’s homeless population. The majority are single men from disadvantaged backgrounds who served overseas, only to return home and learn that the war traveled back with them in the form of anxiety, depression, flashbacks, and drug dependence. More than 70 percent of homeless veterans struggle with alcohol or drug use, and about 45 percent suffer from mental illness; often, these conditions are co-occurring.

The picture in New York City mirrors the national one. As of early July 2008, 585 veterans were served in the city’s Department of Homeless Services shelter system, and approximately 750 were living on the streets.

In 2006, New York City Mayor Michael R. Bloomberg and VA Secretary Jim Nicholson announced an historic agreement to end veteran homelessness in New York City. A year later, DHS, which leads the initiative on behalf of the city, sought a nonprofit partner to take charge of the Borden Avenue Veterans’ Residence in Long Island City, NY. After a competitive bid process, the contract for the 243-bed BAVR was awarded to the Institute for Community Living, a major community-based behavioral healthcare network that has been working to assist the homeless for years. The goal was to establish an innovative short-term transitional housing program for homeless veterans. ICL assumed operating responsibility for the facility on July 1, 2008.

**Service Delivery Model**

As part of its stewardship of the BAVR, ICL is implementing a new social services program—the remodeled residence provides veterans semiprivate or private rooms rather than the large congregate living spaces that characterize city shelters. Rooms are grouped into communities distinguished by the names of “Medal of Honor” winners, and stories of veterans courage are posted nearby. Like the architectural plan, ICL services are formulated to acknowledge the personal strengths of clients and their contributions to the country and to help them through the challenges they face in their recovery.
As part of ICL's support (which includes a room and meals), residents are assigned a case manager to organize the extensive array of services available to them. The case manager-to-client ratio is 1:20. Case managers are part of a multidisciplinary onsite team of mental health, substance abuse, and healthcare staff who work closely with VA and other community providers to collaborate with each resident in creating an Individual Living Plan. The plans are based on a thorough assessment of client background, needs, and preferences and incorporate services drawn from a comprehensive menu of strength-based onsite and community services, which are available from ICL's citywide services, the VA, and other providers.

Individual Living Plans aim to place each veteran in permanent housing within 90 days and provide the necessary supports to ensure permanency, including:
- Community skills development
- Employment assistance
- Mental health support and referral
- Sobriety promotion and harm-reduction service planning
- Recreation and community integration
- Healthcare support services.

All services are informed, wherever possible, by an integrated bundle of five evidence-based practices, or “best practices” recognized by the Substance Abuse and Mental Health Services Administration:
1. Critical time intervention case management
2. Illness management and recovery
3. Motivational interviewing
4. Case Management and Substance Abuse Treatment (Treatment Improvement Protocol 276)
5. Substance Abuse Treatment for Persons with HIV/AIDS (TIP 377).

The delivery of services is guided by awareness of military traditions as well as the history of trauma that many homeless veterans bear from both service-related and postdischarge events. When no clearly defined evidence-based practice exists to fill a specific program purpose, the activities of program case managers and the other social service specialists are determined by the best practices of their specific discipline (substance abuse treatment, employment counseling, recovery, etc.). Ongoing modifications are made as evidence-based practices become available.

Despite the complexity of the co-occurring conditions that are seen at high frequency among people who are homeless, ICL anticipates that the BAVR will yield housing placement and stability outcomes that exceed those resulting from standard approaches for this population. ICL views BAVR as a model for the next generation of services for homeless veterans, which will focus on continuous quality improvement and ensure that services to each veteran are appropriate and effective for his or her individual needs. To that end, ICL will be seeking additional partnerships with providers and researchers to create a viable and effective safety net for our veterans.
The Rhode Island Council of Community Mental Health Organizations is composed of Rhode Island’s private, nonprofit community mental health organizations as well as a few general hospitals providing mental health and addictions services. Established in 1979, RICCMHO is an effective conduit through which member organizations channel their collective expertise to form a united voice of public advocacy for those with mental illnesses and substance use disorders.

RICCMHO primarily offers training and consultation in developing predeployment, deployment, and postdeployment support services for veterans through its partnerships with community providers, family members of veterans, Department of Veterans Affairs staff, and other experts in the state. A small amount of funding for the training activities was made available through a private, in-state foundation; otherwise, all expenses are supported through RICCMHO’s current budget. Behavioral health services delivered by community providers to veterans are reimbursed by commercial insurance plans available to some Guard members and reservists through their employers.

RICCMHO launched its Operation Iraqi Freedom and Operation Enduring Freedom veterans and family training activities through the New England Addictions Technology Transfer Center, whose former director, Susan Storti, contacted the National Council in 2005. As a nurse, educator, and community organizer, Storti knew how the military operated and encouraged RICCMHO to establish relationships with key military personnel. A planning meeting followed, which included mental health and addictions professionals, education representatives, VA staff, veterans’ family members, and other advocates. VA staff expressed concern that they would not be able to fully meet the behavioral health needs of returning veterans and family members, in part because stigma among veterans would reduce contact with the VA system. Stakeholders then prepared a draft document outlining initial plans for a system of care that would respond to the needs of veterans and their families.

In March 2006, both the National Guard and the VA Medical Center began implementing the recommendations of the blueprint. Training on veterans’ issues is now offered in a series of workshops, with curricula developed by community mental health, addictions, and VA staff. Continuing education units will soon be available for some disciplines.

RICCMHO is working to add peer facilitators and peer support coordinators through its veterans’ and family program. Active and retired military veterans and family members will be trained in counseling and support according to training models that are now being evaluated for effectiveness.

A May 2005 conference brought together community service providers to discuss posttraumatic stress disorder, the effects of traumatic brain injury, insurance reimbursement issues, and other key concerns. Rhode Island’s governor and the adjutant general of the National Guard confirmed the importance of mental health services for OIF and OEF veterans as a public health issue.

The Rhode Island Blueprint for veterans’ services evolved after the conference. A system design team continued to meet to clarify the mission of the blueprint and to map out needs, resources, and strategies. This team evolved into the Veterans Task Force of Rhode Island. The task force meets periodically to keep all involved groups and people informed and to address new issues and ideas collaboratively or with an identified member taking the lead.

Department of Veterans Affairs staff expressed concern that they would not be able to fully meet the behavioral health needs of returning veterans and family members, in part because the stigma among veterans would reduce contact with the VA system.
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The Road Home

Texas Fosters Partnerships for Care

Leon Evans, Executive Director; and James Castro, Director of Child and Family Development and Veterans Program Contact—Center for Health Care Services

The Center for Health Care Services, in San Antonio, Texas, is the mental health authority for Bexar County and provides substance abuse and mental retardation services for the area’s civilian population. CHCS employs more than 700 staff and serves 20,000 patients, with an annual budget averaging $50 million.

Known as Military City USA, San Antonio is home to approximately 150,000 veterans, nearly 30 percent of whom are retirees. The city houses three active military bases: Lackland Air Force Base, Randolph Air Force Base, and Fort Sam Houston. Two former bases, Brooks City Base and Kelly USA, also provide military contracting supports and local city commerce. San Antonio’s veterans are served by three military hospitals—Brooke Army Medical Center, Wilford Hall Medical Center, and Audie L. Murphy Memorial Veterans Hospital.

CHCS helps meet the mental health needs of San Antonio’s veterans and their families primarily through two projects, Operation Reunion and the Texas Youth Suicide Prevention Project. Both projects address a growing need in the community that the military hospitals cannot handle alone. Together, these projects account for over $400,000 a year in new revenue for CHCS and have led to numerous referrals for the full array of services that CHCS offers. The agency identifies behavioral health services the military is providing to veterans and families in its facilities and helps to supplement these services and adapt them to the community setting.

CHCS’s opportunities to provide mental healthcare to veterans and their families resulted from strategic partnerships with local military hospitals and other community agencies. Executive Director Leon Evans is committed to partnerships and collaborations in all program and service areas.

Partnerships with the three local military hospitals, the U.S. Department of Defense’s Center for Deployment Psychology, the U.S. Air Force, and the Carl R. Darnell Army Medical Center (to assist TRICARE and active-duty personnel) served to engage the CHCS with the military. In addition, partnerships with the University of Texas Health Sciences Center and with local child and adolescent mental health hospitals that provide services to children of wounded soldiers have enabled CHCS to get involved in veterans’ services.

In August 2006, Evans met with the Brooke Army Medical Center’s Col. Elizabeth Stafford, a pediatrician specializing in the challenges and traumas children face on account of their parents’ deployment and injuries. CHCS executives also met with the chief of staff for U.S. Senator Kay Bailey Hutchinson and National Council Executive Vice President Jeannie Campbell in the course of building partnerships.

In 2007, the Texas Department of State Health Services awarded CHCS a grant directed toward youth suicide prevention. The agency invited key military leadership to participate in this project. The Texas Youth Suicide Prevention Project involves local schools, the Brooke Army Medical Center’s Departments of Pediatrics and Behavioral Medicine, and the independent school district at Fort Sam Houston.
For CHCS, opportunities to provide mental healthcare to veterans and their families resulted from strategic partnerships with local military hospitals and other community agencies. CHCS identifies behavioral health services the military is providing to veterans and families in its facilities and helps to supplement these services and adapt them to the community setting.

CHCS hosts frequent meetings and sponsors forums that bring veterans’ groups together to discuss their mental health and other needs. The agency also supports the community collaborative, Military Coordinating Council for Behavioral Health, headed by Col. Bruce, chief of behavioral medicine at Brooke Army Medical Center and clinical psychology consultant to the U.S. Army Surgeon General.

Operation Reunion
CHCS’s Operation Reunion began with receipt of a grant from a local foundation to provide psychoeducational classes for military family members of wounded soldiers. Classes teach coping strategies and ways to identify and obtain assistance should participants feel themselves or other family members to be at risk for developing mental health problems related to their military family member’s injury. The group format educates family caretakers, facilitates communication with the transitioning veteran, provides awareness and early identification of mental health symptoms, teaches the family how to advocate for services using newly acquired language and knowledge, prepares them for reunions with other loved ones, and promotes the involvement of the injured soldier in the parenting process. Substance abuse treatment is also provided for veterans.

At CHCS, the focus is primarily on care and supports that help military personnel and families reintegrate into the community and access all community services and resources. The agency provides educational group sessions on mental health issues related to deployment, combat, and relationships; impact on child development in response to stressors; and relaxation techniques. To serve military family members who are temporarily residing in San Antonio while their active military soldier receives medical care from Brooke Army Medical Center, CHCS helps them link to mental health and other community services. The agency also educates them on how to access mental health services once the family return to their home community.

CHCS staff receive cultural competency training so they can work more effectively with military personnel and their families.

Texas Youth Suicide Prevention Project
This collaboration is the only federally initiated effort of its kind in Texas and the only suicide prevention program that specifically addresses the needs of the military-dependent population in the United States.

The project is compiling data on the prevalence of suicidal ideation in youths ages 10 to 19 in a local military-dependent population and is assessing the impact of multiple geographic moves and deployments and of having a wounded family member in the household on the emotional functioning of youths.

Military parents are provided a consent form asking whether they would like their child to participate in a study that evaluates for risks of depression or suicide. The screening sites are at Fort Sam Houston Elementary School, the Robert G. Cole Junior and Senior High School clinic, and the Brooke Army Medical Center Pediatric Clinic. The screening tool is administered by a master’s level clinician, licensed professional counselor, psychologist, pediatrician, or registered nurse. The individual’s score on the screening instrument determines the future course of treatment and action, if any, which may include further mental health assessment, hospitalization, or other community support.

CHCS is frequently invited into discussions by the military and other community service providers to determine how to enhance and add services for veterans. Through the Suicide Prevention Project, CHCS continues to learn a great deal about military life in terms of service barriers and gaps. A very open line of communication exists with Brooke Army Medical Center’s Departments of Behavioral Medicine and Pediatrics, the Fort Sam Houston Independent School District health clinic, and the school staff.

Veterans’ Involvement in Providing Services
CHCS employs many retired and former military service members. This provides credibility and prestige to the services offered to the community and helps build trust with military personnel who come for services.

Military culture and other specialized trainings are provided to clinical staff. Family Strong, a volunteer military family advocacy group for military families with special needs children, trains CHCS clinical staff on relevant military competencies. Discussions are underway for CHCS’s clinical staff to participate in internal trainings provided at Brooke Army Medical Center as part of normal clinical training rotations.

Plans to Alter or Expand Services
CHCS is now seeking resources and support for a Multiple Access Portal model to complement services of military hospitals and Veterans Administration clinics. The MAP model would enable military service members and their children, spouses, or primary caregivers to identify, access, and obtain mental health and substance abuse services anywhere in the country. This goal can be accomplished through the nationwide network of community mental health organizations, which have the expertise to mobilize and operate within a MAP framework while collaborating with military institutions.
Washington Supplements VA Services with Community Care

Faith Richie, MBA, Chief Executive Officer; and Scott Swaim, MA, LMHC, Director of Veterans Services—Valley Cities Counseling and Consultation

Valley Cities Counseling and Consultation is a private, nonprofit behavioral health organization serving South King County in Washington state since 1965. Located just south of Seattle, Valley Cities offers a wide array of services for children, adults, and families with mental illness and addiction disorders. The agency’s financial support comes from multiple sources, including Medicaid funds through King County’s Prepaid Health Plan, Medicare, the Department of Children and Family Services, the United Way, public schools, individual program fees, Employee Assistance Program benefits, insurance, and managed care benefits. The agency has an annual budget of $10.4 million and employs approximately 200 people.

In November 2005, voters in King County passed a Veterans and Human Service Levy of 5 cents per $1,000 of appraised property valuation for 6 years, estimated to raise $13.3 million per year. Half of the funds raised annually are intended to support veterans’ services, and half will fund human services for nonveterans. The levy enabled King County to contract with various community agencies to provide veterans’ services, including education and awareness, clinical supervision and training, outreach, and clinical services. Levy funds are also committed to capital projects, such as housing development.

The levy initiated Valley Cities’ efforts to serve veterans and their families. These efforts were boosted with the Government Accountability Office’s report on posttraumatic stress disorder, which led Valley Cities to form a work group to examine:

- The number of veterans the agency was serving
- The methods of facilitating working relationships with the Department of Veterans Affairs and other military partners
- The agency’s capacities and expertise in serving veterans and their families.

Valley Cities also became the first program in the state to enter into partnership with the Washington State Department of Veterans Affairs Trauma and PTSD programming, in October 2006. Valley Cities contracts with the WDVA on a fee-for-service basis to provide services. The agency also has specific grants to serve the family of deployed servicemembers, operate a supportive housing project with 12 units for veterans, conduct two pilot programs partnering with public health for extensive outreach to veterans, and provide trauma screening services and linkage.

Valley Cities’ Veterans Services Program provides a range of clinical services for military personnel and veterans. The agency offers trauma screening for combat stress and PTSD and other mental health services to 120 National Guard members and Reservists in Auburn, Federal Way, Kent, and the Seattle metropolitan area. In partnership with the Washington National Guard, Valley Cities provides support and training for family members on reunion and adjustment issues before, during, and after deployment.

Mental health professionals who are knowledgeable about veterans’ issues and experiences offer clinical services, including individual, group, and family counseling. Screening is offered to returning veterans of Operation Iraqi Freedom and Operation Enduring Freedom. Psychiatric services are provided on site or through the VA. Staff also provide consultation to schools and community agencies on issues unique to serving military members, veterans, and their families.

Valley Cities focused its initial efforts on establishing good relationships with key veterans’ organizations, including federal, state, and county veterans’ affairs staff, Veterans of Foreign Wars, the American Legion, and the Disabled American Veterans. These new relationships have led to a better understanding of the three major systems of care—military (including TriCare), VA, and civilian (community mental health centers)—and how they can interact to facilitate better care. These relationships were instrumental in obtaining the contract with the VA and improving Valley Cities’ services to veterans and their families. Outreach to schools and local employers has addressed veterans’ and family issues and services, which helped to get support for the Veterans and Human Services levy.

Valley Cities is also working with the Muckleshoot Indian tribe to provide mental health services to the tribe’s veterans.

Valley Cities notes that National Guard members and reservists are concerned about the possibility of clinical services information getting back to the military. Veterans on staff are able to address these fears and help create a positive experience. Valley Cities provides service utilization numbers to the VA but no individual identifying information.

Veterans’ involvement in providing services

Having veterans on staff is a great benefit for services and for connectivity to the systems of care. Scott Swaim, the coordinator of the Valley Cities Veterans Program, is a veteran who delivers clinical services and belongs to local chapters of the DAV, the American Legion, the VFW, and the Seattle/King County Veterans Consortium. Valley Cities is reaching out to these and other
Providing staff with information that compares civilian to military life is essential to ensure that staff are culturally competent to serve veterans. This information includes orientation to military terminology, the roles of the various veteran organizations, and some insight into the military experience at an emotional and structural level.

Valley Cities began to educate its clinical staff by completing a 2-hour Introduction and Orientation to Military Life training session with 70 of its staff members. Of the agency's total staff, just 5 are veterans (2 of whom have spouses deployed with OIF or OEF). Providing staff with information that compares civilian to military life is essential to ensure that they are culturally competent to serve veterans. This information includes orientation to military terminology, the roles of the various veteran organizations, and some insight into the military experience at an emotional and structural level.

Valley Cities expects to dedicate significant additional time and attention in training staff on issues related especially to PTSD and evidence-based practices.

Valley Cities has gained exceptional experience on various levels by investing the time and resources to serve veterans and their families. The agency has created a new veterans department to focus the resources and programs and continue to improve service, access, and support for veterans and their families. In addition, it is developing new linkages to VA Homeless programs and employment services.

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CHFF is sponsored by the National Council for Community Behavioral Healthcare and the U.S. Psychiatric Rehabilitation Association. Funded by the Robert Wood Johnson Foundation and organized as a 501(c)(3) tax-exempt entity, CHFF's mission is to improve access to capital for community-based behavioral healthcare providers.

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In May 2008, Give an Hour—a nonprofit 501(c)(3) founded in September 2005 by Barbara V. Romberg, a licensed clinical psychologist—partnered with the American Psychiatric Foundation—the philanthropic and educational arm of the American Psychiatric Association—to launch a nationwide effort to help answer the unmet mental health needs of U.S. veterans returning from Iraq and Afghanistan.

GAH and APF are using a $1 million grant from the Lilly Foundation to recruit and educate volunteer mental health professionals, who become part of a network aiming to bridge the gap in mental health services for soldiers returning from service and their families. The foundation’s goal is to recruit 10 percent of the 400,000 mental health professionals in the United States by 2011 to help address postwar mental health issues such as posttraumatic stress disorder, traumatic brain injury, drug abuse, anxiety, and depression.

GAH points out that the Department of Defense is making an unprecedented attempt to encourage personnel to seek mental health treatment, but a significant increase in demand in some areas has forced the rationing of services, created long waiting lists, and limited individual counseling sessions. In addition, some members of military families, such as parents, siblings, and unmarried partners, do not qualify for care through the Veterans Administration or DoD but are affected nonetheless by the mental health of the veteran.

Another major barrier preventing military personnel from seeking appropriate treatment is the perception of stigma associated with mental healthcare. Many people fear that seeking mental health services will jeopardize their career or standing. Others are reluctant to expose their vulnerabilities to counselors who are often military personnel themselves, given the military culture’s emphasis on strength, confidence, and bravery. Service members might be more inclined to seek help if they knew that the services provided are completely independent of the military.

“This [Lilly] grant will allow us to get out the message that help is available. We want to normalize what our military personnel and their families are experiencing and support the sacrifices that they are making by providing critical mental health support at no cost,” said Romberg, president of GAH. “We will be educating the military community and broader public about these mental health needs in hope of helping veterans keep their lives and families intact.”

GAH is recruiting mental health professionals to volunteer 1 hour each week for a minimum of one year to provide direct services in person, by phone, or in consultation with schools and community organizations that serve the military community. Services are wide ranging and include marital and family therapy, substance abuse counseling, and treatment for PTSD. APF brings strong ties to the psychiatric community and is actively encouraging psychiatrists to join the network.

Only licensed mental health professionals are included in the network. Licenses are verified. Nonlicensed pastoral counselors may be included in the network as long as they meet other criteria, including membership in professional organizations. Volunteers including retired military personnel, members of military families, and concerned civilians throughout the country are helping GAH. Volunteers are checking licenses, distributing brochures, and coordinating community partnership opportunities for troops and family members interested in giving back an hour to their own community.

GAH is reaching out to the military community in several ways. As a member of America Supports You, a DoD program that provides opportunities for citizens to show their support for the U.S. Armed Forces, GAH identifies people involved in postdeployment processing of returning troops. GAH develops collaborative relationships with the commanding officers of returning troops so that the officers are aware of and comfortable with the services it provides. GAH also works closely with a number of veterans service organizations to promote services directly to the family members of troops.

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In this election year, there is a lot of talk about the value of veterans and the desire to help them readjust back to a “normal” life. I am proud to be associated with an organization that reaches out to veterans, that makes accommodations for disabilities and truly appreciates sacrifices that were made. In addition, LWISL software helps other organizations improve the quality of behavioral healthcare provided to veterans and others in need of a little assistance.

Retired Army Sergeant Tim McClaughry

Valley Cities is proud to provide services to our military members, veterans and their families, with a staff that understands the unique needs and experiences of those that serve. For more information on services please visit our website at www.valleycities.org.

Van Buren CMH proudly serves the mental health needs of the veterans, military staff and families in our community. Our professional staff are dedicated to providing unparalleled care with respect to the diversity, needs and rights of each individual. For more information on accessing services visit www.vbcmh.com or call 269-657-5574. 24-hour crisis: 1-800-922-1418

The Mental Health Center of Denver recognizes the contributions and sacrifices made by all our service men and women and how vital they are to maintaining the freedom and way of life we all enjoy.

Andrews Center supports our troops! Free counseling, anger management and substance abuse services are available for East Texas troops and their family members. All services are free and do not enter into a person’s military record! For more information call Carla Carlock-Self at 800-374-6058 ext. 476.

Sciacc Comprehensive Service Development for MIDAA extends heart felt gratitude to our veterans and is an advocate for their well being. Kathleen Sciacca provides dual diagnosis and motivational interviewing training and program development to providers at VA Centers. Visit us at www.pobox.com/~dualdiagnosis or email Kathleen at ksciacca@pobox.com

On behalf of the Board of Director’s and staff of The Harbor Behavioral Health Care Institute, we want to express our deepest appreciation to the brave men and women (and their families) who have answered the call to serve and protect this Nation. These exceptional individuals have made significant sacrifices so that others will not have to.

Wish to Honor Those Who are Protecting Our Freedoms

Helping people lead better lives by providing comprehensive care for crisis, addiction and mental health recovery. We thank our troops and their families for their dedication and sacrifice and we support them in making a safe and healthy return to their communities.

Occupational Therapy: Helping Veterans Live Life to Its Fullest

Thank You.
LWSI offers a software solution, Essentia, that has resulted in definable repeatable processes that reduce the risk of being non-compliant, enhance clinicians’ time to perform treatments, and increases agency revenue. Our customers are maintaining current headcount and increasing productivity.
You stood tall. You stood proud. You stood shoulder to shoulder.

We will always be grateful. We will always remember.

Because when your Nation called, you were there.